DIVISION OF WORKERS' COMPENSATION
**WORKERS' COMPENSATION APPEALS BOARD**

# NOTICE OF APPLICATION

**DATE OF SERVICE:***02/09/2023*

**WCAB CASE NBR:***ADJ17287564*

**DATE OF CLAIMED INJURY:***07/16/2022 - 01/02/2023*

**EMPLOYEE:***ALENA KHAMENIA*

**EMPLOYER:***MACYS INC DBA BLOOMINGDALES LLC*

**INSURER:**

**COMMENT(S)/REMARK(S):**

*AN APPLICATION FOR ADJUDICATION OF CLAIM HAS BEEN FILED WITH THE WORKERS COMPENSATION APPEALS BOARD FOR THE ABOVE CLAIMED INJURY. PLEASE REFERENCE THE ABOVE WCAB ID NUMBER ON ALL CORRESPONDENCE TO THE WCAB.*
*THIS NOTICE CONSTITUTES A CONFORMED COPY OF THE APPLICATION.*
*DATE APPLICATION FILED: 02/08/2023*

WC04


Submission of this eform through EAMS constitutes service upon any internal DWC unit.

Batch ID: 38066289 Date: 02/08/2023 01:02:04 PM

OK


Document Type*: ---select---

Document Title*: ---select---

Document Date: (MM/DD/YYYY)

Author:

File Upload*: Browse...

Attachment

Uploaded Documents

| Document Type | Document Title | File Name | |
|---|---|---|---|
| LEGAL DOCS | 4906(g) DECLARATION | C:\fakepath\01 - declaration.pdf | Delete |
| LEGAL DOCS | VENUE VERIFICATION | C:\fakepath\02 - venue.pdf | Delete |
| LEGAL DOCS | DWC-1 CLAIM FORM | C:\fakepath\05 - DWC - Stress.pdf | Delete |
| LEGAL DOCS | FEE DISCLOSURE STATEMENT | C:\fakepath\03 - fee.pdf | Delete |
| LEGAL DOCS | PROOF OF SERVICE | C:\fakepath\06 - E-FILER PROOF OF SERVICE.pdf | Delete |
| MISC | TYPED OR WRITTEN LETTER | C:\fakepath\04 - application verification.pdf | Delete |

Done

# STATE OF CALIFORNIA
# DWC DISTRICT OFFICE
# E-COVER SHEET

REQUIRED FIELDS SHOWN BY "*"

Is this a new Case?* Yes (•) No ( ) Location: CTL

Companion Cases Exist [ ] Walk Thru Yes ( ) No (•)

More than 15 Companion Cases [ ]

Date: ( MM/DD/YYYY) 02/08/2023

Case Number:* SSN(Numbers Only) 592959857

( ) Specific Injury (If Specific Injury, use the start date as the specific date of injury)

(•) Cumulative Injury 07/16/2022 (START DATE: MM/DD/YYYY) 01/02/2023 (END DATE: MM/DD/YYYY)

Body Part 1 : 841 NERVOUS SYSTEM Body Part 2 : 100 HEAD - NOT SPECIF

Body Part 3 : 800 BODY SYSTEM - NO Body Part 4 : 860 SKIN DERMITITIS, E

Other Body Parts :

**Please check unit to be filed on ( check only one box )***

(•) ADJ ( ) DEU ( ) SIF ( ) UEF ( ) SAU ( ) INT ( ) RSU

**Companion Cases**

**Case 1:**

( ) Specific Injury (If Specific Injury, use the start date as the specific date of injury)

( ) Cumulative Injury (START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

Body Part 1 : Body Part 2 :

Body Part 3 : Body Part 4 :

Other Body Parts :

**Case 2:**

( ) Specific Injury (If Specific Injury, use the start date as the specific date of injury)

( ) Cumulative Injury (START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

Body Part 1 : Body Part 2 :

Body Part 3 : Body Part 4 :

