

DWC-CA form 10214 (a) Page 1 (Rev 11/2008)

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

Case No.			Date of Injury		
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).) Select 3 Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet) Applicant (Completion of this section is required) First Name MI Last Name Address/PO Box (Please leave blank spaces between numbers, names or words) City State Zip Code Employer #1 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)	Case No.			MM/DD/YYYY	
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).) Select 3 Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet) Applicant (Completion of this section is required) First Name MI Last Name Address/PO Box (Please leave blank spaces between numbers, names or words) City State Zip Code Employer #1 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)					
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Applicant (Completion of this section is required) First Name MI Last Name Address/PO Box (Please leave blank spaces between numbers, names or words) City State Zip Code Employer #1 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)	County of princi	ipai piace oi busilless oi empio	byee's automey (Labor Code Section	3301.3(a)(3) 01 (0	()-)
Applicant (Completion of this section is required) First Name MI Last Name Address/PO Box (Please leave blank spaces between numbers, names or words) City State Zip Code Employer #1 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)					
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Address/PO Box (Please leave blank spaces between numbers, names or words) City State Zip Code Employer #1 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)	Applicant (Comple	etion of this section is requir	ed)		
Address/PO Box (Please leave blank spaces between numbers, names or words) City State Zip Code Employer #1 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)					
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Address/PO Box (Please leave blank spaces between numbers, names or words) City State Zip Code Employer #1 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)					
Address/PO Box (Please leave blank spaces between numbers, names or words) City State Zip Code Employer #1 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)	Last Name			_	
City Employer #1 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)	Last Name				
City Employer #1 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)					
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Employer #1 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)					
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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)		matian (Camplatian of this a	action is varying d\		F
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)	Employer #1 Infor	mation (Completion of this s	ection is required)		
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)	Insured	Self-Insured	Legally Uninsured	Uninsu	red
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)					
	Employer Name (P	Please leave blank spaces betw	veen numbers, names or words)		
	Employer Street Ad	ddress/PO Box (Please leave I	olank spaces between numbers, nar	mes or words)	
City State Zip Code	. •	,		,	
City State Zip Code					7: 0 1
	City			State	ZIP Code

laims Administrator Information (if known and if applicable) ame (Please leave blank spaces between numbers, names or words) treet Address/PO Box (Please leave blank spaces between numbers, names or words) ity symployer #2 Information (Completion of this section is required) Insured Self-Insured Legally Uninsured mployer Name (Please leave blank spaces between numbers, names or words) mployer Street Address/PO Box (Please leave blank spaces between numbers, names or words) sity symploser Street Address/PO Box (Please leave blank spaces between numbers, names or words) sity symploser Street Information	State	Zip Code
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laims Administrator Information (if known and if applicable) lame (Please leave blank spaces between numbers, names or words) treet Address/PO Box (Please leave blank spaces between numbers, names or words) sity sity	State 2	Zip Code
Insured Self-Insured Legally 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) Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words) Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)	_	
treet Address/PO Box (Please leave blank spaces between numbers, names or words) Self-Insured	_	
mployer #2 Information (Completion of this section is required) Insured Self-Insured Legally 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 Surrance Carrier Information	_	
Imployer #2 Information (Completion of this section is required) Insured Self-Insured Legally 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 S Insurance Carrier Information	_	
Employer Name (Please leave blank spaces between numbers, names or words) Employer Street Address/PO Box (Please leave blank spaces between numbers, names or wo City S Insurance Carrier Information	Uninsure	d
Employer Name (Please leave blank spaces between numbers, names or words) Employer Street Address/PO Box (Please leave blank spaces between numbers, names or wo City Surance Carrier Information	Uninsure	d
nsurance Carrier Information		
City nsurance Carrier Information		
nsurance Carrier Information	ords)	_
nsurance Carrier Information	State 2	Zip Code
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)		
modrance current manie (i lease leave blank spaces between numbers, names of words)		
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words		
City	s)	

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

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
mployer #3 Information (Completion of this section is required)		
Insured Self-Insured Legally Uninsured	Unins	ured
Employer Name (Please leave blank spaces between numbers, names or words)		
Employer Street Address/PO Box (Please leave blank spaces between numbers, names of	or words)	
City	State	Zip Code
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)		
nsurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names 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
 		I

