

**STATE OF CALIFORNIA  
DEPARTMENT OF INDUSTRIAL RELATIONS  
WORKERS' COMPENSATION APPEALS BOARD**

V.	APPLICANT
	DEFENDANT(S).

CASE NO. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PRE-TRIAL CONFERENCE STATEMENT §5502 (e) (3)  
 NOTICE OF HEARING

LOCATION: \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

SETTLEMENT CONFERENCE JUDGE: \_\_\_\_\_

APPEARANCES:

- INJURED WORKER: \_\_\_\_\_
- INJURED WORKER'S ATTORNEY \_\_\_\_\_  ATTY  HRG REP
- (FIRM NAME AND PERSON APPEARING)
- DEFENDANT'S ATTORNEY \_\_\_\_\_  ATTY  HRG REP
- \_\_\_\_\_  ATTY  HRG REP
- \_\_\_\_\_  ATTY  HRG REP
- \_\_\_\_\_  ATTY  HRG REP
- (FIRM NAME AND PERSON APPEARING) (DEFENDANT)
- OTHERS APPEARING: \_\_\_\_\_
- (L.C., INTERPRETERS, ETC.) \_\_\_\_\_
- ADDRESS RECORD CHANGES: \_\_\_\_\_
- \_\_\_\_\_

**BOX BELOW TO BE COMPLETED ONLY BY WORKERS' COMPENSATION JUDGE**

**DISPOSITION: SET FOR REGULAR HEARING:**  WCAB NOTICE  NOTICE WAIVED

1 HOUR  2 HOURS  1/2 DAY  ALL DAY

BEFORE ANY WCJ  BEFORE WCJ \_\_\_\_\_  BEFORE ANY WCJ OTHER THAN \_\_\_\_\_

CASE(S) SET ON \_\_\_\_\_ AT \_\_\_\_\_ WCJ \_\_\_\_\_ IN \_\_\_\_\_

(DATE) (TIME) (LOCATION)

**OTHER DISPOSITION AND ORDERS:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SERVICE AS ORDERED ON PAGE 4

\_\_\_\_\_  
**WORKERS' COMPENSATION  
 ADMINISTRATIVE LAW JUDGE**

STIPULATIONS

THE FOLLOWING FACTS ARE ADMITTED:

1. \_\_\_\_\_, BORN \_\_\_\_/\_\_\_\_/\_\_\_\_

WHILE  EMPLOYED  ALLEGEDLY EMPLOYED

ON \_\_\_\_\_

DURING THE PERIOD(S) \_\_\_\_\_

AS A(N) \_\_\_\_\_, OCCUPATIONAL GROUP NUMBER \_\_\_\_\_

AT \_\_\_\_\_, CALIFORNIA,

BY \_\_\_\_\_

SUSTAINED INJURY ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT TO \_\_\_\_\_

CLAIMS TO HAVE SUSTAINED INJURY ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT TO \_\_\_\_\_

2. AT THE TIME OF INJURY THE EMPLOYER'S WORKERS' COMPENSATION CARRIER WAS \_\_\_\_\_

THE EMPLOYER WAS  PERMISSIBLY SELF-INSURED  UNINSURED  LEGALLY UNINSURED

3. AT THE TIME OF INJURY, THE EMPLOYEE'S EARNINGS WERE \$ \_\_\_\_\_ PER WEEK, WARRANTING INDEMNITY RATES OF \$ \_\_\_\_\_ FOR TEMPORARY DISABILITY AND \$ \_\_\_\_\_ FOR PERMANENT DISABILITY.

4. THE CARRIER/EMPLOYER HAS PAID COMPENSATION AS FOLLOWS: (TD/PD/VRMA)

TYPE	WEEKLY RATE	PERIOD	TYPE	WEEKLY RATE	PERIOD
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

THE EMPLOYEE HAS BEEN ADEQUATELY COMPENSATED FOR ALL PERIODS OF T/D CLAIMED THROUGH \_\_\_\_\_

5. THE EMPLOYER HAS FURNISHED  ALL  SOME  NO MEDICAL TREATMENT.

THE PRIMARY TREATING PHYSICIAN IS \_\_\_\_\_

6.  NO ATTORNEY FEES HAVE BEEN PAID AND NO ATTORNEY FEE ARRANGEMENTS HAVE BEEN MADE.

7.  OTHER STIPULATIONS \_\_\_\_\_

\_\_\_\_\_  
APPLICANT

\_\_\_\_\_  
DEFENDANT

\_\_\_\_\_  
LIEN CLAIMANT/OTHER

ISSUES

- EMPLOYMENT \_\_\_\_\_
- INSURANCE COVERAGE \_\_\_\_\_
- INJURY ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT \_\_\_\_\_
- PARTS OF BODY INJURED: \_\_\_\_\_
- EARNINGS: EMPLOYEE CLAIMS \_\_\_\_\_ PER WEEK, BASED ON \_\_\_\_\_  
EMPLOYER/CARRIER CLAIMS \_\_\_\_\_ PER WEEK, BASED ON \_\_\_\_\_
- TEMPORARY DISABILITY, EMPLOYEE CLAIMING THE FOLLOWING PERIOD(S): \_\_\_\_\_

