

Application for Adjudication of Claim

OCR form sample packet

This packet contains instructions on how to fill in Optical Character Recognition (OCR) forms, examples of forms and is in the order in which they should be filed with the district office.

Use the table below to help identify the forms that you need to complete when filing an application for adjudication of claim. The table also shows the order in which the forms should be assembled. To help you find the correct document separator sheet, the product delivery unit, document type and document title are in brackets.

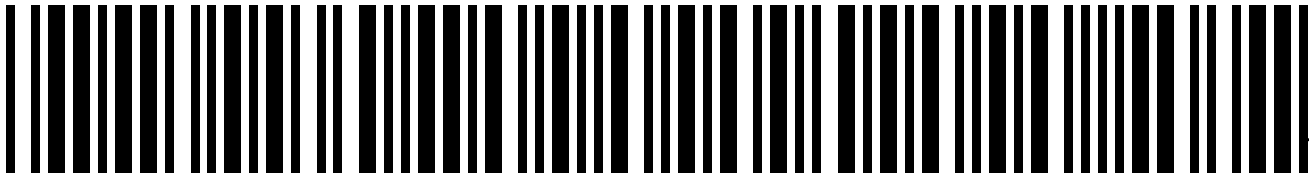
In this packet, you will see examples as filed by the applicant attorney for injured worker. If a lien claimant is filing the forms, then complete and submit the documents identified in this reference table.

	Name of form	Applicant attorney for injured worker	Claims administrator and/or defense attorney	Lien claimant
1	Document cover sheet	x	x	x
2	Document separator sheet	x	x	x
3	Application for adjudication of claim	x	x	x
4	Document separator sheet for labor code section 4906(g) [ADJ-LEGAL DOCS-4906(g) DECLARATION]	x	x	x
5	All declarations pursuant to labor code section 4906(g)	x	x	x
6	Document separator sheet for fee disclosure statement [ADJ-LEGAL DOCS-FEE DISCLOSURE STATEMENT]	x		
7	Fee disclosure statement	x		
8	Document separator sheet for venue authorization [ADJ-LEGAL DOCS-VENUE VERIFICATION]	x		
9	Venue authorization	x		
10	Document separator sheet for lien verification [ADJ-LEGAL DOCS-10770.5 VERIFICATION]			x
11	Lien verification §10770.5			x
12	Document separator sheet for proof of service [ADJ-LEGAL DOCS-PROOF OF SERVICE]	x	x	x
13	Proof of service	x	x	x

This packet is an example of how to fill in forms and the order in which they should be filed with the district office.

STATE OF CALIFORNIA
DWC DISTRICT OFFICE
DOCUMENT COVER SHEET

This example shows documents submitted by a represented injured worker.



Is this a new case? Yes ☒ No ☐ Companion Cases Exist ☐ Walkthrough Yes ☐ No ☐

CHECK "YES" BOX ONLY

DO NOT CHECK THIS BOX

DO NOT CHECK BOXES

More than 15 Companion Cases ☐

09/10/2008 DATE YOU FILL OUT DOCUMENT COVER SHEET

Date:(MM/DD/YYYY)

THERE IS NO CASE NUMBER FOR APPLICATION FOR ADJUDICATION LEAVE BLANK.

Case Number 1

☐ Specific Injury

☐ Cumulative Injury 11/02/2007 (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

IF CUMULATIVE INJURY MUST ENTER START AND END DATE USING MM/DD/YYYY.

SEE BODY PART NUMBER LIST ON PAGE 8

Body Part 1: 420



Body Part 3:

Body Part 2: 100

Body Part 4:

WHEN MORE THAN 5 BODY PARTS USE BODY PART NUMBER 700 IN THIS FIELD

Other Body Parts:

Please check unit to be filed on (check only one box)

☐ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ INT ☐ RSU

Companion Cases

☐ Specific Injury

Case Number 2 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

Body Part 3:

Body Part 2:

Body Part 4:

Other Body Parts:

Example

☐ Specific Injury

Case Number 3

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____

☐ Specific Injury

Case Number 4

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____

Do NOT print or submit blank page(s).

