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STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
PETITION TO TERMINATE LIABILITY FOR TEMPORARY DISABILITY INDEMNITY

Case Number 1

Case Number 2

Case Number 3

Case Number 4

Case Number 5

Injured Worker (Completion of this section is required)

First Name

MI

Last Name

Employer Information

☐ 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 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 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

DEFENDANTS ALLEGE that temporary disability was heretofore found by a WCAB decision of _____ that

temporary disability has been paid in the total sum of $ _____ for the period _____ to _____

that temporary disability terminated on _____

☐ (1) Applicant returned to work on said date.

☐ (2) Applicant was declared able to return to work on said date per report of Dr. _____

Dated _____

☐ (3) Applicant's condition is permanent and stationary as shown by the attached medical report(s).

☐ (4) Applicant's condition has reached maximum medical improvement as shown by the attached medical report(s).

☐ (5) Other _____

Defendants are informed and believe that applicant ☐ is presently working ☐ is not presently working Advances ☐ are ☐ are not

being made on permanent disability indemnity at the rate of $ _____ per week and will continue until

approximately _____.

Defendants request that the Workers' Compensation Appeals Board make an order terminating liability for temporary disability indemnity unless the employee objects, and if the employee does object, that this petition be set for hearing.

All medical reports in petitioner's possession not previously served and filed herein, are attached hereto, served herewith.

_____

(Insurer / Employer)

I declare under penalty of perjury that the allegations contained in this petition are true and correct to the best of my knowledge and belief.

By _____

NOTE: Section 10466 of title 8 of the California Code of Regulations provides as follows: "IF WRITTEN OBJECTION IS NOT RECEIVED TO THE PETITION WITHIN FOURTEEN DAYS OF ITS PROPER FILING AND SERVICE, THE WCAB MAY ORDER TEMPORARY DISABILITY COMPENSATION TERMINATED, in accordance with the facts as stated in the petition or in such other manner as may appear appropriate on the record."