

DWC-CA form 10214 (a) Page 1 (Rev 07/2008)

STATE OF CALIFORNIA DIVISION OF WORKERS' COMPENSATION WORKERS' COMPENSATION APPEALS BOARD STIPULATIONS WITH REQUEST FOR AWARD

		Date of Injury		
Case No.			MM/DD/YYYY	
SSN (Numbers On	ly)			
Venue Choice is b	ased upon: (Completion of t	his section is required)		
Residence of e	mployee (Labor Code section	5501.5(a)(1))		
Location where	injury occurred (Labor Code s	ection 5501.5(a)(2))		
Principal addres	ss of employee's attorney (Lab	oor Code section 5501.5(a)(3))		
Select 3 Letter Office	ce Code For Place/Venue of H	earing (From the Document Cover S	Sheet)	
Applicant (Comple	etion of this section is requir	ed)		
First Name			MI	
Last Name			-	
Address/PO Box (F	Please leave blank spaces bet	ween numbers, names or words)		
City			State	Zip Code
Employer #1 Infor	mation (Completion of this s	ection is required)		
Insured	Self-Insured	Legally Uninsured	Uninsu	red
Employer Name (P	Please leave blank spaces betw	veen numbers, names or words)		_
Employer Street Ad	ddress/PO Box (Please leave l	plank spaces between numbers, nan	nes or words)	_
City			State	Zip Code

surance Carrier Name (Please leave blank spaces between numbers, names or words)		_ +
surance Carrier Street Address/PO Box (Please leave blank spaces between numbers, nam	nes or words)	
ity	State	Zip Code
aims Administrator Information (if known and if applicable)		
ame (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
mployer #2 Information (Completion of this section is required)		
Insured Self-Insured Legally Uninsured	Unins	ured
Employer Name (Please leave blank spaces between numbers, names or words)		
Employer Street Address/PO Box (Please leave blank spaces between numbers, na	ames or words)	
	ames or words) State	Zip Code
Employer Street Address/PO Box (Please leave blank spaces between numbers, na City Insurance Carrier Information If known and if applicable - include even if carrier is adjusted by claims adminit	State	Zip Code
City nsurance Carrier Information	State	Zip Code
Dity Insurance Carrier Information If known and if applicable - include even if carrier is adjusted by claims admin	State	Zip Code

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Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)

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
Employer #3 Information (Completion of this section is required)		
Insured Self-Insured Legally Uninsured	Uninsu	red
Employer Name (Please leave blank spaces between numbers, names or words)		_
Employer Street Address/PO Box (Please leave blank spaces between numbers, names of	r words)	_
City	State	Zip Code
(if known and if applicable - include even if carrier is adjusted by claims administrated 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 v	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
 		ı

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Employer #4 Infor	mation (Completion of this s	section is required)		
Insured	Self-Insured	Legally Uninsured	Unin	sured ——
Employer Name (P	Please leave blank spaces bet	ween numbers, names or words)		
Employer Street Ad	ddress/PO Box (Please leave	blank spaces between numbers, na	mes or words)	
City Insurance Carrier (if known and if ap		rrier is adjusted by claims admin	State	Zip Code
Insurance Carrier Na	ame (Please leave blank spaces b	petween numbers, names or words)		
Insurance Carrier Str	reet Address/PO Box (Please leav	ve blank spaces between numbers, nam	nes or words)	
City Claims Administra	ator Information (if known ar	nd if applicable)	State	Zip Code
	blank spaces between numbers,	names or words) etween numbers, names or words)		
City			State	Zip Code
	stipulate to the issuance of an bor Code section 5313:	Award and/or Order, based upon the	ne following facts	, and waive the
1Employees First	t Name			'
Employees Last	Name		,	
birth date	MM/DD/YYYY	- ,		
while employed at	t			, State
as a(n)		Occupation		Group in
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More than 4 Compa		
	Specific Injury	
ase 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)
ody Part 1:	Body Part 2:	Body Part 3:
ody Part 4:	Other Body Parts:	
	Specific Injury	
ase 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)
ody Part 1:	Body Part 2:	Body Part 3:
ody Part 4:	Other Body Parts:	
	Specific Injury	
ase Number 3	Cumulative Injury	(Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury)
ody Part 1:	Body Part 2:	Body Part 3:
ody Part 4:	Other Body Parts:	
	Specific Injury	
ase 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)
ody Part 1:	Body Part 2:	Body Part 3:
ody Part 4:	Other Body Parts:	
the employer(s) and the		ustained injury(ies) arising out of and in the course of employme

