

## STATE OF CALIFORNIA DEPARTMENT OF INDUSTRIAL RELATIONS DIVISION OF WORKERS' COMPENSATION

## STIPULATIONS WITH REQUEST FOR AWARD

|                       |                               | Date of Injury                    |               |          |
|-----------------------|-------------------------------|-----------------------------------|---------------|----------|
| Case No               |                               |                                   | MM/DD/YYYY    |          |
|                       |                               |                                   |               |          |
| SSN (Numbers Only)    |                               |                                   |               |          |
| Venue Choice is ba    | ased upon: (Completion of     | this section is required)         |               |          |
| Residence of em       | ployee (Labor Code section    | 5501.5(a)(1).)                    |               |          |
| Location where in     | njury occurred (Labor Code    | section 5501.5(a)(2).)            |               |          |
| Principal address     | s of employee's attorney (Lal | bor Code section 5501.5(a)(3).)   |               |          |
| Select 3 Digit Office | Code For Place/Venue of He    | earing (From Instruction Sheet)   |               |          |
| Applicant (Comple     | tion of this section is requ  | ired)                             |               |          |
| First Name            |                               | <b>1</b>                          | MI            |          |
| Last Name             |                               |                                   | _             |          |
| Address/PO Box (PI    | ease leave blank spaces bet   | tween numbers, names or words)    |               | _        |
| City                  |                               |                                   | State         | Zip Code |
| Employer #1 Inform    | nation (Completion of this s  | section is required)              |               |          |
| Insured               | Self-Insured                  | Legally Uninsured                 | Uninsured     | 1        |
| Employer Name (Ple    | ase leave blank spaces betv   | veen numbers, names or words)     |               | -        |
| Employer Street Add   | ress/PO Box (Please leave t   | olank spaces between numbers, nar | mes or words) | _        |
| City                  |                               |                                   | State         | Zip Code |

