

**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):

Organization (Individuals enter first and last names both here and below) _____

For an organization enter the contact person's first name here _____

For an organization enter the contact person's last name here _____

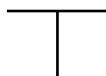
Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____

State _____

Zip Code _____

Phone _____

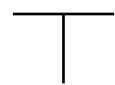


Lien Claimant's Attorney/Representative, if any

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)

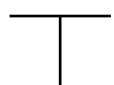
Name

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 (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)

