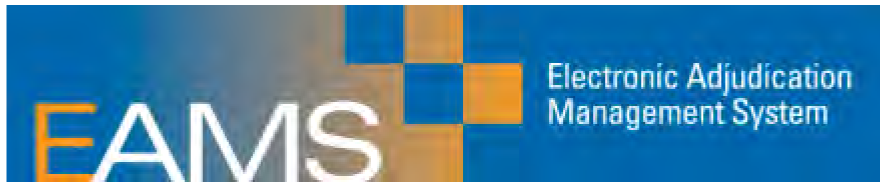


Submission of this eform through EAMS constitutes service upon any internal DWC unit.

Batch ID: 30291368 Date: 11/20/2018 12:41:15 PM

OK

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 [ ]
More than 15 Companion Cases [ ]
Walk Thru Yes ( ) No (●)

Date: (MM/DD/YYYY) 11/20/2018

Case Number:*
SSN(Numbers Only) 567518059

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

(●) Cumulative Injury 11/12/2015 (START DATE: MM/DD/YYYY) 11/12/2018 (END DATE: MM/DD/YYYY)

Body Part 1 : 800 BODY SYSTEM - NO
Body Part 2 : 801 CIRCULATORY SYS

Body Part 3 : 880 OTHER BODY SYST
Body Part 4 :

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	**567518059**

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 90020 LAO

Injured Worker

Field	Value
First Name*	ALAN
MI	
Last Name*	WASHINGTON
Street Address 1 /PO Box*	17628 ALBURTIS AVE APT 23
Street Address 2 /PO Box	
International Address	
City*	ARTESIA
State*	CA
Zip Code* (Numbers Only)	90701

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*	ALBERTSONS DISTRIBUTION CENTER
Employer Street Address/PO Box*	9300 TOLEDO WAY
City*	IRVINE
State*	CA
Zip Code* (Numbers Only)	92618

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

Insurance Carrier Name	SEDGWICK KAISER LEXINGTON

Street Address/PO Box	PO BOX 14188
City	LEXINGTON
State	KY
Zip Code (Numbers Only)	40512

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* 05/15/1956 (Date of birth : MM/DD/YYYY)

, while employed as a(n) DRIVER (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 **11/12/2015** (START DATE: MM/DD/YYYY) and ended on **11/12/2018** (END DATE: MM/DD/YYYY)

The injury occured at* 17628 ALBURTIS AVE APT 23
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

ARTESIA (City)* , CA (State)* 90701 (Zip Code)*

(State which parts of the body were injured)

Body Part 1 :	**800 BODY SYSTEM - NOT SPE**	Body Part 2 :	**801 CIRCULATORY SYSTEM - HEA**
Body Part 3 :	**880 OTHER BODY SYSTEMS**	Body Part 4 :	
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 AND STRAIN DUE TO REPETITIVE MOVEMENTS AND EXPOSURE TO TOXIC
ENVIRONMENT RESULTING IN CONGESTIVE HEART FAILURE

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. Field size limited to 80 characters	

Name of Doctor/Hospital/Clinic 2. 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
- [ ] 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)
NATALIA FOLEY BEVERLY HILLS

Law Firm Number (If Applicable)	11964930
Attorney/Rep First Name	NATALIA
Attorney/Rep MI	
Attorney/Rep Last Name	FOLEY
Street Address/PO Box	8306 WILSHIRE BLVD STE 115
City	BEVERLY HILLS
State	CA
Zip Code (Numbers Only)	90211

Applicant Attorney / Representative Signature	S NATALIA FOLEY
Applicant Signature	

Dated at BEVERLY HILLS (City), California Date 11/20/2018 (MM/DD/YYYY)

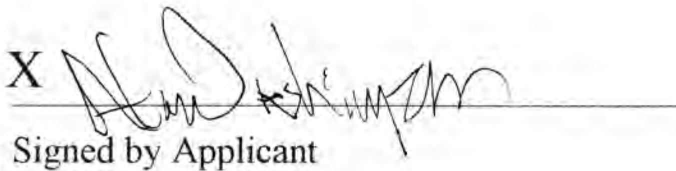
APPLICATION VERIFICATION

I, the undersigned, say that I am the Applicant in this action.

I have read the foregoing Application for Adjudication in regard to my worker compensation case, and I verify that I know the contents thereof, and that the same is true of my own knowledge, except as to the matters which are therein stated upon my information or belief. and as to those matters that I believe to be true.

