STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

Date Of Original Lien: _____ ☐ Original Lien ☐ Amended Lien
MM/DD/YYYY

_____
Case No.

(Choose only one)

☐ a specific injury on _____
(DATE OF INJURY: MM/DD/YYYY)

☐ a cumulative injury which began on _____ and ended on _____
(START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

_____ _____
SSN (Numbers Only) (DATE OF BIRTH: MM/DD/YYYY)

Injured Worker:

_____ ___
First Name MI

_____
Last Name

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

_____ _____ _____
City State Zip Code

Attorney/Representative for Injured Worker:

_____
Name

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

_____ _____ _____
City State Zip Code

Lien Claimant (Completion of this section is required):

_____
Name of Organization filing lien (for individual lien claimants, leave blank)

_____
First Name of Individual filing lien(organizational lien claimants, leave blank)

_____
Last Name of Individual filing lien(organizational lien claimants, leave blank)

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

_____ _____ _____
City State Zip Code

_____
Phone

Lien Claimant's Attorney/Representative, if any

☐ Law Firm/Attorney ☐ Non-Attorney Representative ☐ Lien Claimant not represented

Lien Claimant Law Firm/Representative

First Name

Last Name

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

City State Zip Code

Phone

Employer

Name

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

City State Zip Code

Insurance Carrier or Claims Administrator

Name

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

City State Zip Code

Employer or Claims Administrator Attorney/Representative (if known)

Name

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

City State Zip Code

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of $ _____ against any amount now due or which may hereafter become payable as
Total Lien Amount
compensation to the above-named employee on account of the above-claimed injury.

This request and claim for lien is for (mark appropriate box):

☐ A reasonable attorney's fee for legal services pertaining to any claim for compensation either before the appeals board or before any of the appellate courts, and the reasonable disbursements in connection therewith. (Labor Code § 4903 (a).)

☐ The reasonable expense incurred by or on behalf of the injured employee, as provided by Labor Code § 4600. (Labor Code § 4903 (b).)

☐ Reasonable expense incurred by or on behalf of the injured employee for medical-legal expenses. (Labor Code § 4903 (b).)

☐ The reasonable value of the living expenses of an injured employee or of his or her dependents, subsequent to the injury. (Labor Code § 4903 (c).)

☐ The reasonable burial expenses of the deceased employee. (Labor Code § 4903 (d).)

☐ The reasonable living expenses of the spouse or minor children of the injured employee, or both, subsequent to the date of the injury, where the employee has deserted or is neglecting his or her family. (Labor Code § 4903 (e).)

☐ The reasonable fee for interpreter's services performed on _____ 20 ___ . (Labor Code § 4600 (f).)

☐ The amount of indemnification granted by the California Victims of Crime Program. (Labor Code § 4903 (i).)

☐ The amount of compensation, including expenses of medical treatment, and recoverable costs that have been paid by the Asbestos Workers' Account. (Labor Code § 4903 (j).)

☐ Other Lien(s): Specify nature and statutory basis.

NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

☐ A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

_____ (Signature of Attorney/Representative for Lien Claimant)

_____ (Signature of Lien Claimant)

_____ Date (MM/DD/YYYY)