STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

Date Of Original Lien: _____ (MM/DD/YYYY) ☐ Original Lien ☐ Amended Lien

_____
Case No.

(Choose only one)

☐ a specific injury on _____
(DATE OF INJURY: MM/DD/YYYY)

☐ a cumulative injury which began on _____ (START DATE: MM/DD/YYYY) and ended on _____ (END DATE: MM/DD/YYYY)

_____ _____
SSN (Numbers Only) (DATE OF BIRTH: MM/DD/YYYY)

Injured Worker:

_____ ___
First Name MI

_____
Last Name

_____
Address/PO Box (Please leave blank spaces between numbers, names or words)

_____ _____ _____
City State Zip Code

Attorney/Representative for Injured Worker:

_____
Name

_____
Address/PO Box (Please leave blank spaces between numbers , names or words)

_____ _____ _____
City State Zip Code

Lien Claimant (Completion of this section is required):

_____
Name of Organization filing lien (for individual lien claimants, leave blank)

_____
First Name of Individual filing lien(organizational lien claimants, leave blank)

_____
Last Name of Individual filing lien(organizational lien claimants, leave blank)

_____
Address/PO Box (Please leave blank spaces between numbers, names or words)

_____ _____ _____
City State Zip Code

_____
Phone