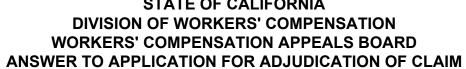


DWC/ WCAB Form 10 (Page 1) (REV. 11/2008)

STATE OF CALIFORNIA DIVISION OF WORKERS' COMPENSATION WORKERS' COMPENSATION APPEALS BOARD



Case Number			
(Choose only one)			
a specific injury on			
(MM/DD/YYY	Y)		
a cumulative trauma injury which began on	and ende		
	(START DATE: MM/DD/YYYY)	TART DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)	
Name(s) of Answering Party(ies) (Please lea	ave blank paces between names, num	bers or words)	
Injured Worker			
 Last Name			
First Name			
Employer Information			
Insured Self-Insured	Legally Uninsured	Uninsur	ed
Employer Name (Please leave blank spaces	s between numbers, names or words)		
Employer Street Address/PO Box (Please le	eave blank spaces between numbers, r	names or words)	_
City		 State	Zip Code
Insurance Carrier Information (if applicab	le - include even if carrier is adiuste		
()PF			,
Insurance Carrier Name (Please leave blank spa	aces between numbers, names or words)		
			_
Insurance Carrier Street Address/PO Box (Pleas	e leave Dialik spaces detween numbers, na	ames or words)	
City		State	Zip Code

WCAB10

Claims Administrator Information (if app	licable)			
lame (Please leave blank spaces between numbers, names or words)				
Street Address/PO Box (Please leave blank spa	aces between numbers, names or words)			
City	State Zip Code			
ANSWERING DEFENDANTS deny the expressly set forth and admit all other m	allegations of the application as indicated below with such explanations as naterial allegations.			
DENIALS (Mark X if allegation is denied)	EXPLAIN BELOW			
Employment				
Occupation				
Injury	(IF DENIAL IS BASED ON DATE OR PART OF BODY INJURED, EXPLAIN FULLY)			
Insurance coverage	(STATE IF EMPLOYER HAS BEEN NOTIFIED TO APPEAR AND DEFEND)			
Liability for self-procured treatment				
Liability for future medical treatment				
Medical-legal costs				
Earnings				

Periods of disability	(GIVE LAST DAY WORKED A	ND CORRECT DATE OF RETUR	RN TO WORK, IF ANY)
Rehabilitation			
Supplemental job displacement / return to work			
Permanent disability	(IF APPORTIONMENT IS CLA	MMED, SO STATE)	
IT IS FURTHER ALLEGED:			
1. Defendants have paid disability indemn	ity in the total amount of \$	at the rate o	f \$
a week beginning	through	plus	
MM/DD/YYYY 2. Affirmative defenses and other matters		MM/DD/YYYY	
The Answer to this Application is being file	d on behalf of (Please check o	one only)	
Employer	Insurance Carrier	Both	
Defendant(s) do(es) not waive the right to and Procedure if other issues develop.	aise additional issues in acco	rdance with the provisions of la	aw and the Rules of Practic
Dated:			
		Phone Number	
Signature			
Firm Name			
Address/PO Box (Please leave blank spaces b	etween numbers, names or word	s)	
The second of th	word	-,	
City	<u> </u>	 State	Zip Code
DWC/ WCAB Form 10 (Page 3) (REV. 11/2008)	+		WCAB10