

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
WORKERS' COMPENSATION APPEALS BOARD

ARBITRATION SUBMITTAL FORM

(Print or type names and addresses; include ZIP Codes)

ID OR CASE No. _____

_____ *Injured Worker* _____ *Address*

_____ *Date of Claimed Injury* _____ *Social Security Number* _____ *Date of Birth*

_____ *Attorney for Injured Worker* _____ *Address*

_____ *Employer* _____ *Address*

_____ *Insurance Carrier or, if Self-Insured, Certificate Name* _____ *Address Where Claim Administered*

_____ *Adjusting Agency, if Agency Administered* _____ *Address*

_____ *Attorney for Employer/Carrier* _____ *Address*

_____ *Party to Arbitration* _____ *Address*

_____ *Attorney* _____ *Address*

_____ *Party to Arbitration* _____ *Address*

_____ *Attorney* _____ *Address*

ISSUES *(Attach additional pages if necessary):*

THE ABOVE ISSUES ARE HEREBY SUBMITTED FOR ARBITRATION UNDER LABOR CODE SECTIONS 5270, ET SEQ., ON THE FOLLOWING GROUNDS:

- Mandatory arbitration under Labor Code Section 5275(a) Voluntary arbitration under Labor Code Section 5275(d)

ARBITRATION SELECTION IS REQUESTED AS FOLLOWS:

Parties herein have agreed to have this case heard before _____
Name of Arbitrator

_____ *Address* _____ *Telephone No.*

Parties herein have unsuccessfully attempted to name an arbitrator and hereby request arbitrator selection pursuant to Labor Code Section 5271(b).

Dated at _____, California, on _____,

_____ *Party or Counsel/Representative* _____ *Party or Counsel/Representative*