

**INFORMATION PROVIDED TO INTERESTED PERSONS**  
UNDER THE  
BASIC CRAFTS WORKERS' COMPENSATION BENEFITS TRUST FUND ADDENDUM

---

---

ENCLOSED INFORMATION PROVIDED BY:  
ADR Director  
Steven Siemers  
Basic Crafts Workers' Compensation Benefits Trust Fund  
265 Hegenberger Road, Suite 240  
Oakland, CA 94621-1480  
Telephone: (510) 568-5920  
Fax: (510) 568-5279

INFORMATION PROVIDED TO:

---

---

---

Case No. \_\_\_\_\_

Employee's Name: \_\_\_\_\_

Relevant Employer(s): \_\_\_\_\_

Other: \_\_\_\_\_

---

---

- \_\_\_\_\_ Workers' Compensation Addendum
- \_\_\_\_\_ Rules of Practice and Procedure
- \_\_\_\_\_ Medical Providers Exclusive List
- \_\_\_\_\_ Medical Evaluators Exclusive List
- \_\_\_\_\_ Rehabilitation Providers Exclusive List
- \_\_\_\_\_ Selected Information from the Employee Packet:
  - \_\_\_\_\_ Introductory letter from Basic Crafts Workers' Compensation Benefits Trust Fund
  - \_\_\_\_\_ Overview of Workers' Compensation Addendum
  - \_\_\_\_\_ Overview of Alternative Dispute Prevention and Resolution System
  - \_\_\_\_\_ Overview of Ombudsman's Role in the Alternative Dispute Prevention on System
  - \_\_\_\_\_ Overview of Exclusive Lists
- \_\_\_\_\_ Workers' Compensation Grievance
- \_\_\_\_\_ Director's Notice of Informal Conciliation
- \_\_\_\_\_ Arbitration Request
- \_\_\_\_\_ Declaration of Readiness to Arbitrate
- \_\_\_\_\_ Information Request & Production Form
- \_\_\_\_\_ Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NOTICE OF OMBUDSMAN'S "FINAL RESPONSE"**  
UNDER THE  
BASIC CRAFTS WORKERS' COMPENSATION BENEFITS TRUST FUND ADDENDUM

Case No. \_\_\_\_\_

\_\_\_\_\_  
(Employee's Name)

\_\_\_\_\_  
(Employer's Name)

\_\_\_\_\_  
(Social Security Number)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City, State & Zip Code)

\_\_\_\_\_  
(City, State & Zip Code)

NOTICE IS HEREBY GIVEN TO THE EMPLOYEE THAT:

The Ombudsman has provided the Employee a "final response" in accordance with the Workers' Compensation Addendum:

If the Employee is not satisfied with the Ombudsman's "final response" and elects to pursue the matter further, the **Employee has 30 days** after receipt of this "final response" to file a Workers' Compensation Grievance with the ADR Director:

ADR Director  
Steven Siemers  
Basic Crafts Workers' Compensation Benefits Trust Fund  
265 Hegenberger Road, Suite 240  
Oakland, CA 94621-1480  
Telephone: (510) 568-5920  
Fax: (510) (510) 568-5279

Refer to Article VII of the Workers' Compensation Addendum for information concerning the procedure to follow, and the conditions and limits to additional aid and counseling from the Ombudsman. Workers' Compensation Grievance Forms may be obtained from the ADR Director or Ombudsman.

FROM:  
Ombudsman for the Alternative Dispute Prevention and Resolution System  
Steven Siemers  
Basic Crafts Workers' Compensation Benefits Trust Fund  
265 Hegenberger Road, Suite 240  
Oakland, CA 94621-1480  
Telephone: (510) 568-5920  
Fax: (510) 568-5279

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Ombudsman's Signature)

cc: Steven Siemers, ADR Director  
Employee's Insurance Carrier

**GRIEVANCE**  
UNDER THE  
BASIC CRAFTS WORKERS' COMPENSATION BENEFITS TRUST FUND ADDENDUM

Case No. \_\_\_\_\_

\_\_\_\_\_  
(Employee's Name)

\_\_\_\_\_  
(Employer's Name)

\_\_\_\_\_  
(Social Security Number)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City, State & Zip Code)

\_\_\_\_\_  
(City, State & Zip Code)

If other, name, etc.: \_\_\_\_\_

1. While employed as a \_\_\_\_\_ on \_\_\_\_\_  
(occupation at time of injury) (date of injury)

at \_\_\_\_\_ by the employer, the employee sustained injury arising out of and in the  
(name and location of job site)

course of employment to \_\_\_\_\_  
(state what parts of the body were injured)