☐ Specific Injury

Case Number 5

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____

Example

District office codes for place of venue

Legend	
Abbreviation	Office
AHM	Anaheim
ANA	Santa Ana
BAK	Bakersfield
EUR	Eureka
FRE	Fresno
GOL	Goleta
LAO	Los Angeles
LBO	Long Beach
MDR	Marina del Rey
OAK	Oakland
OXN	Oxnard
POM	Pomona
RDG	Redding
RIV	Riverside
SAC	Sacramento
SAL	Salinas
SBR	San Bernardino
SDO	San Diego
SFO	San Francisco
SJO	San Jose
SLO	San Luis Obispo
SRO	Santa Rosa
STK	Stockton
VNO	Van Nuys

Use this document to complete forms, but do not file this document with your forms.

DO NOT PRINT OR
SUBMIT THIS PAGE.

Body Part Code List

The body part codes listed below are used to complete forms that require the listing of the part of the body that is in issue. Please do not file this document with your forms.

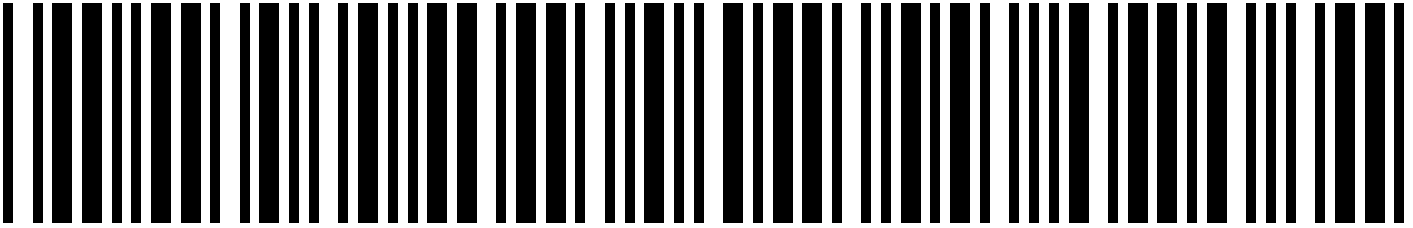
100	Head - not specified	500	Lower extremities - not specified
110	Brain	510	Legs - above ankles, not specified
120	Ear - not specified	511	Thigh femur
121	Ear - external	513	Knee Patella
124	Ear - internal including hearing	515	Lower leg tibia and fibula
130	Eye - including optic nerves and vision	518	Leg - multiple parts any combination of above parts
140	Face - not specified	519	Leg - not specified
141	Jaw - including chin and mandible	520	Ankle malleolus
144	Mouth - including lips, tongue, throat and taste	530	Foot not ankle or toe
145	Teeth	540	Toes
146	Nose - including nasal passages, sinus and smell	598	Lower extremities - multiple parts any combination of above parts
148	Face - multiple parts any combination of above parts	700	Multiple parts more than five major parts use only in fifth position of listing of body parts
149	Face - forehead, cheeks, eyelids	800	Body system - not specific
150	Scalp	801	Circulatory system - heart -other than heart attack, blood, arteries,veins, etc.
160	Skull	802	Circulatory system - Heart attack
198	Head - multiple injury any combination of above parts	810	Digestive system - stomach
200	Neck	820	Excretory system - kidneys, bladder, intestines, etc.
300	Upper extremities - not specified	830	Musculo-skeletal system - bones, joints, tendons, muscles, etc.
310	Arm - above wrist not specified	840	Nervous system - not specified
311	Arm - upper arm humerus	841	Nervous system - stress
313	Arm - elbow head of radius	842	Nervous system - Psychiatric/psych
315	Arm -forearm radius and ulna	850	Respiratory system - lungs, trachea, etc.
318	Arm - multiple parts any combination of above parts	860	Skin dermatitis, etc.
319	Arm - not specified	870	Reproductive systems
320	Wrist	880	Other body systems
330	Hand - not wrist or fingers	999	Unclassified - insufficient information to identify body parts
340	Fingers		
398	Upper extremities - multiple parts any combination of above parts		
400	Trunk - not specified		
410	Abdomen - including internal organs and groin		
411	Hernia		
420	Back - including back muscles, spine and spinal cord		
430	Chest - including ribs, breast bone and internal organs of the chest		
440	Hips - including pelvis, pelvic organs, tailbone, coccyx and buttocks		
450	Shoulders - scapula and clavicle		
498	Trunk - use for side; multiple parts any combination of above parts		

Do NOT print or submit this page

Use this document to complete forms, but do not file this document with your forms.

