STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS

WORKERS' COMPENSATION APPEALS BOARD

ARBITRATION SUBMITTAL FORM

(Print or type names and addresses; include ZIP Codes)

ID OR CASE No.

Injured Worker	*Address*
Date of Claimed Injury / *Social Security Number* / *Date of Birth*	
Attorney for Injured Worker	*Address*
Employer	*Address*
Insurance Carrier or, if Self-Insured, Certificate Name	*Address Where Claim Administered*
Adjusting Agency, if Agency Administered	*Address*
Attorney for Employer/Carrier	*Address*
Party to Arbitration	*Address*
Attorney	*Address*
Party to Arbitration	*Address*
Attorney	*Address*

ISSUES *(Attach additional pages if necessary):*

THE ABOVE ISSUES ARE HEREBY SUBMITTED FOR ARBITRATION UNDER LABOR CODE SECTIONS 5270, ET SEQ., ON THE FOLLOWING GROUNDS:

☐ Mandatory arbitration under Labor Code Section 5275(a) ☐ Voluntary arbitration under Labor Code Section 5275(d)

ARBITRATION SELECTION IS REQUESTED AS FOLLOWS:

☐ Parties herein have agreed to have this case heard before _____
Name of Arbitrator

_____
Address *Telephone No.*

☐ Parties herein have unsuccessfully attempted to name an arbitrator and hereby request arbitrator selection pursuant to Labor Code Section 5271(b).

Dated at _____, California, on _____, _____

Party or Counsel/Representative	*Party or Counsel/Representative*