2. The injury occurred as follows: \_\_\_\_\_  
(explain what employee was doing at the time of injury and how injury was received)

3. Days off work because of the injury: \_\_\_\_\_  
(specify the number of days off work and the dates for those days)

4. Medical Treatment was received: \_\_\_\_\_  
(yes) (no) (date of last treatment)

Medical treatment was provided by \_\_\_\_\_  
(name and address of all medical providers)

5. This Grievance is filed because of a dispute about: Temporary Disability Payments \_\_\_ Permanent Disability Payments' \_\_\_\_\_

Reimbursement for Medical Expenses: \_\_\_\_\_ Compensation at the Proper Rate: \_\_\_\_\_ Rehabilitation: \_\_\_\_\_ Medical Treatment \_\_\_\_\_

Other (Explain) \_\_\_\_\_

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Employee's Signature, or Attorney's if represented)

Must be timely filed with the ADR Director  
Steve Siemers  
Basic Crafts Workers' Compensation Benefits Trust Fund  
265 Hegenberger Road, Suite 240  
Oakland, CA 94621-1480  
Telephone: (510) 568-5920; Fax: (510) 568-5279

**GRIEVANCE**  
 UNDER THE  
 BASIC CRAFTS WORKERS' COMPENSATION BENEFITS TRUST FUND ADDENDUM

**(DEATH CASE ONLY)**

Case No. \_\_\_\_\_

\_\_\_\_\_  
 (Deceased Employee's Name & Social Security No.)

\_\_\_\_\_  
 (Employer's Name)

\_\_\_\_\_  
 (Street Address)

\_\_\_\_\_  
 (Street Address)

\_\_\_\_\_  
 (City, State & Zip Code)

\_\_\_\_\_  
 (City, State & Zip Code)

\_\_\_\_\_  
 (Applicant's Name)

\_\_\_\_\_  
 (Street Address)

\_\_\_\_\_  
 (City, State & Zip Code)

1. While employed as a \_\_\_\_\_ on \_\_\_\_\_  
(occupation at time of injury) (date of injury)  
 at \_\_\_\_\_ by the employer, the employee sustained injury arising out of and in the  
(name and location of job site)  
 course of employment to \_\_\_\_\_  
(state what parts of the body were injured)

2. The injury occurred as follows: \_\_\_\_\_  
(explain what employee was doing at the time of injury and how injury was received)  
 \_\_\_\_\_, resulting in death on \_\_\_\_\_  
(date of death)

3. The employee left the following dependents:

Name	Date of Birth	Relationship	Address

Employee requests: Death Benefit \_\_\_\_\_ Burial Expense \_\_\_\_\_ Unpaid Compensation \_\_\_\_\_ Unpaid Medical Expenses \_\_\_\_\_

Other (Explain): \_\_\_\_\_

\_\_\_\_\_  
 (Date)

\_\_\_\_\_  
 (Employee's Signature, or Attorney's if represented)

Must be timely filed with the ADR Director:  
 Steve Siemers  
 Basic Crafts Workers' Compensation Benefits Trust Fund  
 265 Hegenberger Road, Suite 240  
 Oakland, CA 94621-1480  
 Telephone: (510) 568-5920; Fax: (510) 568-5279

**ADR DIRECTOR'S NOTICE OF INFORMAL CONCILIATION**  
UNDER THE  
BASIC CRAFTS WORKERS' COMPENSATION BENEFITS TRUST FUND ADDENDUM

---

---

NOTICE PROVIDED BY:

ADR Director  
Steven Siemers  
Basic Crafts Workers' Compensation Benefits Trust Fund  
265 Hegenberger Road, Suite 240  
Oakland, CA 94621-1480  
Telephone: (510) 568-5920  
Fax: (510) 568-5279

NOTICE PROVIDED TO:

Employee  
 Employer's Insurance Co.  
 Ombudsman  
 Other: \_\_\_\_\_

Case No. \_\_\_\_\_

Employee's Name: \_\_\_\_\_

Employer(s): \_\_\_\_\_

Other: \_\_\_\_\_

---

---

INFORMAL CONCILIATION WILL BE HELD regarding the attached Workers' Compensation Grievance(s) at the following time and place:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ALL PARTIES, or their authorized representatives, are hereby ordered to meet and seek a negotiated resolution of dispute(s) raised by the attached Grievance(s), pursuant to the Workers' Compensation Addendum. All representatives must have authority to settle all issues at the Informal Conciliation.

