

DWC-WCAB form 10214 (a) -1 Page 1 (Rev 4/2014)

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

		Date of Injury		
Case No.			MM/DD/YYYY	
SSN (Numbers Only	y)			
Venue Choice is ba	ased upon: (Completion of	this section is required)		
County of reside	nce of employee (Labor Cod	de section 5501.5(a)(1) or (d).)		
County where in	jury occurred (Labor Code se	ection 5501.5(a)(2) or (d).)		
County of princip	oal place of business of empl	loyee's attorney (Labor Code section	5501.5(a)(3) or (d	<b>I</b> ).)
 Select 3 Letter Office	e Code For Place/Venue of F	Hearing (From the Document Cover S	Sheet)	
Applicant (Complet	tion of this section is requi	red)		
First Name			MI	
Last Name			-	
Address/PO Box (P	lease leave blank spaces be	tween numbers, names or words)		
City			State	Zip Code
Employer #1 Inforn	nation (Completion of this	section is required)		
Insured	Self-Insured	Legally Uninsured	Uninsu	ıred
Employer Name (Pl	ease leave blank spaces bet	tween numbers, names or words)		
Employer Street Ad	dress/PO Box (Please leave	blank spaces between numbers, nan	nes or words)	
City			State	Zip Code
+				

nsurance Carrier Name (Please leave blank spaces between numbers, names or words)		
, , , , , , , , , , , , , , , , , , ,		-
surance Carrier Street Address/PO Box (Please leave blank spaces between numbers, n	names or words)	
mario darrior direct Address, i d box (i lease leave blank spaces between numbers, ii	idinos di Wolds)	
ty	State	Zip Code
ims 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	State	Zip Code
mployer #2 Information (Completion of this section is required)		
Insured Self-Insured Legally Uninsured	Unins	ured
mployer Name (Please leave blank spaces between numbers, names or words)		
imployer Street Address/PO Box (Please leave blank spaces between numbers,	names or words)	
	names or words)  State	Zip Code
City  Surance Carrier Information	State	Zip Code
City  Isurance Carrier Information	State	Zip Code
City surance Carrier Information f known and if applicable - include even if carrier is adjusted by claims adm	State	Zip Code
Employer Street Address/PO Box (Please leave blank spaces between numbers,  Dity  Issurance Carrier Information If known and if applicable - include even if carrier is adjusted by claims adm  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)	State ninistrator)	Zip Code

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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
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Employer #4 Inforr	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 Ac	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 Na	me (Please leave blank spaces b	petween 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	itor Information (if known ar	nd if applicable)	State	Zip Code	
Name (Please leave I	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	·			,	tate
as a(n)		Occupation		, Group	in
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More than 4 Compa	inion Cases	ı
	Specific Injury	+
Case Number 1	Cumulative Injury	(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 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:	
		ustained injury(ies) arising out of and in the course of employmen
	(Please list all	l body parts injured)
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2. The injury (ies) caused temporary disability for the period	through
for which indemnity has been	1
MM/DD/YYYY	n paid at \$ per week
2(a). The injury(ies) caused additional temporary disability for the	
	MM/DD/YYYY
through at the rate of \$	Rate in the amount of \$ Indemnity Paid
The injury(ies) caused permanent disability of	% for which indemnity is payable at \$
per week beginning in the	sum of \$, less credit for such payments
previously made. And a life pension of \$	per week thereafter.
An informal rating has / has not (Select one) been prev	iously 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:	

9.Other stipulations:			
<u></u>			
Dated	Applicant		
Applicant's Attorney or Authorized Representative:    Law Firm/Attorney			
Law Fillin Monthly 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 Sig	ınature	I
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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:			
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		Zip Code	
	State	Zip Code	
Dated	State	Zip Code	
Dated	State  Defense Attorne		

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Defendant's Attorney or Authorized Representative:		
Law Firm/Attorney Non Attorney Representative		
First Name		
Leat Name		
Last Name		
Firm Number		
Law Firm Name		
Address/PO Box (Please leave blank spaces between numbers, names or w	vords)	
	0.00)	
City	State	Zip Code
DatedMM/DD/YYYY	Defense Attorney S	Signaturo
	Deletise Attorney	oignature
Interpreter License Number:		
Interpreter Name	Interpreter Lice	nse Number
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