I declare under penalty of perjury that the foregoing is true and correct.

Date: **11/12/2018**



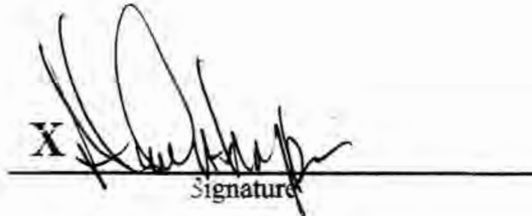
X ______________________

Signed by Applicant

DECLARATION PURSUANT TO LABOR CODE SECTION 4906(g)

Pursuant to Labor Code Section 4906(g), I declare under penalty of perjury that I have not violated Section 139.3 and I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

Dated: 11/12/18



X ______________________
Signature

Dated: 11/12/18

____
Signature

Before signing this form, you should be aware that: "Any person who makes or causes to be made any knowingly false or fraudulent material statement or representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony."

PRINT CLEAR

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

Estado ng California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

CLAIM FORM PARA SA BAYAD-PINSALA SA MGA MANGGAGAWA (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 in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

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.

Empleyado: Sagutan ang seksyon ng **"Empleyado"** at ibigay ang form sa iyong pinagtatrabahuhan. Magtago ng isang kopya at markahan itong **"Pansamantalang Resibo ng Empleyado"** hanggang matanggap mo ang nalagdaan at napetsahang kopya mula sa iyong pinagtatrabahuhan. Maaari kang tumawag sa Division of Workers' Compensation at pakinggan ang nakarekord na mga impormasyon sa **(800) 736-7401.** Kasama ang isang pagpapaliwanag tsa mga benepisyo sa bayad-pinsala sa mga manggagawa sa Paunawa Tungkol sa Posibleng Pagiging Karapat-dapat, na siyang pabalat na papel ng form na ito. Tanggalin at itago ang paunawang ito bilang sanggunian sa hinaharap.

Natanggap mo na rin dapat ang isang pulyeto mula sa iyong pinagtatrabahuhan na naglalarawan sa mga benepisyo ng bayad-pinsala sa mga manggagawa at ang mga proseso para makuha ang mga ito. Maaari kang makatanggap ng mga nakasulat na paunawa mula sa iyong pinagtatrabahuhan o sa tagapangasiwa ng mga claim nito tungkol sa iyong claim. Kung iaalok ng iyong tagapangasiwa ng mga claim na padalhan ka ng mga paunawa sa elektronikong paraan, at sumang-ayon kang tatanggapin ang mga paunawa sa pamamagitan lamang ng email, mangyaring ibigay ang iyong email address sa ibaba at tsekan ang naaangkop na kahon. Kung paglaon ay magdesisyon kang gusto tumanggap ng mga paunawa sa pamamagitan ng koreo, dapat mong ipagbigay-alam sa iyong pinagtatrabahuhan sa pamamagitan ng sulat.

Sinumang tao na gagawa o magiging dahilan ng anumang sinasadyang hindi totoo o mapanlinlang na materyal na pahayag o materyal na representasyon para sa layuning pagkuha o pagkakait ng mga benepisyo o pagbabayad sa bayad-pinsala sa mga manggagawa ay gumagawa ng isang krimen.

Employee—complete this section and see note above ***Empleyado—sagutan ang seksyon na ito at tingnan ang paunawa sa itaas***

1. Name. *Pangalan.* ALAN WASHINGTON Today's Date. *Petsa Ngayon.* 11/12/2018
2. Home Address. *Address ng Tirahan.* 17628 ALBURTIS AVE APT 23
3. City. *Lungsod.* ARTESIA State. *Estado.* CA Zip. *Zip.* 90701
4. Date of Injury. *Petsa ng Pagkapinsala.* 11/12/2017 - 11/12/2018 Time of Injury. *Oras ng Pagkapinsala.* ______ a.m. ______ p.m.
5. Address and description of where injury happened. *Address at paglalarawan ng lugar na pinangyarihan ng pinsala.* WORK SITE 9300 TOLEDO WAY IRVINE CA 92618
6. Describe injury and part of body affected. *Ilarawan ang pinsala at apektadong bahagi ng katawan.* Congestive Heart Failure aggravated by the employment due to long term exposure to toxic environment, prolonged work related stress, prolonged work related repetitive movements and other work related factors
7. Social Security Number. *Social Security Number.* 567-51-8059
8. ☐ Check if you agree to receive notices about your claim by email only. ☐ *Tsekan kung sumasang-ayon kang tumanggap ng mga paunawa tungkol sa iyong claim sa pamamagitan ng email lamang.* Employee's e-mail. *E-mail ng Empleyado.* ______

