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

Case No. _____

Date of Injury _____
MM/DD/YYYY

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).)

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) _____

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

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 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

Employer #3 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 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

Employer #4 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 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

The parties hereto stipulate to the issuance of an Award and/or Order, based upon the following facts, and waive the requirements of Labor Code section 5313:

1. _____
Employees First Name

_____ ,
Employees Last Name

birth date _____ ,
MM/DD/YYYY

while employed at _____ , _____
State

as a(n) _____ , _____ in
Occupation Group

☐ More than 4 Companion 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 their insurer(s) listed above and who sustained injury(ies) arising out of and in the course of employment to

(Please list all body parts injured)

2. The injury (ies) caused temporary 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 additional temporary disability for the period _____ (MM/DD/YYYY) through _____ (MM/DD/YYYY) at the rate of $ _____ (Rate) in the amount of $ _____ (Indemnity Paid)

3. The injury(ies) caused permanent disability of _____ % for which indemnity is payable at $ _____ (Indemnity Rate) per week beginning _____ (MM/DD/YYYY) in the sum of $ _____ , less credit for such payments previously made. ☐ And a life pension of $_____ (Life Pension) per week thereafter.

An informal rating ☐ has / ☐ has not (Select one) been previously issued in case no(s) _____ .

4.There ☐ is ☐ is Not a need for medical treatment to cure or relieve from the effects of said injury (ies).

5. Medical-legal expenses and/or liens are payable by defendant as follows:

6. Applicant's attorney requests a fee of $ _____

☐ Fees to be commuted as follows:

7. Liens Against compensation are payable as follows:

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

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

_____
Law Firm name

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

_____ _____ _____
City State Zip Code

Dated _____
MM/DD/YYYY

_____
Applicant 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

Dated MM/DD/YYYY

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

Dated MM/DD/YYYY

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

Dated MM/DD/YYYY

Defense Attorney Signature

Interpreter License Number:

Interpreter Name

Interpreter License Number