| Claims Administrator Information (if known and if applicable)  Name (Please leave blank spaces between numbers, names or words)  Street Address/PO Box (Please leave blank spaces between numbers, names or words)  City State Zip Code  Employer #2 Information (Completion of this section is required)  Insured Self-Insured Legally Uninsured Uninsured  Employer Name (Please leave blank spaces between numbers, names of words)  Employer Street Address/PO Box (Please leave blank spaces between numbers, names of words)   |                     |                               |                                  |                    |          |
|--|---------------------|-------------------------------|----------------------------------|--------------------|----------|
| City State Zip Code  Claims Administrator Information (if known and if applicable)  Name (Please leave blank spaces between numbers, names or words)  Street Address/PO Box (Please leave blank spaces between numbers, names or words)  City State Zip Code  Employer #2 Information (Completion of this section is required)  Insured Self-Insured Legally Uninsured Uninsured  Employer Name (Please leave blank spaces between numbers, names or words)  Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)  City State Zip Code  Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)  Insurance Carrier Name (Please leave blank spaces between numbers, names or words) | Insurance Carrier N | lame (Please leave blank spac | es between numbers, names or w   | ords)              |          |
| City State Zip Code  Claims Administrator Information (if known and if applicable)  Name (Please leave blank spaces between numbers, names or words)  Street Address/PO Box (Please leave blank spaces between numbers, names or words)  City State Zip Code  Employer #2 Information (Completion of this section is required)  Insured Self-Insured Legally Uninsured Uninsured  Employer Name (Please leave blank spaces between numbers, names or words)  Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)  City State Zip Code  Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)  Insurance Carrier Name (Please leave blank spaces between numbers, names or words) |                     |                               |                                  |                    |          |
| Claims Administrator Information (if known and if applicable)  Name (Please leave blank spaces between numbers, names or words)  Street Address/PO Box (Please leave blank spaces between numbers, names or words)  City State Zip Code  Employer #2 Information (Completion of this section is required)  Insured Self-Insured Legally Uninsured Uninsured  Employer Name (Please leave blank spaces between numbers, names of words)  Employer Street Address/PO Box (Please leave blank spaces between numbers, names of words)  City State Zip Code  Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)  Insurance Carrier Name (Please leave blank spaces between numbers, names or words)                      | Insurance Carrier S | street Address/PO Box (Please | leave blank spaces between num   | bers, names or wo  | rds)     |
| Claims Administrator Information (if known and if applicable)  Name (Please leave blank spaces between numbers, names or words)  Street Address/PO Box (Please leave blank spaces between numbers, names or words)  City State Zip Code  Employer #2 Information (Completion of this section is required)  Insured Self-Insured Legally Uninsured Uninsured  Employer Name (Please leave blank spaces between numbers, names of words)  Employer Street Address/PO Box (Please leave blank spaces between numbers, names of words)  City State Zip Code  Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)  Insurance Carrier Name (Please leave blank spaces between numbers, names or words)                      |                     |                               |                                  |                    |          |
| Name (Please leave blank spaces between numbers, names or words)  Street Address/PO Box (Please leave blank spaces between numbers, names or words)  City State Zip Code  Employer #2 Information (Completion of this section is required)  Insured Self-Insured Legally Uninsured Uninsured  Employer Name (Please leave blank spaces between numbers, names or words)  Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)  City State Zip Code  Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)  Insurance Carrier Name (Please leave blank spaces between numbers, names or words)   | City                |                               |                                  | State              | Zip Code |
| Street Address/PO Box (Please leave blank spaces between numbers, names or words)    State   Zip Code  | Claims Administra   | ator Information (if known an | d if applicable)                 |                    |          |
| City  Employer #2 Information (Completion of this section is required)  Insured Self-Insured Legally Uninsured  Employer Name (Please leave blank spaces between numbers, names of words)  Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)  City State Zip Code  Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)  Insurance Carrier Name (Please leave blank spaces between numbers, names or words)  Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)  | Name (Please leave  | e blank spaces between numb   | ers, names or words)             |                    |          |
| City  Employer #2 Information (Completion of this section is required)  Insured Self-Insured Legally Uninsured  Employer Name (Please leave blank spaces between numbers, names of words)  Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)  City State Zip Code  Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)  Insurance Carrier Name (Please leave blank spaces between numbers, names or words)  Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)  |                     |                               |                                  |                    |          |
| Employer #2 Information (Completion of this section is required)  Insured Self-Insured Legally Uninsured Uninsured  Employer Name (Please leave blank spaces between numbers, names of words)  Employer Street Address/PO Box (Please leave blank spaces between numbers, names of words)  City State Zip Code  Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)  Insurance Carrier Name (Please leave blank spaces between numbers, names or words)  Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)  | Street Address/PO   | Box (Please leave blank space | es between numbers, names or wo  | ords)              |          |
| Employer #2 Information (Completion of this section is required)  Insured Self-Insured Legally Uninsured Uninsured  Employer Name (Please leave blank spaces between numbers, names of words)  Employer Street Address/PO Box (Please leave blank spaces between numbers, names of words)  City State Zip Code  Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)  Insurance Carrier Name (Please leave blank spaces between numbers, names or words)  Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)  |                     |                               |                                  |                    |          |
| Insured Self-Insured Legally Uninsured Uninsured  Employer Name (Please leave blank spaces between numbers, names or words)  Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)  City State Zip Code  Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)  Insurance Carrier Name (Please leave blank spaces between numbers, names or words)  Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)  | City                |                               |                                  | State              | Zip Code |
| Employer Name (Please leave blank spaces between numbers, names or words)  Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)  City State Zip Code  Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)  Insurance Carrier Name (Please leave blank spaces between numbers, names or words)  Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)  | Employer #2 Infor   | mation (Completion of this s  | ection is required)              |                    |          |
| Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)  City State Zip Code  Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)  Insurance Carrier Name (Please leave blank spaces between numbers, names or words)  Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)   | Insured             | Self-Insured                  | Legally Uninsured                | Uninsu             | red      |
| City  State  Zip Code  Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)  Insurance Carrier Name (Please leave blank spaces between numbers, names or words)  Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)   | Employer Name (P    | lease leave blank spaces betw | veen numbers, names or words)    |                    |          |
| Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)  Insurance Carrier Name (Please leave blank spaces between numbers, names or words)  Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)  | Employer Street Ac  | ldress/PO Box (Please leave b | olank spaces between numbers, na | ames or words)     |          |
| (if known and if applicable - include even if carrier is adjusted by claims administrator)  Insurance Carrier Name (Please leave blank spaces between numbers, names or words)  Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)  | City                |                               |                                  | State              | Zip Code |
| Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)  |                     |                               | rrier is adjusted by claims admi | nistrator)         |          |
|  | Insurance Carrier N | Name (Please leave blank spac | ces between numbers, names or w  | vords)             |          |
| City State Zip Code  | Insurance Carrier S | Street Address/PO Box (Please | e leave blank spaces between num | nbers, names or wo | ords)    |
|  | City                |                               |                                  | State              | Zip Code |