You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Makakatanggap ka ng mga paunawa tungkol sa benepisyo sa pamamagitan ng regular na sulat kung hindi ka pipili, o kung hindi mag-aalok ang iyong tagapangasiwa ng mga claim ng opsyon na elektronikong serbisyo.*

9. Signature of employee. *Lagda ng empleyado.* X [signature]

Employer—complete this section and see note below. ***Pinagtatrabahuhan—sagutan ang seksyon na ito at tingnan ang paunawa sa ibaba.***

10. Name of employer. *Pangalan ng pinagtatrabahuhan.* ______
11. Address. *Address.* ______
12. Date employer first knew of injury. *Petsang unang malaman ng pinagtatrabahuhan ang tungkol sa pinsala.* ______
13. Date claim form was provided to employee. *Petsang ibinigay ang claim form sa empleyado.* ______
14. Date employer received claim form. *Petsang natanggap ng pinagtatrabahuhan ang claim form.* ______
15. Name and address of insurance carrier or adjusting agency. *Pangalan at address ng tagapagdulot ng seguro o ahensiyang nagsasaayos.* ______
16. Insurance Policy Number. *Insurance Policy Number.* ______
17. Signature of employer representative. *Lagda ng kinatawan ng pinagtatrabahuhan.* ______
18. Title. *Titulo.* ______ 19. Telephone. *Telepono.* ______

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

Pinagtatrabahuhan: *Kailangan mong lagyan ng petsa ang form na ito at magbigay ng mga kopya sa iyong tagapagseguro o tagapangasiwa ng mga claim at sa empleyado, dependent o kinatawan na nagsusumite ng claim sa loob ng **isang araw ng trabaho** pagkatanggap sa form mula sa empleyado.*

ANG PAGLAGDA SA FORM NA ITO AY HINDI PAG-AKO NG PANANAGUTAN

☐Employer copy/ Kopya ng pinagtatrabahuhan ☐Employee copy/ Kopya ng empleyado ☐Claims Administrator/ Tagapangasiwa ng mga Claim ☐Temporary Receipt/ *Pansamantalang Resibo*

State of California
Department of Industrial Relations
Division of Workers' Compensation

FEE DISCLOSURE STATEMENT

If you choose to be represented by an attorney, your attorney's fees will be deducted from your benefits. The fee will be approved by the Workers' Compensation Appeals Board with consideration given to the: (1) responsibility assumed by the attorney; (2) care exercised in representing you; (3) time involved; and, (4) results obtained.

Attorney's fees normally range from 9% to 15% of the benefits awarded.

There are certain circumstances where your employer (or his/her insurer) may be liable to pay your attorney's fees. For example, if the employer disputes a permanent disability evaluation obtained when you were not represented by an attorney, your employer may be liable for any attorney fees you incur because of the dispute.

If at any time you no longer wish to be represented by the attorney, you may withdraw from representation by notifying the attorney. If you withdraw from representation, the fee amount found by a workers' compensation judge to be the fair value of any work the attorney did in your case will be deducted from your award.

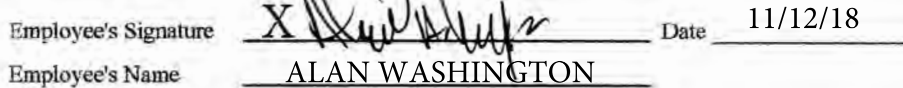
Your case is being filed at the Division of Workers' Compensation at the following location:

XXXXXXXXXXX LAO

The employee has been advised of the district office at which his or her case will be filed and that he or she may be required to attend conferences or hearings at this location at his or her own expense.

An Information and Assistance Officer may be able to answer your questions concerning your workers' compensation benefits at no charge to you. The Officer may be able to resolve your problems without the need for litigation.

