

## STATE OF CALIFORNIA DIVISION OF WORKERS' COMPENSATION WORKERS' COMPENSATION APPEALS BOARD STIPULATIONS WITH REQUEST FOR AWARD

		Date of Injury		
Case No.		ı	MM/DD/YYYY	
		<del></del>		
SSN (Numbers Onl	<u> y)</u>	ı		
Venue Choice is ba	ased upon: (Completion of this s	ection is required)		
Residence of er	mployee (Labor Code section 5501	.5(a)(1))		
Location where	injury occurred (Labor Code sectio	n 5501.5(a)(2))		
Principal addres	ss of employee's attorney (Labor C	ode section 5501.5(a)(3))		
Select 3 Letter Offic	e Code For Place/Venue of Hearin	g (From the Document Cover S	Sheet)	
Applicant (Comple	tion of this section is required)			
First Name			MI	
Last Name			_	+
Address /DO Day /D	Nana lagua blank angga batuaga			_
Address/PO Box (P	Please leave blank spaces between	numbers, names or words)		
City			State	Zip Code
Employer #1 Inforr	nation (Completion of this section	n is required)		
Insured	Self-Insured	Legally Uninsured	Uninsure	d
Employer Name (D	lease leave blank spaces between	numbers, names or words)		-
Linployer Name (i	lease leave blattik spaces between	numbers, names or words)		
				-
Employer Street Ac	ldress/PO Box (Please leave blank	spaces between numbers, nar	mes or words)	
City			 State	Zip Code
•				

Insurance Carrier Name	(Please leave blank spaces b	between numbers, names or words)		_ +
nsurance Carrier Street	Address/PO Box (Please leav	ve blank spaces between numbers, nam	nes or words)	
City			State	Zip Code
laims Administrator	Information (if known ar	nd if applicable)		
Name (Please leave blar	nk spaces between numbers,	names or words)		
Street Address/PO Box (	Please leave blank spaces be	etween numbers, names or words)		_
City			State	Zip Code
Employer #2 Informat	tion (Completion of this s	section is required)		
Insured	Self-Insured	Legally Uninsured	Unins	ured
Employer Name (Plea	se leave blank spaces bet	ween numbers, names or words)		
Employer Street Addre	ess/PO Box (Please leave	blank spaces between numbers, na	mes or words)	
City			State	Zip Code
nsurance Carrier Info if known and if appli		rrier is adjusted by claims admini	strator)	
Insurance Carrier Name	(Please leave blank spaces t	petween numbers, names or words)		
Insurance Carrier Street	Address/PO Box (Please lea	ve blank spaces between numbers, nam	nes or words)	
City			State	Zip Code
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Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)

Name (Please leave	blank spaces between numl	bers, names or words)		
Street Address/PO B	ox (Please leave blank spac	ces between numbers, names or wor	rds)	_
City			State	Zip Code
mployer #3 Informa	ation (Completion of this s	ection is required)		
Insured	Self-Insured	Legally Uninsured	Uninsu	ıred
Employer Name (Ple	ase leave blank spaces betw	ween numbers, names or words)		_
Employer Street Add	ress/PO Box (Please leave l	blank spaces between numbers, nar	mes or words)	
City			State	Zip Code
			strator)	
f known and if appl	licable - include even if ca	rrier is adjusted by claims adminis		
f known and if appl	licable - include even if can me (Please leave blank spa		ords)	
f known and if appl nsurance Carrier Na nsurance Carrier Stree	licable - include even if can me (Please leave blank spa	ces between numbers, names or wo	ords)	Zip Code
nsurance Carrier Nansurance Carrier Stree	licable - include even if can me (Please leave blank spa	ces between numbers, names or wo	es or words)	Zip Code
nsurance Carrier Nansurance Carrier Stree	licable - include even if can me (Please leave blank spa et Address/PO Box (Please leav	ces between numbers, names or wo	es or words)	Zip Code
Insurance Carrier Na Insurance Carrier Stree City Claims Administrato Name (Please leave	ime (Please leave blank spanter Address/PO Box (Please leave blank spanter Address)	ces between numbers, names or wo	es or words)  State	Zip Code

