STATE OF CALIFORNIA

Workers' Compensation Verification

VCB–30–09073 (Rev. 1/2022)

CALIFORNIA CalVCB VICTIM COMPENSATION BOARD

CalVCB Application #:

Victim Information

Name _____ DOB _____
First, Middle, Last

SSN _____ Date of Crime _____

Temporary Disability Benefit

Weekly gross wage upon which temporary benefits were based ..... _____ $Per Week

Weekly temporary disability benefit amount ..... _____ $Per Week

Total dollar amount paid for temporary disability benefits..... _____ $Total

Dates of temporary disability: From _____ To _____

Describe the injuries resulting in the disability _____

_____

Permanent Disability Benefit

Date the victim was considered permanent and stationary _____

Has a permanent award been made? Yes ☐ No ☐

If yes, Amount $ _____ Date Started _____ Date Ended _____

Expenses paid by permanent award:

Award Type	Amount of Award	Award Type	Amount of Award
Medical	$ _____	Death Benefits	$ _____
Wage	$ _____	Funeral/Burial	$ _____
Rehabilitation	$ _____	Other, please describe.....	$ _____
Pain/Suffering.....	$ _____		

Have all crime-related bills been paid? Yes ☐ No ☐

If no, please explain _____

If rehabilitation benefits were paid: Date Started _____ Date Ended _____

If death benefits were paid: To whom? _____

If funeral/burial benefits were paid: To whom? _____

If attorney fees were paid: Attorney Name _____ Phone _____

Attorney Address _____

Denial and Appeal Information:

If the claim was denied, please provide the denial letter and any supporting documentation.

Has an appeal been filed? Yes ☐ No ☐

If yes, Workers Compensation Appeals Board number _____

Status of the appeal _____

DECLARATION:

I declare under penalty of perjury under the laws of the State of California (Penal Code sections 72, 118, and 129) that: I have read all of the questions contained on this verification form, and to the best of my information and belief, all my answers are true, correct, and complete. I further understand that if I have knowingly provided any information that is false, intentionally incomplete, or misleading, I may be found liable for filing a false claim with the State of California, and may be liable for up to three times the amount of damages the State of California sustains, in addition to the costs of a civil action brought to recover any of those penalties or damages; or for a civil penalty of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000) for each false claim. (California Government Code, sections 12650-12656) Finally, I understand that if I have intentionally provided any information that is false, incomplete, or misleading, I may be guilty of a misdemeanor punishable by up to one year in the county jail and/or a fine of up to one thousand dollars ($1,000), or a felony punishable by up to three years in state prison and/or a fine of up to ten thousand dollars, ($10,000). (California Penal Code, sections 17, 18, and 72)

Printed Name _____ Title _____ Phone _____
Of the person completing this form

Signature of the person named above _____ Date _____

Mail completed application to:
California Victim Compensation Board
PO Box 3036
Sacramento, CA 95812-3036

Fax: 1-866-902-8669