Call this toll-free number: *1-800-736-7401*

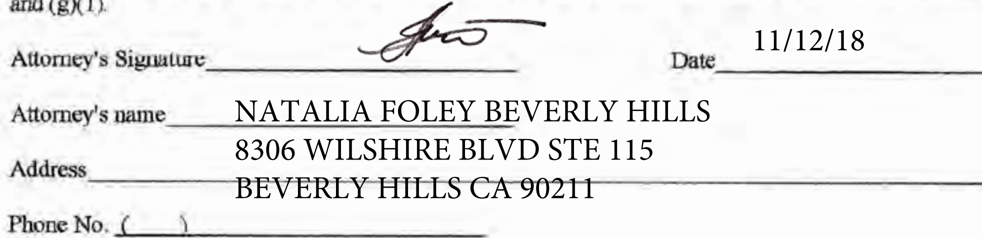


Employee's Signature X ______________ Date 11/12/18

Employee's Name ALAN WASHINGTON

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 worker' compensation benefits or payments is guilty of a felony.

I hereby declare under penalty of perjury that I am the attorney representing the above-named employee, or am an attorney licensed by the State Bar of California regularly employed by the firm by which the employee will be represented, and have advised the employee of their rights as set forth above and in Labor Code section 4906(e) and (g)(1).



Attorney's Signature ______________ Date 11/12/18

Attorney's name NATALIA FOLEY BEVERLY HILLS

Address 8306 WILSHIRE BLVD STE 115
BEVERLY HILLS CA 90211

Phone No. ( )

VENUE AUTHORIZATION

I HEREBY AUTHORIZE MY WORKERS' COMPENSATION CASE(S) FOR

INJURY(IES) DATED ______________________________ TO BE

FILED AT THE ______LAO______________________ WORKERS'

COMPENSATION APPEALS BOARD.

DATED: 11/12/18

X

APPLICANT

APPLICANT'S ATTORNEY:

NATALIA FOLEY BEVERLY HILLS
UAN 11964930
LAW OFFICES OF NATALIA FOLEY
8306 WILSHIRE BLVD STE 115
BEVERLY HILLS CA 90211
TEL 310 707 8098
FAX 310 626 9632
NFOLEYLAW@GMAIL.COM

E-Filer: NATALIA FOLEY, ESQ
UAN: **NATALIA FOLEY BEVERLY HILLS**
EAMS #: **11964930**
Address: LAW OFFICES OF NATALIA FOLEY
8306 WILSHIRE BLVD STE 115, BEVERLY HILLS CA 90211
Tel 310 707 8098; Fax 310 626 9632; Email: nfoleylaw@gmail.com

PROOF OF SERVICE

ALAN WASHINGTON vs ALBERTSONS DISTRIBUTION CENTER	ADJ11233298 ADJ11233336

State Of California
County of Los Angeles
I am employed in the county of Los Angeles, State of California.
I am over the age of 18 years and not a party to the within action; my business address is:
8306 WILSHIRE BLVD STE 115
BEVERLY HILLS CA 90211
I am readily familiar with the firm's business practice of processing correspondence for mailing. In the ordinary course of business, the correspondence would be deposited with the United States Postal Service on that same day with postage thereon fully prepaid at my business address above. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after the date of deposit for mailing as listed.
On 11/20/2018 I served the foregoing documents described as:

APPLICATION FOR ADJUDICATION
DECLARATION 4906 VENUE AUTHORIZATION
FEE DISCLOSURE APPLICATION VERIFICATION FORM DWC1

on the interested parties in this action, by placing a true copy thereof in a sealed envelope with postage thereon fully prepaid, in the United States Mail at my address stated above, addressed as follows:

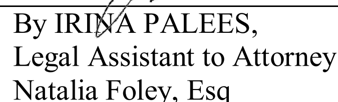
CA State Division of Workers' Compensation
Los Angeles district office
320 W. 4th Street, 9th floor
Los Angeles, CA 90013-1954

NICK PARKS, Claim Examiner
ALBERTSONS
Workers' Comp. Dept., MS-7300,
P.O. Box 29223,
Phoenix, AZ 85038-9223

Alan J. Washington
17628 Alburtis #23
Artesia CA 90701

Sedgwick CMS
P.O. Box 14152
Lexington, KY 40512

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
Executed on: 11/20/2018 at Los Angeles, CA



By IRINA PALEES,
Legal Assistant to Attorney
Natalia Foley, Esq