Other Body Parts :

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
# WORKERS' COMPENSATION APPEALS BOARD
# APPLICATION FOR ADJUDICATION OF CLAIM

| | |
|---|---|
| Case Number | |
| SSN | 592959857 |

*Amended Application* ☐

***Venue Choice is based upon:***

- ◯ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)
- ◯ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)
- ◉ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

* Enter the zipcode for the venue choice designated above, and then tab to Hearing Location Field and choose the corresponding Hearing Location Code: 92808 AHM

***Injured Worker***

| | |
|---|---|
| First Name* | ALENA |
| MI | |
| Last Name* | KHAMENIA |
| Street Address 1 /PO Box* | 18444 COLLINS STR |
| Street Address 2 /PO Box | |
| International Address | |
| City* | TARZANA |
| State* | CA |
| Zip Code* (Numbers Only) | 91356 |

## Applicant (If other than injured employee)

◯ Insurance Carrier ◯ Employer ◯ Lien Claimant

| | |
|---|---|
| Name | |
| Street Address 1 /PO Box | |
| Street Address 2 /PO Box | |
| City | |
| State | |
| Zip Code (Numbers Only) | |

## Employer Information

◯ Insured ◯ Self-Insured ◯ Legally Uninsured ◉ Uninsured

| | |
|---|---|
| Employer Name* | MACYS INC DBA BLOOMINGDALES LLC |
| Employer Street Address/PO Box* | 14060 RIVERSIDE DR |
| City* | SHERMAN OAKS |
| State* | CA |
| Zip Code* (Numbers Only) | 91423 |

**Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)**

| | |
|---|---|
| Insurance Carrier Name | |
| Street Address/PO Box | |
| City | |
| State | |
| Zip Code (Numbers Only) | |

**Claims Administrator Information (if known and if applicable)**

| | |
|---|---|
| Name | |
| Street Address/PO Box | |
| City | |
| State | |
| Zip Code (Numbers Only) | |

IT IS CLAIMED THAT :

1. The injured worker born* 02/18/1981 (Date of birth : MM/DD/YYYY)

, while employed as a(n) SALES PERSON

(Occupation at the time of injury)

suffered a: ( Choose only one )

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

◉ cumulative trauma injury which began on

07/16/2022 and ended on 01/02/2023

(START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

The injury occured at* 14060 RIVERSIDE DR

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

SHERMAN OAKS , CA 91423

(City)* (State)* (Zip Code)*

(State which parts of the body were injured)

Body Part 1 : 841 NERVOUS SYSTEM - STRE Body Part 2 : 100 HEAD - NOT SPECIFIED

Body Part 3 : 800 BODY SYSTEM - NOT SPE Body Part 4 : 860 SKIN DERMITITIS, ETC.

Other Body Parts :

2.The injury occurred as follows:

( Explain What The Worker Was Doing At The Time Of Injury And How The Injury Occured )

Field size limited to 325 characters

| |
|---|
| STRESS DUE TO HOSTILE WORK ENVIRONMENT |
| |
| |
| |
| |
| |
| |

3. Actual earnings at the time of injury

Rate of Pay $ _____ ◯ Monthly ◯ Weekly ◯ Hourly

State value of tips, meals, lodging or other advantages regularly received $ _____ ◯ Monthly ◯ Weekly ◯ Hourly

Number of hours worked per week. _____

4. The injury caused disability as follows

Last day off work due to injury : _____

(MM/DD/YYYY)

First Period of Disability: Start date _____ (MM/DD/YYYY) End date _____ (MM/DD/YYYY)

Second Period of Disability: Start date _____ (MM/DD/YYYY) End date _____ (MM/DD/YYYY)

## 5. Compensation

Compensation was paid : ◉ Yes ◯ No

| | |
|---|---|
| Total paid: | |
| Weekly rate(s): | |
| Date of last payment: | |

(MM/DD/YYYY)

