SAVE PRINT CLEAR

Division of Workers' Compensation
Arbitrator Application

Originating district office: _____

Name of applicant: _____

Date of law degree _____ Law school _____

California State Bar membership no./date of admission to the California Bar: _____

Mailing Address: _____

_____ _____ _____

Work phone number Other phone number Fax number

Email Address: _____

QUALIFICATIONS PURSUANT TO LABOR CODE §5270.5(a): (check those that apply.)

_____ Certified Workers' Compensation Specialist

_____ Eligible to be Certified Workers' Compensation Specialist

- _____ 5 years experience as attorney
- _____ 50 Continuing Education Units in Workers' Compensation in last 5 years

_____ Retired Workers' Compensation Judge

_____ Retired Appeals Board member

_____ Certified Workers' Compensation Pro-Tempore Judge

EXPERIENCE IN THE FIELD OF WORKERS' COMPENSATION YEARS

_____ _____

_____ _____

PRIMARY REPRESENTATION _____ APPLICANT _____ DEFENDANT

AREA OF AVAILABILITY: _____ STATEWIDE _____ NORTH ONLY _____ SOUTH ONLY

_____ LIMITED AREA-SPECIFY BY DISTRICT OFFICE (CHECK ALL THAT APPLY)

North: __EUR __OAK __RDG __SAC __SAL __SFO __SJO __SRO __STK

South: __AHM __BAK __FRE __GOL __GRO __ LBO __LAO __OXN __POM ___RIV __ SBR __SDO __ANA __MDR __VNO

I agree to abide by *Code of Civil Procedure* §170.6, and *Labor Code* §5270.5 (b), which states:
"No attorney shall be included in a panel if s/he has served as a judge in any proceeding involving the same case, or has represented, or whose firm has represented, any party in the same case."

_____

Applicant's signature

STATE OF CALIFORNIA, County of_____ on this____ day of_____20_____, before me, sworn, personally appeared _____ known to me to be or has established that s/he is the person whose name is subscribed to the within Instrument, and acknowledged to me s/he 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

Approved: _____ _____

Administrative Director Date

Mail to:
Division of Workers' Compensation
Attn: Administrative Director
1515 Clay Street, 17th Floor
Oakland, CA 94612