- PERMANENT AND STATIONARY DATE:  
EMPLOYEE CLAIMS \_\_\_/\_\_\_/\_\_\_, BASED ON \_\_\_\_\_  
EMPLOYER/CARRIER CLAIMS \_\_\_/\_\_\_/\_\_\_, BASED ON \_\_\_\_\_

- PERMANENT DISABILITY     APPORTIONMENT
- OCCUPATION AND GROUP NUMBER CLAIMED: BY EMPLOYEE \_\_\_\_\_  
BY EMPLOYER/CARRIER \_\_\_\_\_

- NEED FOR FURTHER MEDICAL TREATMENT \_\_\_\_\_
- LIABILITY FOR SELF-PROCURED MEDICAL TREATMENT \_\_\_\_\_

LIENS:

<u>LIEN CLAIMANT</u>	<u>TYPE OF LIEN</u>	<u>AMOUNT AND PERIODS PAID</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- ATTORNEY FEES
- OTHER ISSUES: \_\_\_\_\_

\_\_\_\_\_  
APPLICANT

\_\_\_\_\_  
DEFENDANT

\_\_\_\_\_  
LIEN CLAIMANT/OTHER

**PRE-TRIAL CONFERENCE STATEMENT**

**CASE NO.** \_\_\_\_\_

**THIS PAGE FOR JUDGE'S USE ONLY**

**JUDGE'S CONFERENCE NOTES:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ORDERS**

**IT IS ORDERED** PURSUANT TO WCAB RULE 10500, THAT  DEFENDANT  APPLICANT  LIEN CLAIMANT SERVE FORTHWITH THIS  PRE-TRIAL CONFERENCE STATEMENT  NOTICE OF HEARING ON ALL PARTIES OR THEIR REPRESENTATIVE SHOWN ON THE OFFICIAL ADDRESS RECORD AND ANY ADDITIONAL LIEN CLAIMANTS WHOSE LIENS ARE SHOWN UNDER **ISSUES** (PAGE 3).

**IT IS FURTHER ORDERED** THAT  DEFENDANT  APPLICANT  LIEN CLAIMANT SERVE TIMELY NOTICE OF THE TIME AND PLACE OF ALL REGULAR HEARING SESSIONS ON ALL LIEN CLAIMANTS WHOSE LIENS ARE SHOWN UNDER ISSUES, TOGETHER WITH THE **FOLLOWING NOTICE: YOUR LIEN IS AT ISSUE AND WILL BE ADJUDICATED AT REGULAR HEARING.**

**IT IS FURTHER ORDERED** THAT THE PROOF OF SERVICE ORDERED ABOVE BE FILED WITH THE WCAB **ONLY** ON REQUEST OF THE ASSIGNED WORKERS' COMPENSATION JUDGE.

OTHER DISPOSITION AND ORDERS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SERVICE OF THIS DOCUMENT WAS MADE PERSONALLY UPON \_\_\_\_\_ BY WCJ.

DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_

**WORKERS' COMPENSATION  
ADMINISTRATIVE LAW JUDGE**



1. APPLICANT, BORN \_\_\_\_\_, SUSTAINED OR CLAIMS INJURY AS FOLLOWS:

	(1)	(2)	(3)	(4)
CASE NO.				
DOI				
	CLAIMS <input type="checkbox"/> ADMITTED <input type="checkbox"/>	CLAIMS <input type="checkbox"/> ADMITTED <input type="checkbox"/>	CLAIMS <input type="checkbox"/> ADMITTED <input type="checkbox"/>	CLAIMS <input type="checkbox"/> ADMITTED <input type="checkbox"/>
BODY PARTS				
JOB TITLE(S) OCCUPATIONAL GROUP NO(S).				
EARNINGS & TD/PD RATES				
EMPLOYER				
CARRIER ADJUSTED BY				
WORK COMP SECURED BY	INSURED <input type="checkbox"/> SELF-INSURED <input type="checkbox"/> UNINSURED <input type="checkbox"/>	INSURED <input type="checkbox"/> SELF-INSURED <input type="checkbox"/> UNINSURED <input type="checkbox"/>	INSURED <input type="checkbox"/> SELF-INSURED <input type="checkbox"/> UNINSURED <input type="checkbox"/>	INSURED <input type="checkbox"/> SELF-INSURED <input type="checkbox"/> UNINSURED <input type="checkbox"/>
COVERAGE DATES				

2. THE CARRIER/EMPLOYER HAS PAID COMPENSATION AS FOLLOWS:

<u>TYPE</u>	<u>WEEKLY RATE</u>	<u>PERIOD</u>	<u>PAID BY</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3.  THE EMPLOYEE HAS BEEN ADEQUATELY COMPENSATED FOR ALL PERIODS OF TEMPORARY DISABILITY CLAIMED THROUGH \_\_\_\_\_.

4. THE EMPLOYER HAS FURNISHED  ALL  SOME  NO MEDICAL TREATMENT.  
THE PRIMARY TREATING PHYSICIAN IS \_\_\_\_\_.

5.  NO ATTORNEY FEES HAVE BEEN PAID AND NO ATTORNEY FEE AGREEMENTS HAVE BEEN MADE.

6.  OTHER STIPULATIONS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_