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Employer #4 Inform	mation (Completion of this s	section is required)			
Insured	Self-Insured	Legally Uninsured	Unins	sured	
Employer Name (P	lease leave blank spaces bet	ween numbers, names or words)			
Employer Street Ad	ddress/PO Box (Please leave	blank spaces between numbers, na	ames or words)		
City Insurance Carrier I (if known and if ap		rrier is adjusted by claims admin	State	Zip Code	
Insurance Carrier Nar	me (Please leave blank spaces b	netween numbers, names or words)			
Insurance Carrier Stre	eet Address/PO Box (Please leav	ve blank spaces between numbers, nan	nes or words)		
City Claims Administra	tor Information (if known ar	nd if applicable)	State	Zip Code	
Name (Please leave b	blank spaces between numbers,	names or words)			
Street Address/PO Bo	ox (Please leave blank spaces be	etween numbers, names or words)			
City			State	Zip Code	
requirements of Lab	oor Code section 5313:	Award and/or Order, based upon the	ne following facts	, and waive the	+
Employees Last	Name		,		
birth date	MM/DD/YYYY	- ,			
while employed at				, -	State
as a(n)		Occupation		, Group	in
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Case Number 1	Cumulative Injury	'
Rody Part 1		(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYYY) (If Specific Injury, use the start date as the specific date of injury)
	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:	
		ustained injury(ies) arising out of and in the course of employme

2. The injury (ies) caused tempo	rary disability for the period	M	M/DD/YYYY	_ through
	for which indemnity has been	en paid at \$		per week.
MM/DD/YYYY			Indemnity Paid	
2(a). The injury(ies) caused addit	ional temporary disability for th	e period	MM/DD/YYY	Y
through	at the rate of \$		in the amount of \$	
MM/DD/YYYY		Rate	_	Indemnity Paid
3. The injury(ies) caused perman	nent disability of	_ % for wh	nich indemnity is paya	ible at \$ Indemnity Rate
per week beginning	MM/DD/YYYY	e sum of \$, less	credit for such payments
previously made.	ife pension of \$Life Pension	per week	thereafter.	
Labor Code §4658(d) adjustme				
Increase rate to \$	as of			
	MN	I/DD/YYYY		
Decrease rate to \$	as of			
		I/DD/YYYY		
Not Applicable	_			
An informal rating has / 4. There is is Not a new 5. Medical-legal expenses and/o	has not (Select one) been pre	e or relieve fr	om the effects of said	l injury (ies).
6. Applicant's attorney requests	a fee of \$			
Fees to be commuted as foll	ows:			
7. Liens Against compensation a	are payable as follows:			
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9.Other stipulations:			
Dated	Applicant		
INIIVII DUNTITI	Арріісані		
Applicant's Attorney or Authorized Representative:			1
Law Firm/Attorney Non Attorney Representative			+
			'
First Name			
Last Name			
Firm Number			
Law Firm name			
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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5440 0/10/111 10217 (a) 1 age / (100 11/2000)			-

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

Defendant's Attorney or Authorized Representative:			
Law Firm/Attorney Non Attorney Representative			
			\perp
First Name			
First Name			
Last Name			
Lastinanie			
Firm Number			
Law Firm Name			
Address/PO Box (Please leave blank spaces between numbers, names or words)			
Address/1 & Box (1 lease leave blank spaces between numbers, names of words)			
City	Ctoto	Zip Code	
City	State	Zip Code	
Dated			
MM/DD/YYYY ———	Defence Atterney	Cianatura	
	Defense Attorney	Signature	
Defendant's Attorney or Authorized Representative:			
Law Firm/Attorney Non Attorney Representative			
First Name			
Last Name			
Firm Number			
Law Firm Name			
Address/PO Box (Please leave blank spaces between numbers, names or words)			
City	State	Zip Code	
	State	Zip Code	
Dated	State	Zip Code	
Dated	State Defense Attorne		

Defendant's Attorney or	Authorized Representative:			
Law Firm/Attorney	Non Attorney Representative			
First Name				
Last Name				
Firm Number				
Law Firm Name				
Address/PO Box (Please lea	ave blank spaces between numbers, names or word:	s)		
`	,	,		
City		State	Zip Code	
DatedMM/DD/\				
IVIIVI/DD/	1111	Defense Attorney	Signature	
Interpreter Licence Num	ber:			
Interpreter Nar	me	Interpreter Lice	ense Number	