THE OMBUDSMAN will attend to aid and counsel the Employee only if requested by the Employee. The Ombudsman will not discuss matters regarding the Employee's claims, complaints or inquires with any attorney representing the Employee.

ALL PARTIES are further ordered to:

1. Contact the ADR Director no less than three (3) work days before the scheduled date to confirm their attendance, and to receive and provide any other information that may be necessary;
2. Contact the ADR Director if resolution of all issues is reached before the scheduled date; and
3. Bring to the Informal Conciliation all documents and information that may help in resolution of the dispute.

Documents Attached:

\_\_Workers' Compensation Grievance(s)

\_\_Other:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

Form 105 (September 30, 2004)  
Basic Crafts Workers' Compensation Benefits Trust Fund

# ARBITRATION REQUEST

UNDER THE  
BASIC CRAFTS WORKERS' COMPENSATION BENEFITS TRUST FUND ADDENDUM

Case No. \_\_\_\_\_

The  Employee's Name: \_\_\_\_\_  
 Employer's Name: \_\_\_\_\_  
 Other Name: \_\_\_\_\_  
("Requesting Party")

hereby requests the ADR Director to schedule an arbitration hearing pursuant to the Workers' Compensation Addendum. Requesting Party declares that it made a good faith attempt to resolve the dispute at Informal Conciliation.

The issues are:

Compensation Rate                       Rehabilitation  
 Temporary Disability                       Self-procured Treatment  
 Permanent Disability                       Future Medical Treatment  
 Other: \_\_\_\_\_

1. If represented by legal counsel, identify: \_\_\_\_\_  
(name, address & telephone number)

2. Has the Employee undergone medical evaluation from a QME or AME: \_\_\_\_\_ If so, have all  
(yes) (no)  
adverse parties been served with the medical reports: \_\_\_\_\_ If not, will a medical evaluation be  
necessary: \_\_\_\_\_ (yes) (no)

3. Date Requesting Party will be prepared to present evidence at an arbitration hearing: \_\_\_\_\_. If  
longer than 30 days from date of Request, explain the reasons why: \_\_\_\_\_

4. If Requesting Party is an Employee, the Employee hereby declares that he or she understands that, upon  
the filing of this Arbitration Request, the Ombudsman will no longer aid or counsel him or her regarding  
issues covered by this Request, in accordance with the Workers' Compensation Addendum.

## SERVICE

Names and address of parties, including attorneys and representatives, served with a copy of this  
Arbitration Request:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

(Signature)

(Address)

(Telephone Number)

Must be timely filed with the ADR Director:

Steven Siemers  
Basic Crafts Workers' Compensation Benefits Trust Fund  
256 Hegenberger Road, Suite 240  
Oakland, CA 94621-1480  
Telephone: (510) 568-5920; Fax: (510) 568-5279



# NOTICE TO TESTIFY AND PRODUCE

UNDER THE  
BASIC CRAFTS WORKERS' COMPENSATION BENEFITS TRUST FUND ADDENDUM

---

---

Employee: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

Other: \_\_\_\_\_

Case No. (if known): \_\_\_\_\_

---

---

TO:

YOU ARE COMMANDED to appear at the place, date and time specified below to testify in an arbitration hearing in the above matter.  
Place of testimony: \_\_\_\_\_  
Date and time: \_\_\_\_\_

YOU ARE COMMANDED to appear at the place, date and time specified below to testify at a deposition hearing in the above matter.  
Place of deposition: \_\_\_\_\_  
Date and time: \_\_\_\_\_

YOU ARE COMMANDED to produce and permit inspection of the following documents or objects at the place, date and time specified below. You may comply by mailing the documents and objects described to the person serving this Notice at the place identified below within 10 days.  
Documents or objects: \_\_\_\_\_  
Place: \_\_\_\_\_  
Date and time: \_\_\_\_\_

---

---

Person Serving Notice:

Name:

Address:

Telephone and FAX Numbers:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**ADR DIRECTOR'S NOTICE OF SCHEDULED ARBITRATION**  
UNDER THE  
BASIC CRAFTS WORKERS' COMPENSATION BENEFITS TRUST FUND ADDENDUM

NOTICE PROVIDED BY:

ADR Director  
Steven Siemers  
Basic Crafts Workers' Compensation Benefits Trust Fund  
265 Hegenberger Road, Suite 240  
Oakland, CA 94621-1480  
Telephone: (510) 568-5920  
Fax: (510) 568-5279

NOTICE PROVIDED TO:

Employee  
 Employer's Insurance Co.  
 Ombudsman  
 Other: \_\_\_\_\_

Case No. \_\_\_\_\_

Employee's Name: \_\_\_\_\_

Relevant Employer(s): \_\_\_\_\_

Other: \_\_\_\_\_

ARBITRATION WILL BE HELD regarding all unresolved issues at the following time and place:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ALL PARTIES, or their authorized representatives, are hereby ordered to appear and arbitrate all unresolved issues, pursuant to the Workers' Compensation Addendum. All representatives must have authority and be prepared to present all evidence regarding, and to settle, all unresolved issues.

