



7. Medical Treatment was received  Yes  No \_\_\_\_\_ date of last treatment  
Furnished by employer or carrier  Yes  No

List physicians or hospitals not provided or paid for by employer \_\_\_\_\_

\_\_\_\_\_  
(name of person or entity providing or paying for medical care)

8. Reports or records of the following physicians will be offered in evidence and are attached: \_\_\_\_\_  
(list by name and date)

List all other medical reports: \_\_\_\_\_  
(list by name and date)

9. The following other documents will be offered in evidence and are attached: \_\_\_\_\_

10. List other claims of industrial injury or applications filed by this injured worker: \_\_\_\_\_

(If no application filed, attach copy or copies of Employee's Claim for Workers' Compensation Benefits (Form DWC-1 ) If application filed, give case number and location filed. )

NOTE: If additional space is needed to answer Items 1 through 10, attach additional pages to Application.

#### DECLARATION UNDER PENALTY OF PERJURY

I, \_\_\_\_\_ the applicant, applicant's attorney or representative, declare under penalty of perjury that applicant has completed discovery; that all medical reports in my possession or control have been filed and served as required by the WCAB Rules of Practice and Procedure; that a copy of this application together with all supporting documents has been served on opposing parties (see proof of service attached); that applicant is ready to proceed to  hearing  mandatory arbitration  voluntary arbitration on the issues indicated above; that the following efforts to resolve the issues have been made:

\_\_\_\_\_ and that applicant expects to present \_\_\_\_\_ witnesses and I estimate the time required for the hearing will be \_\_\_\_\_ hours.

(If arbitration selected, Arbitration Submittal Form must be attached.)

Dated at \_\_\_\_\_, California  
(city)

\_\_\_\_\_  
(applicant's attorney or representative signature)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(applicant's signature)

\_\_\_\_\_  
(applicant's attorney or representative)

\_\_\_\_\_  
(applicant's telephone number)

\_\_\_\_\_  
(address and telephone number of attorney or representative)

**This Application may not be filed without a dated and completed Employee's Claim for Workers' Compensation Benefits form provided by the employer describing this claim of injury or disability. Attach copy of Employee's Claim for Workers' Compensation Benefits form. (See Instruction #1)**