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

| Name (Please leave                      | e blank spaces between numb   | ers, names or words)                |                   | _        |   |
|---|-------------------------------|-------------------------------------|-------------------|----------|---|
| Street Address/PO                       | Box (Please leave blank space | es between numbers, names or wor    | ds)               | _        |   |
| City                                    |                               |                                     | <br>State         | Zip Code | _ |
| Employer #3 Infor                       | mation (Completion of this s  | section is required)                |                   |          |   |
| Insured                                 | Self-Insured                  | Legally Uninsured                   | ☐ Uninsu          | red      |   |
| Employer Name (P                        | lease leave blank spaces betw | veen numbers, names or words)       |                   |          |   |
|   |                               |                                     |                   |          |   |
| Employer Street Ac                      | ddress/PO Box (Please leave I | plank spaces between numbers, nar   | nes or words)     |          |   |
| City                                    |                               |                                     | State             | Zip Code |   |
| Insurance Carrier<br>(if known and if a |                               | arrier is adjusted by claims admini | istrator)         |          |   |
| Insurance Carrier N                     | Name (Please leave blank spa  | ces between numbers, names or wo    | ords)             |          |   |
| Insurance Carrier S                     | Street Address/PO Box (Please | e leave blank spaces between numb   | pers, names or wo | ords)    |   |
| City                                    |                               |                                     | State             | Zip Code | _ |
| Claims Administra                       | tor Information (if known ar  | nd if applicable)                   |                   |          |   |
| Name (Please leave                      | e blank spaces between numb   | ers, names or words)                |                   |          |   |
| Street Address/PO                       | Box (Please leave blank space | es between numbers, names or wor    | ds)               | _        |   |
| City                                    |                               |                                     | State             | Zip Code | _ |

Claims Administrator Information (if known and if applicable)

| Insured  | Self-Insured                 | Legally Uninsured                  | Uninsured               |                |
|--|------------------------------|------------------------------------|-------------------------|----------------|
| Employer Name (P                               | lease leave blank spaces bet | ween numbers, names or words)      |                         | -              |
| mployer Street Ad                              | ddress/PO Box (Please leave  | blank spaces between numbers, na   | nmes or words)          | -              |
| City<br>nsurance Carrier<br>if known and if ap |                              | arrier is adjusted by claims admir | State                   | Zip Code       |
| nsurance Carrier N                             | Name (Please leave blank spa | nces between numbers, names or w   | vords)                  | -              |
| nsurance Carrier S                             | Street Address/PO Box (Pleas | e leave blank spaces between num   | bers, names or words    | <del>s</del> ) |
| City   |                              |                                    | State                   | Zip Code       |
| laims Administra                               | ator Information (if known a | nd if applicable)                  |                         |                |
| ame (Please leave                              | e blank spaces between numb  | pers, names or words)              |                         |                |
| reet Address/PO                                | Box (Please leave blank spac | es between numbers, names or wo    | rds)                    | •              |
| City   |                              | <u> </u>                           | State                   | Zip Code       |
| abor Code Section                              |                              | Award and/or Order, based upon t   | he following facts, and | d waive the    |
| Employee First N                               | lame                         |                                    |                         |                |
| Employee Last N                                | lame                         |                                    | ,                       |                |
| birth date                                     | MM/DD/YYYY                   | _,                                 |                         |                |
| while employed a                               | at                           |                                    |                         | ,,             |
| as a(n)  |                              |                                    |                         | , <u> </u>     |
|  |                              | Occupation                         |                         | ,<br>Group     |

|                         | Specific Injury                        |  |  |
|-------------------------|--|--|--|
| Case 1                  | Cumulative Injury                      | Start Date: MM/DD/YYYY)  | End Date: MM/DD/YYYY)                          |
|                         | camalative injury                      | (If Specific Injury, use the start date as the   | specific date of injury)                       |
| Body Part 1 :           | Body Part 2 :                          | Body Par   | t 3 :  |
| Body Part 4 :           | Other Body Par                         | s:   |  |
|                         | Specific Injury                        |  |  |
| Case 2                  | Cumulative Injury                      | Start Date: MM/DD/YYYY)  (If Specific Injury, use the start date as the start date a | End Date: MM/DD/YYYY) specific date of injury) |
| Body Part 1 :           | Body Part 2 :                          | Body Par   | t 3 :  |
| Body Part 4 :           | Other Body Par                         | S:   |  |
|                         | Specific Injury                        |  |  |
| Case 3                  | Cumulative Injury                      | Start Date: MM/DD/YYYY)  (If Specific Injury, use the start date as the start date a | End Date: MM/DD/YYYY) specific date of injury) |
| Body Part 1 :           | Body Part 2 :                          | Body Par   | t 3 :  |
| Body Part 4 :           | Other Body Par                         | s:   |  |
|                         | Specific Injury                        |  |  |
| Case 4                  | Cumulative Injury                      | Start Date: MM/DD/YYYY)  (If Specific Injury, use the start date as the s  | End Date: MM/DD/YYYY) specific date of injury) |
| Body Part 1 :           | Body Part 2 :                          | Body Par   | t 3 :  |
| Body Part 4 :           | Other Body Par                         | s:   |  |
|                         |  |  |  |
| ру                      | (Employer(s))                          | <ul> <li>whose compensation insurance c</li> </ul>   | arrier(s) was/were                             |
|                         | (                                      | and who sustained injury   | (ies) arising out of and in th                 |
| course of employment to | o (Please list all body parts injured) |  |  |
|                         |  |  |  |