ALL PARTIES are further ordered to:

1. Contact the ADR Director no less than three (3) work days before the scheduled date to confirm their attendance, and to receive and provide any other information that may be necessary;
2. Contact the ADR Director if resolution of all issues is reached before the scheduled date.

Documents Attached:

\_\_ Workers' Compensation Grievance(s)

\_\_ Other: \_\_\_\_\_

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

BASIC CRAFTS WORKERS' COMPENSATION  
ALTERNATIVE DISPUTE RESOLUTION SYSTEM

**COMPROMISE AND RELEASE**

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)

1. The employee, born \_\_\_\_\_, claims that he/she was employed at \_\_\_\_\_,  
(city)

\_\_\_\_\_, as a(n) \_\_\_\_\_ by the employer(s), can claims to have  
(state) (occupation)

sustained injury arising out of and in the course of employment:

(State with specificity the date(s) of injury(ies) and what part(s) of body, conditions or systems are being settled)

on \_\_\_\_\_ to \_\_\_\_\_

on \_\_\_\_\_ to \_\_\_\_\_

on \_\_\_\_\_ to \_\_\_\_\_

on \_\_\_\_\_ to \_\_\_\_\_

on \_\_\_\_\_ to \_\_\_\_\_

Body parts, conditions and systems may not be incorporated by reference to medical reports.

2. Unless otherwise expressly stated, upon approval of this compromise agreement by the Basic Crafts ADR Director or a mediator or an arbitrator and payment in accordance with the provisions hereof, the employee releases and forever discharges the above-named employer(s) and insurance carrier(s) from all claims and causes of action within the exclusive jurisdiction of the Basic Crafts Workers' Compensation Program, whether

Applicant/Employee: \_\_\_\_\_

now known or ascertained, or which may hereafter arise or develop as a result of the above-referenced injury(ies), including any and all liability of the employer(s) and insurance carrier(s) and each of them to the dependents, heirs, executors, representatives, administrators or assigns of the employee. PARTIES MAY NOT WAIVE CIVIL CODE SECTION 1542.

3. This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury set forth in Paragraph No. 1 despite any language to the contrary in this document or any addendum.

4. Unless otherwise expressly stated, approval of this agreement RELEASES ANY AND ALL CLAIMS OF APPLICANT'S DEPENDENTS TO DEATH BENEFITS RELATING TO INJURY OR INJURIES COVERED BY THIS COMPROMISE AGREEMENT. The parties have considered the release of these benefits in arriving at the sum in Paragraph No. 7.

5. Unless otherwise expressly ordered by the Basic Crafts ADR Director, a mediator or an arbitrator, approval of this agreement does not release any claim applicant may have for vocational rehabilitation benefits or supplemental job displacement benefits.

6. The parties represent that the following facts are true: (If facts are disputed, state what each party contends under Paragraph No. 9.)

EARNINGS AT TIME OF INJURY \$ \_\_\_\_\_

TEMPORARY DISABILITY INDEMNITY PAID \$ \_\_\_\_\_ Weekly Rate: \$ \_\_\_\_\_

Period(s) Paid: \_\_\_\_\_

PERMANENT DISABILITY INDEMNITY PAID \$ \_\_\_\_\_ Weekly Rate \$ \_\_\_\_\_

Period(s) Paid: \_\_\_\_\_

TOTAL MEDICAL BILLS PAID \$ \_\_\_\_\_

Total Unpaid Medical Expense to be Paid By: \_\_\_\_\_

Unless otherwise specified herein, the employer will pay no medical expenses incurred after approval of this agreement.

7. The parties agree to settle the above claims on account of the injury(ies) by the payment of the **SUM OF \$** \_\_\_\_\_. The following amounts are to be deducted from the settlement amount:



10. It is agreed by all parties hereto that the filing of this document confers upon the Basic Crafts ADR Director the discretion to set the matter for hearing, reserving to the parties the right to put in issue any of the facts admitted herein. If an arbitration is held with this document used as the moving document, the defendants shall have available to them all defenses that were available as of the date of filing of this document. The Basic Crafts ADR Director, a mediator or an arbitrator may either approve this Compromise and Release or disapprove it and recommend to the ADR Director that the matter be set for an informal conciliation.