*6.* **Has the worker received any unemployment insurance benefits and/or any unemployment compensation disability benefits (state disability) since the date of injury?**

◯ Yes ◯ No

## 7. Medical treatment

Medical treatment was received : ◯ Yes ◯ No

All treatment was furnished by the Employer or Insurance Carrier : ◯ Yes ◯ No

| | |
|---|---|
| Date of last treatment | |

(MM/DD/YYYY)

Other treatment was provided/paid by:
(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

**Did Medi-Cal pay for any health care related to this claim ? :** ◯ Yes ◯ No

**Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or examined for this injury, but that were not provided or paid for by the employer or insurance carrier:**

| | |
|---|---|
| Name of Doctor/Hospital/Clinic 1.<br>Field size limited to 80 characters | |

| | |
|---|---|
| Name of Doctor/Hospital/Clinic 2.<br>Field size limited to 80 characters | |

## 8. Other cases have been filed for industrial injuries by this employee as follows:

| | |
|---|---|
| Case Number 1 | |
| Case Number 2 | |
| Case Number 3 | |
| Case Number 4 | |

**9. This application is filed because of a disagreement regarding liability for:**

- [x] Temporary disability indemnity
- [x] Permanent disability indemnity
- [x] Reimbursement for medical expense
- [x] Rehabilitation
- [x] Medical treatment
- [x] Supplemental Job Displacement/Return to Work
- [x] Compensation at proper rate
- [x] Other (Specify) ALL OTHER BENEFITS

Is the Applicant Represented?: (•) Yes ( ) No if "No", applicant is to sign and date below.

if "Yes", applicant's representative is to complete the following and is to sign and date below

(•) Law Firm/Attorney ( ) Non Attorney Representative

| Law Firm or Company Name(If Applicable) |
|---|
| WORKERS DEFENDERS ANAHEIM |

| | |
|---|---|
| Law Firm Number (If Applicable) | 13792552 |
| Attorney/Rep First Name | NATALIA |
| Attorney/Rep MI | |
| Attorney/Rep Last Name | FOLEY |
| Street Address/PO Box | 751 S WEIR CANYON RD STE 157-455 |
| City | ANAHEIM |
| State | CA |
| Zip Code (Numbers Only) | 92808 |

| | |
|---|---|
| Applicant Attorney / Representative Signature | S NATALIA FOLEY |
| Applicant Signature | |

Dated at ANAHEIM (City), California Date 02/08/2023 (MM/DD/YYYY)

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

# WORKERS' COMPENSATION CLAIM FORM (DWC 1)

# *PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)*

**Employee:** Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

***Empleado:*** *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicación de los beneficios de compensación al trabajador.*

*Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.*

**Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.**

**Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".**

**Employee—complete this section and see note above** ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* Aleen — Today's Date. *Fecha de Hoy.* 01-16-2023
2. Home Address. *Dirección Residencial.* 18444 Collins St Tarzana
3. City. *Ciudad.* Tarzana — State. *Estado.* CA — Zip. *Código Postal.* 91356
4. Date of Injury. *Fecha de la lesión (accidente).* 07-16-2022 - 01-02-2023 — Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurio el accidente.* 14060 Riverside Dr Sherman Oaks CA 91423
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* Stress due to hostile work environment
7. Social Security Number. *Número de Seguro Social del Empleado.* 592 95 9857
8. Signature of employee. *Firma del empleado.* X Aleen Klein

**Employer—complete this section and see note below.** ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.*
10. Address. *Dirección.*
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.*
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.*
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.*
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.*
15. Insurance Policy Number. *El número de la póliza de Seguro.*
16. Signature of employer representative. *Firma del representante del empleador.*
17. Title. *Título.* — 18. Telephone. *Teléfono.*

**Employer:** You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

***Empleador:*** *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

*EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD*

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/ *Copia del Empleado* ☐ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

7/1/04 Rev.