Example

DOCUMENT SEPARATOR SHEET



Product Delivery Unit

ADJ

Document Type

LEGAL DOCS

Document Title

APPLICATION FOR ADJUDICATION

Document Date

04/16/2008

DATE OF DOCUMENT FOLLOWING
DOCUMENT SEPARATOR SHEET

MM/DD/YYYY

Author

UNIFORM ASSIGNED NAME

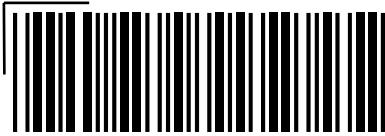
IF YOU ARE A CLAIMS ADMINISTRATOR,
HEARING REPRESENTATIVE OFFICE OR LAW
FIRM, USE YOUR OFFICE'S UNIFORM
ASSIGNED NAME. FOR ALL OTHERS ENTER
YOUR NAME.

Office Use Only

Received Date

MM/DD/YYYY

Example



STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
APPLICATION FOR ADJUDICATION OF CLAIM



NO CASE NUMBER - LEAVE BLANK

☐ Amended Application

Case No.

SEE PAGE 6 FOR ADDITIONAL INSTRUCTIONS ON COMPLETING THIS FORM.

SSN (Numbers Only)

Venue choice is based upon (Completion of this section is required)

- ☒ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)
- ☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)
- ☐ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

VNO

3 DIGIT OFFICE CODE MUST BE IN COUNTY OF BOX CHECKED ABOVE

Select 3 - Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Injured Worker (Completion of this section is required)

JOHN

First Name

MI

MILLER

Last Name

1234 WILLOW ROAD

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

International Address (Please leave blank spaces between numbers, names or words)

VAN NUYS

City

CA

State

91401

Zip Code

Applicant (If other than Injured Worker)

☐ Insurance Carrier ☐ Employer ☐ Lien Claimant

Name (Please leave

USE THE UNIFORM ASSIGNED NAME AND ADDRESS FOR THE CLAIMS ADMINISTRATOR, IF YOU ARE AN INSURANCE CARRIER. USE YOUR NAME AND ADDRESS, IF YOU ARE AN EMPLOYER OR A LIEN CLAIMANT.

Street Address/PO

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Example

Employer Information (Completion of this section is required) **MUST CHECK ONE BOX**

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

COMPANY INJURED EMPLOYEE WORKED FOR AT TIME OF INJURY

Employer Name (Please leave blank spaces between numbers, names or words)

COMPANY ADDRESS - MUST INCLUDE STREET ADDRESS OR PO BOX NUMBER

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

MUST INCLUDE CITY, STATE AND ZIP CODE

City State Zip Code

Insurance Carrier Information (If known and if applicable - include even if carrier is adjusted by claims administrator)

NAME OF EMPLOYER'S INSURANCE CARRIER

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

INSURANCE CARRIER'S ADDRESS - MUST INCLUDE STREET ADDRESS OR PO BOX NUMBER

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

MUST INCLUDE CITY, STATE AND ZIP CODE

City State Zip Code

Claims Administrator Information (If known and if applicable)

UNIFORM ASSIGNED NAME OF CLAIMS ADMINISTRATOR

Name (Please leave blank spaces between numbers, names or words)

CLAIMS ADMINISTRATOR ADDRESS - MUST USE THE ONE IN UAN DATABASE.

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

MUST INCLUDE CITY, STATE AND ZIP CODE

City State Zip Code

CLAIMS ADMINISTRATOR MEANS A SELF-ADMINISTERED INSURER, A SELF ADMINISTERED SELF-INSURED EMPLOYER, A SELF-ADMINISTERED JOINT POWERS AUTHORITY, A SELF-ADMINISTERED LEGALLY UNINSURED OR A THIRD PARTY ADMINISTRATOR.

