

IRONWORKERS WORKERS' COMPENSATION ALTERNATIVE DISPUTE RESOLUTION SYSTEM

STIPULATIONS WITH REQUEST FOR AWARD

Case No(s). _____

Social Security No. _____

Applicant (Employee)

Address

Correct Name(s) of Employer(s)

Address(es)

Name(s) of Insurance Carrier(s) Claims Administrator(s)

Address(es)

The parties hereto stipulate to the issuance of an Award and/or Order, based upon the following facts, and waive the requirements of Labor Code section 5313:

1. _____, born _____, while employed within the State of California as _____, _____ on _____, by _____
(Occupation) (Group) (Date of injury) (Employer)

whose compensation insurance carrier was _____ sustained injury arising out of and in the course of employment to _____.
(Parts of Body injured)

2. The injury caused additional temporary disability for the periods _____ through _____ for which indemnity has been paid at \$ _____ per week.

2(a). The injury caused additional temporary disability for the period _____ through _____ at the rate of \$ _____, and in the amount of \$ _____.

3. The injury caused permanent disability of _____%, for which indemnity is payable at \$_____ per week beginning _____, in the sum of \$_____, less credit for such payments previously made.

___ And a life pension of \$_____ per week thereafter.

4. There is/is not a need for medical treatment to cure or relieve from the effects of said injury.

5. Medical-legal expenses are payable by defendant as follows:

6. Applicant's attorney requests a fee of \$_____

___ Fees to be commuted.

7. Liens against compensation are payable as follows:

8. Other stipulations:

Dated

Applicant

Attorney for Applicant

Attorney or Authorized Representative for Defendant

Address of Attorney for Applicant

Address of Attorney or Authorized Representative