STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

STIPULATIONS WITH REQUEST FOR AWARD

Case No _____ Date of Injury _____ MM/DD/YYYY

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 Digit Office Code For Place/Venue of Hearing (From Instruction Sheet) _____

Applicant (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 #1 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 _____

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

Employer #2 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

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

Employer #3 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

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

Employer #4 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

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

The parties hereto stipulate to the issuance of an Award and/or Order, based upon the following facts, and waive the Labor Code Section 5313:

1. _____
Employee First Name

_____ ,
Employee Last Name

birth date _____ ,
MM/DD/YYYY

while employed at _____ , _____
State

as a(n) _____ , _____
Occupation Group

☐ More than 4 Companion Cases

Case 1 ☐ Specific Injury ☐ 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 :

Case 2 ☐ Specific Injury ☐ 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 :

Case 3 ☐ Specific Injury ☐ 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 :

Case 4 ☐ Specific Injury ☐ 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 :

by _____ whose compensation insurance carrier(s) was/were
(Employer(s))

_____ and who sustained injury(ies) arising out of and in the

course of employment to (Please list all body parts injured) _____

_____

_____

2. The injury(ies) caused temporary disability for the period _____ (MM/DD/YYYY) through _____ (MM/DD/YYYY) for which indemnity has been paid at $_____ (Indemnity Paid) per week.

2(a). The injury(ies) caused additional temporary disability for the period _____ (MM/DD/YYYY) through _____ (MM/DD/YYYY) at the rate of $_____ (Rate) in the amount of $_____ (Indemnity Paid)

3. The injury(ies) caused permanent disability of _____% for which indemnity has been paid at $_____ (Indemnity Paid) per week beginning _____ (MM/DD/YYYY), in the sum of $_____, less credit for such payments previously made. ☐ And a life pension of $_____ (Life Pension) per week thereafter.

Labor Code §4658(d) adjustment:

☐ Increase rate to $_____ as of _____ (MM/DD/YYYY)

☐ Decrease rate to $_____ as of _____ (MM/DD/YYYY)

☐ Not Applicable

An informal rating ☐ has / ☐ has Not (Select one) been previously issued Case No(s) _____

Applicant / Employee: _____ Case No(s). _____

4. There ☐ is ☐ is Not a need for medical treatment to cure or relieve from the effects of said injury(ies).

5. Medical-legal expenses and/or liens are payable by defendant as follows:

_____

_____

6. Applicant's attorney requests a fee of $ _____

☐ Fees to be commuted as follows:

_____

_____

_____

7. Liens against compensation are payable as follows:

_____

_____

_____

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

9. Other stipulations:

Dated ____________________ MM/DD/YYYY

____________________ Applicant

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

Dated ____________________ MM/DD/YYYY

____________________ Applicant Attorney Signature

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

Dated MM/DD/YYYY Defense Attorney Signature

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

Dated MM/DD/YYYY Defense Attorney Signature

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

Dated MM/DD/YYYY

Defense Attorney Signature

Interpreter Licence Number:

Interpreter Name

Interpreter License Number