2. The injury (ies) caused temporary disability for	the period	MM/DD/YYYY	through
	emnity has been paid a	F	er week.
MM/DD/YYYY		Indemnity Paid	I
2(a).The injury(ies) caused additional temporary of	lisability for the period	MM/DD/YYYY	,
through at the	e rate of \$	in the amount of \$	
MM/DD/YYYY	Rate		Indemnity Paid
3. The injury(ies) caused permanent disability of	% for w	hich indemnity has been լ	paid at \$Indemnity Paid
per week beginning	in the sum of	\$, less	credit for such payments
previously made.	per we	eek thereafter.	
Labor Code §4658(d) adjustment:	Life Pension		
Increase vate to C			
as of	MM/DD/YYY	<u> </u>	
Decrease rate to \$			
as of	MM/DD/YYY	/	
Not Applicable	IVIIVI/UU/1111	•	
·			
An informal rating has / has not (Select	one) been previously is	sued in case no(s)	
4.There is is Not a need for medical tre	atment to cure or reliev	e from the effects of said	injury (ies).
5. Medical-legal expenses and/or liens are payab	e by defendant as follo	ws:	
6. Applicant's attorney requests a fee of \$			J
Fees to be commuted as follows:			
7. Liens Against compensation are payable as fol	ows:		
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9.Other stipulations:			
+			
Dated	Applicant		
WIWI DEFT T T	Дрисан		
Applicant's Attorney or Authorized Representative:			1
Law Firm/Attorney Non Attorney Representative			+
First Name			
Last Name			
Firm Number			
		-	
Law Firm name			
Address/PO Box (Please leave blank spaces between numbers, names or words)		-	
Addition O Dox (1 lease leave blatik spaces between numbers, flames of words)			
City	 State	Zip Code	
Dated	Applicant Attorney Sig	nature	
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8. Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

Defendant's Attorney or Authorized Representative:			
Non Attorney Representative			
			\top
First Name			ı
Last 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	
,	State	2.p 0000	
DatedMM/DD/YYYY			
Wilvi, DD/1111	Defense Attorney	Signature	
Defendant's Attorney or Authorized Representative:			
Law Firm/Attorney Non Attorney Representative			
First Name			
Last Name			
Firm Number			
Low Firm Nama			
Law Firm Name			
Law Firm Name			
		_	
Law Firm Name Address/PO Box (Please leave blank spaces between numbers, names or words)			
Address/PO Box (Please leave blank spaces between numbers, names or words)	Stata	Zip Code	
Address/PO Box (Please leave blank spaces between numbers, names or words)	State	Zip Code	
Address/PO Box (Please leave blank spaces between numbers, names or words) City	State	Zip Code	
Address/PO Box (Please leave blank spaces between numbers, names or words) City	State	 Zip Code	
Address/PO Box (Please leave blank spaces between numbers, names or words) City Dated			
Address/PO Box (Please leave blank spaces between numbers, names or words) City Dated	State Defense Attorne		

Defendant's Attorney or Authorized Representative:			
Law Firm/Attorney Non Attorney Representative			
First Name			
Last Name			
Firm Number			
Law Firm Name			
Law Filli Name			
Address (DO Day (Diseas I asses blank assess between assess as seemed)	X		
Address/PO Box (Please leave blank spaces between numbers, names or words))		
City	State	Zip Code	
DatedMM/DD/YYYY	Defense Attorney	Signature	
	,	- J	
Interpreter Licence Number:			
·			
		N	
Interpreter Name	Interpreter Lice	ense Number	