IT IS CLAIMED THAT (Complete all relevant information):

MUST INCLUDE INJURED EMPLOYEE'S DATE OF BIRTH

1. The injured worker, born _____, while employed as a(n) _____
(DATE OF BIRTH: MM/DD/YYYY) (OCCUPATION AT THE TIME OF INJURY)

JOB TITLE WHEN INJURED

(Choose only one)

☐ specific injury

DATE OF ACCIDENT

(Date of injury: MM/DD/YYYY)

INJURY DATE/S MUST MATCH DATE/S INDICATED ON DOCUMENT COVER SHEET.

suffered a :

☐

cumulative injury

which began on

(Start Date: MM/DD/YYYY)

and ended on

(End Date: MM/DD/YYYY)

The injury occurred at

MAY PUT "INJURED ON JOB SITE" OR COMPLETE ADDRESS WHERE INJURY OCCURED.

Street Address/PO Box - Please leave blank spaces between numbers, names or words

MUST INCLUDE CITY AND ZIPCODE. USE "CA" FOR STATE.

City State Zip Code

Example

(State which parts of the body were injured)

BODY PARTS MUST MATCH THE BODY PARTS INDICATED ON THE DOCUMENT COVER SHEET

Body Part 1: 420 BACK

Body Part 2: 100 HEAD

Body Part 3:

Body Part 4:

Other Body Parts:

IF MORE THAN 5 INJURED BODY PARTS, MAY ENTER 700 MULTIPLE IN OTHER BODY PARTS FIELD AND INCLUDE ADDITIONAL BODY PARTS IN SECTION 2.

2. The injury occurred as follows:

(EXPLAIN WHAT THE WORKER WAS DOING AT THE TIME OF INJURY AND HOW THE INJURY OCCURED)

3. Actual earnings at the time of injury:

Rate of Pay \$

☐ Monthly
☐ Weekly
☐ Hourly

State value of tips, meals, lodging, or other advantages, regularly received

\$

☐ Monthly
☐ Weekly
☐ Hourly

Number of hours worked per week

DO NOT ENTER NONE, UNKNOWN OR N/A. IF YOU DON'T HAVE INFORMATION, LEAVE BLANK.

4. The injury caused disability as follows:

Last day off work due to injury:

MM/DD/YYYY

First Period of Disability:

Start Date

MM/DD/YYYY

End Date

MM/DD/YYYY

Second Period of Disability:

Start Date

MM/DD/YYYY

End Date

MM/DD/YYYY

5. Compensation:

Compensation was paid:

☐ Yes ☐ No

Total paid:

Weekly rate(s):

Date of last payment:

MM/DD/YYYY

6. Has the worker received any unemployment insurance benefits and/or any unemployment compensation disability benefits (state disability) since the date of injury?

☐ Yes ☐ No

Medical treatment was received:

☐ Yes ☐ No

☐ Yes ☐ No

Other treatment was provided/paid by: _____
(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

☐ Yes ☐ No

Name of Doctor/Hospital/Clinic 2 (Please leave blank spaces between numbers, names or words)

Case Number 4

MUST SELECT AT LEAST ONE.

- | | |
|--|---|
| <input type="checkbox"/> Temporary disability indemnity | <input type="checkbox"/> Permanent disability indemnity |
| <input type="checkbox"/> Reimbursement for medical expense | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Medical treatment | <input type="checkbox"/> Supplemental Job Displacement/Return to Work |
| <input type="checkbox"/> Compensation at proper rate | <input type="checkbox"/> Other (Specify) _____ |

Is the Applicant Represented? ☒ Yes ☐ No If "No", applicant is to sign and date below.

If "Yes", applicant's representative is to complete the following and is to sign and date below.

☐ Law Firm/Attorney ☐ Non-Attorney Representative

UNIFORM ASSIGNED NAME OF ATTORNEY FOR CLAIMS ADMINISTRATOR, INJURED WORKER OR LIEN CLAIMANT

Law Firm or Company Name (If Applicable)

Law Firm Number (If Applicable)

Attorney/Representative First Name

MI

Attorney/Representative Last Name

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

MUST INCLUDE SIGNATURE WHEN APPLICANT IS REPRESENTED

APPLICANT MUST SIGN WHEN NOT REPRESENTED

Applicant Attorney/Representative Signature

Applicant Signature

Dated at _____, California

City

Date 04/16/2008

MM/DD/YYYY

DOCUMENT DATE ON
DOCUMENT SEPARATOR
SHEET

INSTRUCTIONS

FILING AND SERVICE OF A DECLARATION OF READINESS IS A PREREQUISITE TO THE SETTING OF A CASE FOR HEARING.

Effect of Filing Application

Filing of this application begins formal proceedings against the defendant(s) named in your application.