**11. WARNING TO EMPLOYEE: SETTLEMENT OF YOUR WORKERS' COMPENSATION CLAIM BY COMPROMISE AND RELEASE MAY AFFECT OTHER BENEFITS YOU ARE RECEIVING OR MAY BECOME ENTITLED TO RECEIVE IN THE FUTURE FROM SOURCES OTHER THAN WORKERS' COMPENSATION.**

By signing this agreement, applicant (employee) acknowledges that he/she has read and understands this agreement and has had any questions he/she may have had about this agreement answered to his/her satisfaction.

*Witness the signature hereof this* \_\_ day of \_\_\_\_\_, 20\_\_, at \_\_\_\_\_

\_\_\_\_\_  
Witness 1 (Date)

\_\_\_\_\_  
Applicant (Employee) (Date)

\_\_\_\_\_  
Witness 2 (Date)

\_\_\_\_\_  
Attorney for Applicant (Date)

\_\_\_\_\_  
Interpreter (Date)

\_\_\_\_\_  
Attorney for Defendant (Date)

STATE OF CALIFORNIA

County of \_\_\_\_\_

On this \_\_ day of \_\_\_\_\_, 20\_\_, before me, \_\_\_\_\_, a Notary Public in and for the said County and State, residing therein, duly commissioned and sworn, personally appeared \_\_\_\_\_ known to me to be the person(s) whose name(s) is/are subscribed to the within Instrument, and acknowledged to me that he/she executed the same.

*In Witness Whereof, I have hereunto set my hand and affixed my official seal the day and year in this Certificate first above written.*

---

Notary Public in and for said County and State of California

BASIC CRAFTS WORKERS' COMPENSATION  
ALTERNATIVE DISPUTE RESOLUTION SYSTEM

**STIPULATIONS WITH  
REQUEST FOR AWARD**

Case No. \_\_\_\_\_

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  
(Employee)

employed within the State of California as \_\_\_\_\_, \_\_\_\_\_ on \_\_\_\_\_,  
(Occupation) (Group) (Date of Injury)

by \_\_\_\_\_ whose compensation insurance carrier was  
(Employer)

\_\_\_\_\_ sustained injury arising out of and in the course

of employment to \_\_\_\_\_.  
(Parts of body injured)

2. The injury caused temporary disability for the period(s) \_\_\_\_\_ 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

\$ \_\_\_\_\_.

Case No(s). \_\_\_\_\_

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

**BASIC CRAFTS WORKERS' COMPENSATION  
ALTERNATIVE DISPUTE RESOLUTION SYSTEM**

**NOTICE AND REQUEST FOR ALLOWANCE OF LIEN**

\_\_\_\_\_  
Injured worker

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date of Claimed Injury

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Attorney for Injured Worker

\_\_\_\_\_  
Address

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Address

\_\_\_\_\_  
Insurance Carrier, or Self-Insured, Certificate Name

\_\_\_\_\_  
Adjusting Agency, if Agency Administered

\_\_\_\_\_  
Address Where Claim Administered

\_\_\_\_\_  
Attorney for Employer/Carrier

\_\_\_\_\_  
Address

\_\_\_\_\_  
Lien Claimant

\_\_\_\_\_  
Address

The lien claimant hereby requests the Basic Crafts Workers' Compensation Program to determine and allow as a lien the sum of \$\_\_\_\_\_ against any amount now due or which may hereafter become payable as compensation to the above named worker on account of the above claimed injury.

This request and claim for lien is for (Mark appropriate box):

The reasonable expense incurred by or on behalf of said worker for medical treatment to cure or relieve from the effects of said injury; or

The reasonable medical expense incurred to prove a contested claim; or

\_\_\_ The reasonable value of living expenses of said worker or of his or her dependents, subsequent to injury; or

\_\_\_ The reasonable living expenses of the spouse or minor children, or both, of said worker, subsequent to the date of injury, where such worker has deserted or is neglecting his or her family; or

\_\_\_ The reasonable fee for interpreter's services performed on \_\_\_\_\_; or

\_\_\_ Other: \_\_\_\_\_

**Note: An itemized statement justifying the lien must be attached.**

**A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.**

\_\_\_\_\_  
Signature of Attorney for Lien Claimants    Signature of Lien Claimant    Date

***Employee's Consent to Allowance of Lien***

***I consent to the requested allowance of lien against my compensation.***

\_\_\_\_\_  
Signature of Attorney for Injured Worker    Signature of Injured Worker