

STATE OF CALIFORNIA  
DEPARTMENT OF INDUSTRIAL REALTIONS  
**WORKER'S COMPENSATION APPEALS BOARD**

NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

**ID OR CASE NUMBER :** \_\_\_\_\_

Name of Injured Worker : \_\_\_\_\_ Date of Birth : \_\_\_\_\_  
Address : \_\_\_\_\_  
City, State, Zip Code : \_\_\_\_\_ SS # : \_\_\_\_\_

Employer : \_\_\_\_\_ Address : \_\_\_\_\_  
City, State, Zip Code : \_\_\_\_\_ Date of Claimed Injury : \_\_\_\_\_  
Attorney for Injured Worker : \_\_\_\_\_ Address : \_\_\_\_\_  
City, State, Zip Code : \_\_\_\_\_  
Insurance Carrier or, if Self-Insured, Certificate Name : \_\_\_\_\_  
Address Where Claim Administered : \_\_\_\_\_  
City, State, Zip Code : \_\_\_\_\_  
Adjusting Agency, if Agency Administered : \_\_\_\_\_  
Attorney for Employer/Carrier : \_\_\_\_\_ Address : \_\_\_\_\_  
City, State, Zip Code : \_\_\_\_\_  
Lien Claimant : **ADVANCED IMAGING NEWPORT COAST**  
280 Newport Center Drive, Suite 100, Newport Beach, CA 92660  
Tel (949) 644-4100 Fax (949) 644-4170  
Attorney for Lien Claimant Worker : \_\_\_\_\_ Address : \_\_\_\_\_  
City, State, Zip Code : \_\_\_\_\_

The lien claimant hereby request the Worker's Compensation Appeals Board to determine and allow as a lien the sum of \_\_\_\_\_ Dollars (\$) 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 : (Please mark the appropriate box.)

- Reasonable expense incurred by, or on behalf of said worker for medical treatment to cure or have relief from the effects of said injury;
- Reasonable medical expense incurred to prove contested claim;
- Reasonable value of living expenses of said worker or of his/her dependents, subsequent to the injury;
- Reasonable living expenses of the spouse or minor children, or both, of said worker, subsequent to date of injury where such worker has deserted or is neglecting his/her family;
- Reasonable fee for interpreter's services performed on \_\_\_\_\_ of the year \_\_\_\_\_.

NOTE : ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED.

For injuries occurring on or after January 1, 1990, for which the lien does not have a WCAB Identification Number, the lien claimant declares under penalty or perjury that :

- A copy of the original completed Employer's Claim for Worker's Compensation Benefits (DWC Form 1) is attached, or
- The lien claimant does not have a copy of the forms, but made the following efforts to secure one

A copy of the lien and supporting documents were served by mail or delivered to each of the above named parties.

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

\_\_\_\_\_  
Signature of Lien Claimant

\_\_\_\_\_  
Date

**EMPLOYEES'S CONSENT TO ALLOWANCE OF LIEN**  
**(CONSENT TO THE REQUESTED ALLOWANCE OF A LIEN AGAINST MY COMPENSATION)**

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

\_\_\_\_\_  
Signature of Injured Worker