Assistance in Filling Out Application

You may request the assistance of an information and assistance officer of the Division of Workers' Compensation.

Right to Attorney

You may be represented by an attorney or agent, or you may represent yourself. The attorney's fee will be set by the Workers' Compensation Appeals Board at the time the case is decided and is ordinarily payable out of your award.

Filling Out Application

For "amended" applications, the venue choice must be the same as that specified on the original application, unless an order changing venue has issued. A street or P.O. Box address within the United States must be entered for the place where the injury occurred. Therefore, if the injury did not occur at a fixed or identifiable location (such as a field, a highway, or on water), or if the injury occurred outside of the United States, the employer's business address or another appropriate address must be specified; however, a short explanation regarding the place of injury may be appended to the application. If medical treatment has been paid for by Medi-Cal, Medicare, group health insurance, or a private carrier, please specify.

Service of Documents

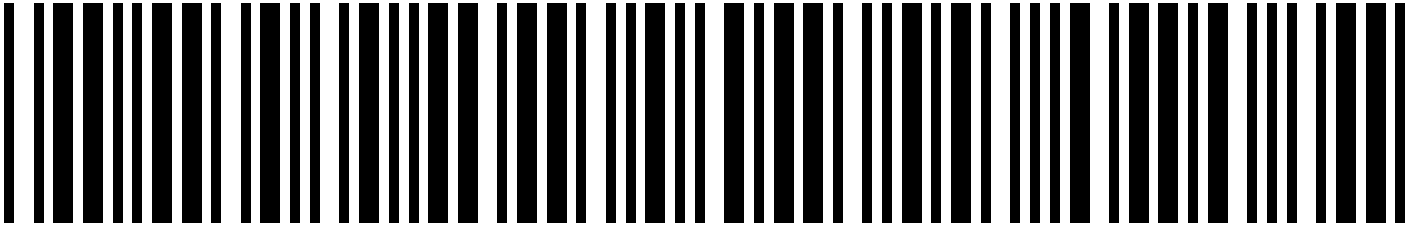
Your attorney or agent will serve all documents in accordance with Labor Code section 5501 and the Workers' Compensation Appeals Board's Rules of Practice and Procedure.

If you have no attorney or agent, copies of this application will be served by the Workers' Compensation Appeals Board on all parties. If you file any other document, you must mail or deliver a copy of the document to all parties in the case.

IMPORTANT!

If any applicant is under 18 years of age, it will be necessary to file a Petition for Appointment of Guardian ad Litem. Forms for this purpose may be obtained at the district office of the Workers' Compensation Appeals Board, or by calling the district office and requesting this form.

DOCUMENT SEPARATOR SHEET



Product Delivery Unit

ADJ

Document Type

LEGAL DOCS

Document Title

4906(g) DECLARATION

Document Date

04/16/2008

MM/DD/YYYY

ENTER DATE OF DOCUMENT FOLLOWING
DOCUMENT SEPARATOR SHEET

Author

UNIFORM ASSIGNED NAME

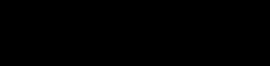
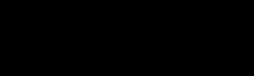
IF YOU ARE A CLAIMS ADMINISTRATOR,
REPRESENTATIVE OR LAW FIRM, USE YOUR
OFFICE'S UNIFORM ASSIGNED NAME. FOR
ALL OTHERS, ENTER YOUR NAME.

Office Use Only

Received Date

MM/DD/YYYY

Example



[REDACTED]

[REDACTED]

[REDACTED]

I have not violated Labor Code §139.3.

A photostatic copy of this declaration shall be as valid as the original.

