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STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
COMPROMISE AND RELEASE

Case Number 1

Case Number 2

Case Number 3

Case Number 4

Case Number 5

SSN (Numbers Only)

Venue Choice is based upon: (Completion of this section is required)

- [ ] Residence of employee (Labor Code section 5501.5(a)(1))
- [ ] Location where injury occurred (Labor Code section 5501.5(a)(2))
- [ ] Principal address of employee's attorney (Labor Code section 5501.5(a)(3))

Select 3 Letter Office Code For Place/Venue of Hearing (From Document Cover Sheet)

Employee(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 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

Applicant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Law Firm Number

Law Firm Name

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

City State Zip Code

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Law Firm Number

Law Firm Name

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

IT IS CLAIMED THAT:

1. The injured employee, born _____ , alleges that while employed as a(n)
(DATE OF BIRTH: MM/DD/YYYY)

_____ , sustained injury
(OCCUPATION AT THE TIME OF INJURY)

arising out of and in the course of employment at the locations and during the dates listed below:

(State with specificity the date(s) of injury(ies) and what part(s) of body, conditions or systems are being settled.)

☐ 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:

The injury occurred at
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

City , State Zip Code .

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ 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:

The injury occurred at

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

City , State Zip Code .

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ 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 2: Other Body Parts:

The injury occurred at

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

City , State Zip Code .

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ 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:

The injury occurred at

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

City , State Zip Code .

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ Specific Injury

Case Number 5 ☐ 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:

The injury occurred at

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

City , State Zip Code .

Body parts, conditions and systems may not be incorporated by reference to medical reports.

2. Upon approval of this compromise agreement by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge and payment in accordance with the provisions hereof, the employee releases and forever discharges the above-named employer(s) and insurance carrier(s) from all claims and causes of action, whether now known or ascertained or which may hereafter arise or develop as a result of the above-referenced injury(ies), including any and all liability of the employer(s) and the insurance carrier(s) and each of them to the dependents, heirs, executors, representatives, administrators or assigns of the employee. Execution of this form has no effect on claims that are not within the scope of the workers' compensation law or claims that are not subject to the exclusivity provisions of the workers' compensation law, unless otherwise expressly stated.

3. This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury set forth in Paragraph No. 1 despite any language to the contrary in this document or any addendum.

4. Unless otherwise expressly stated, approval of this agreement RELEASES ANY AND ALL CLAIMS OF APPLICANT'S DEPENDENTS TO DEATH BENEFITS RELATING TO THE INJURY OR INJURIES COVERED BY THIS COMPROMISE AGREEMENT. The parties have considered the release of these benefits in arriving at the sum in Paragraph 7. Any addendum duplicating this language pursuant to Sumner v WCAB (1983) 48 CCC 369 is unnecessary and shall not be attached.

5. Unless otherwise expressly ordered by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge, approval of this agreement does not release any claim applicant may have for vocational rehabilitation benefits or supplemental job displacement benefits.

6. The parties represent that the following facts are true: (If facts are disputed, state what each party contends under Paragraph No. 9.)

EARNINGS AT TIME OF INJURY $

TEMPORARY DISABILITY INDEMNITY PAID Weekly Rate $

Period(s) Paid (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

PERMANENT DISABILITY INDEMNITY PAID Weekly Rate $

Period(s) Paid (Start Date: MM/DD/YYYY) End date (End Date: MM/DD/YYYY)

TOTAL MEDICAL BILLS PAID $ Total Unpaid Medical Expense to be Paid By:

Unless otherwise specified herein, the employer will pay no medical expenses incurred after approval of this agreement.

7. The parties agree to settle the above claim(s) on account of the injury(ies) by the payment of the SUM OF

$ _____
Settlement Amount

The following amounts are to be deducted from the settlement amount:

$ _____ for permanent disability advances through _____

$ _____ for temporary disability indemnity overpayment, if any.

$ _____ payable to _____

$ _____ payable to _____

$ _____ payable to _____

$ _____ payable to _____

$ _____ requested as applicant's attorney's fee.

LEAVING A BALANCE OF $ _____ , after deducting the amounts set forth above and less further permanent disability advances made after the date set forth above. Interest under Labor Code section 5800 is included if the sums set forth herein are paid within 30 days after the date of approval of this agreement.

8. Liens not mentioned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary):

9. The parties wish to settle these matters to avoid the costs, hazards and delays of further litigation, and agree that a serious dispute exists as to the following issues (initial only those that apply). ONLY ISSUES INITIALED BY APPLICANT AND HIS/HER REPRESENTATIVE AND DEFENDANTS, REPRESENTATIVES ARE INCLUDED WITHIN THIS SETTLEMENT.

Applicant	Defendant	
_____	_____	earnings
_____	_____	temporary disability
_____	_____	jurisdiction
_____	_____	apportionment
_____	_____	employment
_____	_____	injury AOE/COE
_____	_____	serious and willful misconduct
_____	_____	discrimination (Labor Code §132a)
_____	_____	statute of limitations
_____	_____	future medical treatment
_____	_____	other _____
_____	_____	permanent disability _____
_____	_____	self-procured medical treatment, except as provided in Paragraph 7
_____	_____	vocational rehabilitation benefits/supplemental job displacement benefits

COMMENTS:

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

10. It is agreed by all parties hereto that the filing of this document is the filing of an application, and that the workers' compensation administrative law judge may in its discretion set the matter for hearing as a regular application, reserving to the parties the right to put in issue any of the facts admitted herein and that if hearing is held with this document used as an application, the defendants shall have available to them all defenses that were available as of the date of filing of this document, and that the workers' compensation administrative law judge may thereafter either approve this Compromise and Release or disapprove it and issue Findings and Award after hearing has been held and the matter regularly submitted for decision.

11. WARNING TO EMPLOYEE: SETTLEMENT OF YOUR WORKERS' COMPENSATION CLAIM BY COMPROMISE AND RELEASE MAY AFFECT OTHER BENEFITS YOU ARE RECEIVING TO WHICH YOU BECOME ENTITLED TO RECEIVE IN THE FUTURE FROM SOURCES OTHER THAN WORKERS' COMPENSATION, INCLUDING BUT NOT LIMITED TO SOCIAL SECURITY, MEDICARE AND LONG-TERM DISABILITY BENEFITS.

THE APPLICANT'S (EMPLOYEE'S) SIGNATURE MUST BE ATTESTED TO BY TWO DISINTERESTED PERSONS OR ACKNOWLEDGED BEFORE A NOTARY PUBLIC

By signing this agreement, applicant (employee) acknowledges that he/she has read and understands this agreement and has had any questions he/she may have had about this agreement answered to his/her satisfaction.

Witness the signature hereof this _____ day of _____, _____ at _____

Witness 1	(Date)	Applicant (Employee)	(Date)
Witness 2	(Date)	Attorney for Applicant	(Date)
Interpreter	(Date)	Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)

ACKNOWLEDGMENT

State of California
County of _____)

On _____ before me, _____
(insert name and title of the officer)

personally appeared _____,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ **(Seal)**