| 2. The injury(ies) caused temporar   | y disability for the period | MM/DD/                 | YYYY               | through                        |
|--------------------------------------|-----------------------------|------------------------|--------------------|--------------------------------|
| MM/DD/YYYY                           | for which indemnity         | has been paid at \$_   | Indemnity Paid     | per week.                      |
| 2(a).The injury(ies) caused additio  | nal temporary disability f  | or the period _        | MM/DD/             | YYYY                           |
| throughMM/DD/YYYY                    | at the rate of              | f \$<br>Rate           | in the amount o    | of \$Indemnity Paid            |
| 3. The injury(ies) caused permane    | nt disability of            | % for which i          | ndemnity has be    | een paid at \$Indemnity Paid   |
| per week beginning                   | ///DD/YYYY                  | , in the sum of $\$$ _ |                    | ,less credit for such payments |
| previously made.                     |                             | per week th            | nereafter.         |                                |
| Increase rate to \$                  |                             | MM/DD/YYYY             |                    |                                |
| Decrease rate to \$                  |                             | MM/DD/YYYY             |                    |                                |
| ☐ Not Applicable                     |                             |                        |                    |                                |
| An informal rating  has /            | has Not (Select one) be     | en previously issue    | d Case No(s)       |                                |
| 4. There ☐ is ☐ is Not a need        | for medical treatment to    | cure or relieve from   | n the effects of s | aid injury(ies).               |
| 5. Medical-legal expenses and/or l   | iens are payable by defe    | ndant as follows:      |                    |                                |
|                                      |                             |                        |                    |                                |
| 6. Applicant's attorney requests a f | ee of \$                    |                        |                    |                                |
| Fees to be commuted as follows:      | ws:                         |                        |                    |                                |
|                                      |                             |                        |                    |                                |
| 7. Liens against compensation are    | payable as follows:         |                        |                    |                                |
|                                      |                             |                        |                    |                                |
|                                      |                             |                        |                    |                                |

| 9. Other stipulations:   |               |
|--|---------------|
|  |               |
|  |               |
|  |               |
|  |               |
|  |               |
|  |               |
|  |               |
|  |               |
|  |               |
| DatedApplica   | nt            |
|  | •••           |
| Applicant's Attorney or Authorized Representative:                         |               |
| Law Firm/Attorney Non Attorney Representative                              |               |
| First Name   |               |
| Last Name  |               |
| Law Firm Number  |               |
| Law Firm Name  | <u> </u>      |
| Address/PO Box (Please leave blank spaces between numbers, names or words) |               |
| City   | Zip Code      |
| Dated Applicant Attorney   | <br>Signature |

8. Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

| Defendant's Attorney or A | uthorized Representative:                  |                  |                |
|---------------------------|--|------------------|----------------|
| Law Firm/Attorney         | Non Attorney Representative                |                  |                |
| First Name                |  |                  |                |
| Last Name                 |  |                  |                |
| Law Firm Number           |  |                  |                |
| Law Firm Name             |  |                  |                |
| Address/PO Box (Please le | eave blank spaces between numbers, names c | or words)        |                |
| City                      |  | State            | Zip Code       |
| Dated                     |  | Defense Attorney | Signature      |
| Defendant's Attorney or A | Authorized Representative:                 |                  |                |
| Law Firm/Attorney         | ☐ Non Attorney Representative              |                  |                |
| First Name                |  |                  |                |
| Last Name                 |  |                  |                |
| Law Firm Number           |  |                  |                |
| Law Firm Name             |  |                  |                |
| Address/PO Box (Please le | eave blank spaces between numbers, names o | or words)        |                |
| City                      |  | State            | Zip Code       |
| Dated                     |  | Deferre All      | . Circa at usa |
| IVIIVI/DD/11111           |  | Defense Attorney | / Signature    |

| Defendant's Attorney or  | Authorized Representative:               |                 |              |
|--------------------------|--|-----------------|--------------|
| Law Firm/Attorney        | Non Attorney Representative              |                 |              |
| First Name               |  |                 |              |
| Last Name                |  |                 |              |
| Law Firm Number          |  |                 |              |
| Law Firm Name            |  |                 |              |
| Address/PO Box (Please I | eave blank spaces between numbers, names | or words)       |              |
| City                     |  | State           | Zip Code     |
| Dated                    |  | Defense Attorne | y Signature  |
| Interpreter Licence Numl | per:                                     |                 |              |
| Interpreter Na           | me                                       | Interpreter Lie | cense Number |
|                          |  |                 |              |