DATED: 4/16/21

~~[REDACTED]~~

[REDACTED]

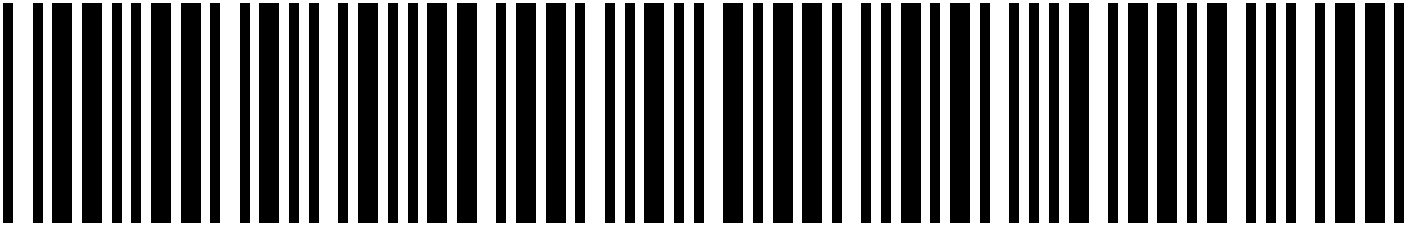
[REDACTED]

[REDACTED]

[REDACTED]

Example

DOCUMENT SEPARATOR SHEET



Product Delivery Unit

ADJ

Document Type

LEGAL DOCS

Document Title

FEE DISCLOSURE

Document Date

04/16/2008

DATE OF DOCUMENT FOLLOWING
DOCUMENT SEPARATOR SHEET

MM/DD/YYYY

Author

UNIFORM ASSIGNED NAME

LAW FIRM ONLY - USE YOUR
UNIFORM ASSIGNED NAME

Office Use Only

Received Date

MM/DD/YYYY

Example

State of California
Department of Industrial Relations
Division of Workers' Compensation

FEE DISCLOSURE STATEMENT

If you choose to be represented by an attorney, your attorney's fees will be deducted from your benefits. The fee will be approved by the Workers' Compensation Appeals Board, with consideration given to the: (1) responsibility assumed by the attorney; (2) care exercised in representing you; (3) time involved; and, (4) results obtained.

Attorney's fees normally range from 9% to 12% of the benefits awarded. However a fee of 15% may be charged if the case is complicated and time consuming. If your attorney has also represented you before the Rehabilitation Unit, there may also be a fee allowed for this representation.

There are certain circumstances where your employer (or his/her insurer) may be liable to pay your attorneys' fees. For example, if employer disputes a permanent disability evaluation obtained when you were not represented by an attorney, your employer may, be liable for any attorney fees you incur because of the dispute.

If at anytime you no longer wish to be represented by the attorney, you may withdraw from representation by notifying the attorney. If you withdraw from representation, the fee amount found by a workers' compensation judge to be the fair value of any work the attorney did in your case will be deducted from your award.

An Information and Assistance Officer may be able to answer your questions concerning your workers' compensation benefits at no charge to you. He/She may be able to resolve your problems without the need for litigation.

Call this toll-free number: 1-800-736-7401

Employee's Signature



Date: 9/16/08

Employee's Name



Attorney's Signature



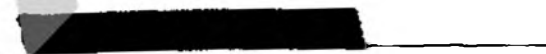
Date: _____

Attorney's Name



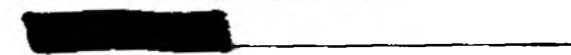
Address







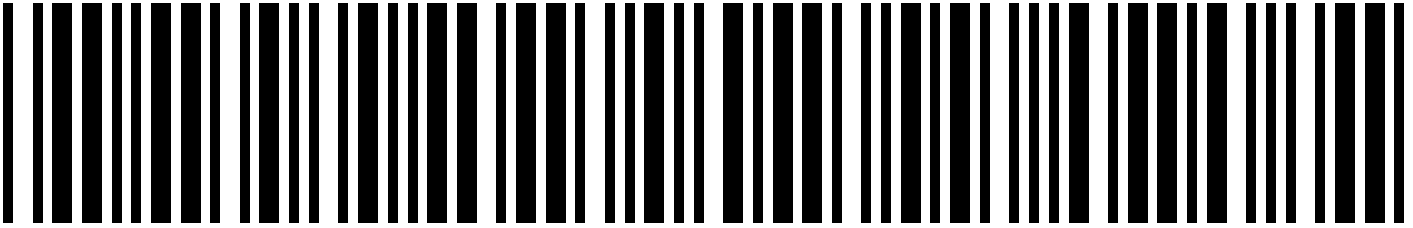
Phone No.



Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of felony.

