

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



Date Of Original Lien: \_\_\_\_\_  
MM/DD/YYYY

Original Lien

Amended Lien

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) \_\_\_\_\_

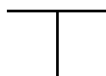
First Name of Individual filing lien(organizational lien claimants, leave blank) \_\_\_\_\_

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 \_\_\_\_\_

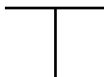


**Lien Claimant's Attorney/Representative, if any**

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)**

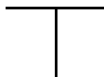
\_\_\_\_\_  
Name

\_\_\_\_\_  
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 compensation to the above-named employee on account of the above-claimed injury.

Total Lien Amount

**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)