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Insured	Self-Insured	Legally Uninsured	Unins	sured —
Employer Name (F	Please leave blank spaces bet	ween numbers, names or words)		
Employer Street A	ddress/PO Box (Please leave	blank spaces between numbers, na	mes or words)	
City surance Carrier f known and if ap		arrier is adjusted by claims admini	State	Zip Code
nsurance Carrier Na	ame (Please leave blank spaces l	petween numbers, names or words)		
nsurance Carrier Str	reet Address/PO Box (Please lea	ve blank spaces between numbers, nam	es or words)	
City Iaims Administra	ator Information (if known a	nd if applicable)	State	Zip Code
lame (Please leave	blank spaces between numbers,	names or words)		
treet Address/PO B	Box (Please leave blank spaces b	etween numbers, names or words)		
City			State	Zip Code
equirements of Lat	bor Code section 5313:	Award and/or Order, based upon th	e following facts	, and waive the
Employees First	t Name			
Employees Last	: Name			
birth date	MM/DD/YYYY	- <b>,</b>		
while employed a	t			
as a(n)		Occupation		,Group
		Cocupation		Gloup

More than 4 Compa	anion Cases	,
	Specific Injury	+
Case Number 1	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 2:	Body Part 3:
Body Part 4:	Other Body Parts:	
	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 2:	Body Part 3:
Body Part 4:	Other Body Parts:	
	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 2:	Body Part 3:
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 2:	Body Part 3:
Body Part 4:	Other Body Parts:	
by the employer(s) and th	neir insurer(s) listed above and who s	sustained injury(ies) arising out of and in the course of employment
	(Please list al	ll body parts injured)

2. The injury (ies) caused temp	orary disability for the period		through
	for which indemnity ha		per week.
MM/DD/YYYY			Indemnity Paid
2(a).The injury(ies) caused add	itional temporary disability f	or the period	MM/DD/YYYY
through	at the rate of \$	s ir	n the amount of \$
throughMM/DD/YYY	Y	Rate ir	Indemnity Paid
3. The injury(ies) caused perma	anent disability of	% for which in	demnity has been paid at \$Indemnity Paid
per week beginning	MM/DD/YYYY	in the sum of \$	, less credit for such payments
previously made. And a	life pension of \$	per week the	ereafter.
Labor Code §4658(d) adjustm	Life Per nent:	nsion	
Increase rate to \$	as of		
		MM/DD/YYYY	
Decrease rate to \$	as of		
Not Applicable	43 01	MM/DD/YYYY	
An informal rating has /	has not (Select one) bee	n previously issued ir	n case no(s)
4.There is is Not a ne	eed for medical treatment to	cure or relieve from	the effects of said injury (ies).
5. Medical-legal expenses and	or liens are payable by defe	endant as follows:	
6. Applicant's attorney requests	a fee of \$		
Fees to be commuted as fo	llows:		
7. Liens Against compensation	are payable as follows:		
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9.Other stipulations:		
Dated		
MM/DD/YYYY	Applicant	
Applicant's Attorney or Authorized Representative:		
Law Firm/Attorney Non Attorney Representative		
First Name		
Last Name		
Firm Number		
Fiffi Number		
Law Firm number		-
Law Film number		
		_
Address/PO Box (Please leave blank spaces between numbers, names or words)		
City	State	Zip Code
Dated	Applicant Attorney Sig	nature
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8. Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

Defendant's Attorney or Authorized Representative:			
Non Attorney Representative Law Firm/Attorney			
irst Name			
ast Name			
aw Firm Number			
aw Firm Name			
ddress/PO Box (Please leave blank spaces between numbers, names or words)			
ty	State	Zip Code	
mted	Defense Attorney	Signature	
Law Firm/Attorney Non Attorney Representative			
ast Name			
rm Number			
aw Firm Name			
ddress/PO Box (Please leave blank spaces between numbers, names or words)			
ity	State	Zip Code	
ated			
	Defense Attorn	ey Signature	
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Defendant's Attorney or Authorized Representative:			
Law Firm/Attorney Non Attorney Representative			+
First Name			ı
Last Name			
Firm Number			
Law Firm Name			
Address/PO Box (Please leave blank spaces between numbers, names or words)			
City	State	Zip Code	
Dated	Defense Attorney S	Signature	
Interpreter Licence Number:			
Interpreter Name	Interpreter Lice	ense Number	