Example

DOCUMENT SEPARATOR SHEET



THIS IS AN EXAMPLE OF THE DOCUMENT
SEPARATOR SHEET FOR VENUE
AUTHORIZATION

Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title VENUE VERIFICATION

Document Date 04/16/2008
MM/DD/YYYY

ENTER THE DATE OF THE VENUE
AUTHORIZATION

Author JOHN SMITH

ON VENUE AUTHORIZATION DOCUMENT
SEPARATOR SHEET, LIST INJURED WORKER
AS THE AUTHOR.

Office Use Only

Received Date _____
MM/DD/YYYY

Example

I HEREBY AUTHORIZE MY WORKERS' COMPENSATION CASE(S) FOR INJURY(IES)
DATED _____ TO BE
FILED AT THE VAN NUYS
WORKERS' COMPENSATION APPEALS BOARD.

DATED: 4/16/2008 X _____
APPLICANT _____

Applicant's Attorney:

_____, Drive, Suite _____
_____, CA _____

TEL: (____) _____
FAX: (____) _____

WORKERS' COMPENSATION APPEALS BOARD.

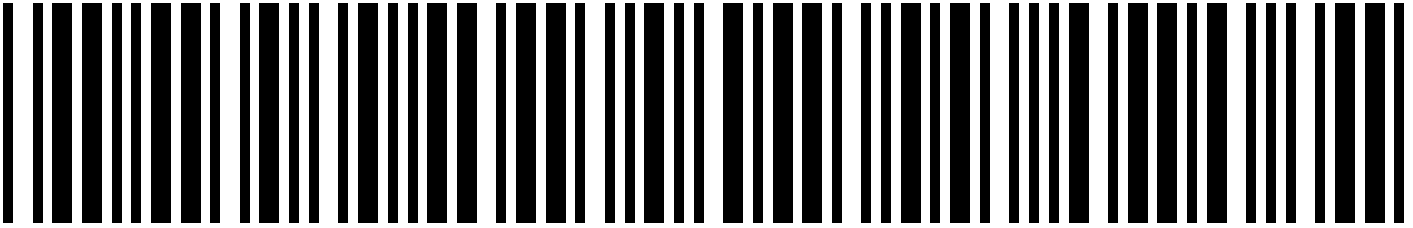
X  
APPLICANT

[REDACTED] Drive, Suite [REDACTED]
[REDACTED], CA [REDACTED]

TEL: () -
FAX: () -

Example

DOCUMENT SEPARATOR SHEET



Product Delivery Unit

ADJ

Document Type

LEGAL DOCS

Document Title

PROOF OF SERVICE

Document Date

04/16/2008

DATE OF DOCUMENT FOLLOWING
DOCUMENT SEPARATOR SHEET

MM/DD/YYYY

Author

UNIFORM ASSIGNED NAME

IF YOU ARE A CLAIMS
ADMINISTRATOR,
REPRESENTATIVE OR LAW FIRM,
USE YOUR OFFICE'S UNIFORM
ASSIGNED NAME. FOR ALL
OTHERS, ENTER YOUR NAME.

Office Use Only

Received Date

MM/DD/YYYY

Example



Proof of Service

I am at least 18 years of age, not a party to this action, and I am a resident of or employed in the county where the mailing took place.

My business address is:



On 04/16/2008 served a true copy of the following documents, along with supporting documents, described as: Application of adjudication of claim, 4906(g), fee disclosure statement and venue authorization by enclosing them in a sealed envelope addressed to each of the parties named and at the addresses set forth in the Party List, and placing each envelope for collection and mailing at the business address herein following our ordinary business practices, with postage fully prepaid, or by other previously agreed-upon method of electronic service.

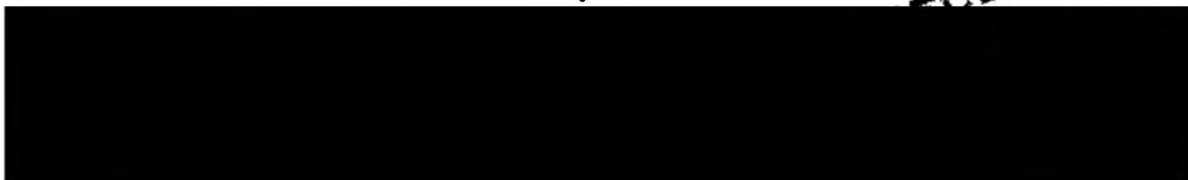
I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: 04/16/2008

Declarant Signature



Party List



RECEIVED

Example