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Batch ID: 34661878 Date: 04/28/2021 11:37:40 AM

OK

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
COMPROMISE AND RELEASE

ADJ12721933
Case Number 1

ADJ12721676
Case Number 2

Case Number 3

Case Number 4

Case Number 5

561256071
SSN (Numbers Only)

Venue Choice is based upon: (Completion of this section is required)

☐ 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).)

AHM
Select 3 Letter Office Code For Place/Venue of Hearing (From Document Cover Sheet)

Employee(Completion of this section is required)

ANNETTE
First Name

MI

GARNER
Last Name

1928 W 108 TH STR
Address/PO Box (Please leave blank spaces between numbers, names or words)

LOS ANGELES
City

CA
State

90047
Zip Code

Employer Information (Completion of this section is required)

☒ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

MISSION SCHOOL TRANSPORTATION
Employer Name (Please leave blank spaces between numbers, names or words)

20 SOTELLO ST.
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

LOS ANGELES

CA

90012

Applicant's Attorney or Authorized Representative:

☒ Law Firm/Attorney ☐ Non Attorney Representative

NATALIA
First Name

FOLEY
Last Name

13792552
Law Firm Number

WORKERS DEFENDERS ANAHEIM
Law Firm Name

8018 E. SANTA ANA CANYON RD.,
Address/PO Box (Please leave blank spaces between numbers, names or words)

ANAHEIM | CA | 92808
City | State | Zip Code

Defendant's Attorney or Authorized Representative:

☒ Law Firm/Attorney ☐ Non Attorney Representative

NADINE
First Name

ELKHATTAT
Last Name

6405254
Law Firm Number

MICHAEL SULLIVAN FULLERTON
Law Firm Name

PO BOX 85059
Address/PO Box (Please leave blank spaces between numbers, names or words)

SAN DIEGO | CA | 92186
City | State | Zip Code

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

VANLINER INSURANCE COMPANY
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

ONE PREMIER DRIVE
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

FENTON | MO | 63026
City | State | Zip Code

Claims Administrator information (if known and if applicable)

NATIONAL INTERSTATE RICHFIELD
Name (Please leave blank spaces between numbers, names or words)

PO BOX 521
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

RICHFIELD | OH | 44286
City | State | Zip Code

IT IS CLAIMED THAT:

1. The injured employee, born 11/15/1959 (DATE OF BIRTH: MM/DD/YYYY), alleges that while employed as a(n) _____ (OCCUPATION AT THE TIME OF INJURY), sustained injury arising out of and in the course of employment at the locations and during the dates listed below:

(State with specificity the date(s) of injury(ies) and what part(s) of body, conditions or systems are being settled.)

☐ Specific Injury

ADJ12721933 (Case Number 1) ☒ Cumulative Injury 12/01/2018 (Start Date: MM/DD/YYYY) 11/01/2019 (End Date: MM/DD/YYYY)

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

Body Part 1: NECK-200 Body Part 2: UPPER EXT.-300 Body Part 3: CHEST-430

Body Part 4: SHOULDERS-450 Other Body Parts: LOWER EXTREMITIES-500

The injury occurred at WORKPLACE
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

_____ City _____ State _____ Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ Specific Injury

ADJ12721676
Case Number 2

☒ Cumulative Injury

01/01/2018 (Start Date: MM/DD/YYYY)

10/31/2019 (End Date: MM/DD/YYYY)

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

Body Part 1: NERVOUS SYSTEM- 841 Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The injury occurred at _____

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

_____ _____ _____.

City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ Specific Injury

_____
Case Number 3

☐ Cumulative Injury

_____ (Start Date: MM/DD/YYYY) _____ (End Date: MM/DD/YYYY)

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

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 2: _____ Other Body Parts: _____

The injury occurred at _____

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

_____ _____ _____.

City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ Specific Injury

_____
Case Number 4

☐ Cumulative Injury

_____ (Start Date: MM/DD/YYYY) _____ (End Date: MM/DD/YYYY)

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

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

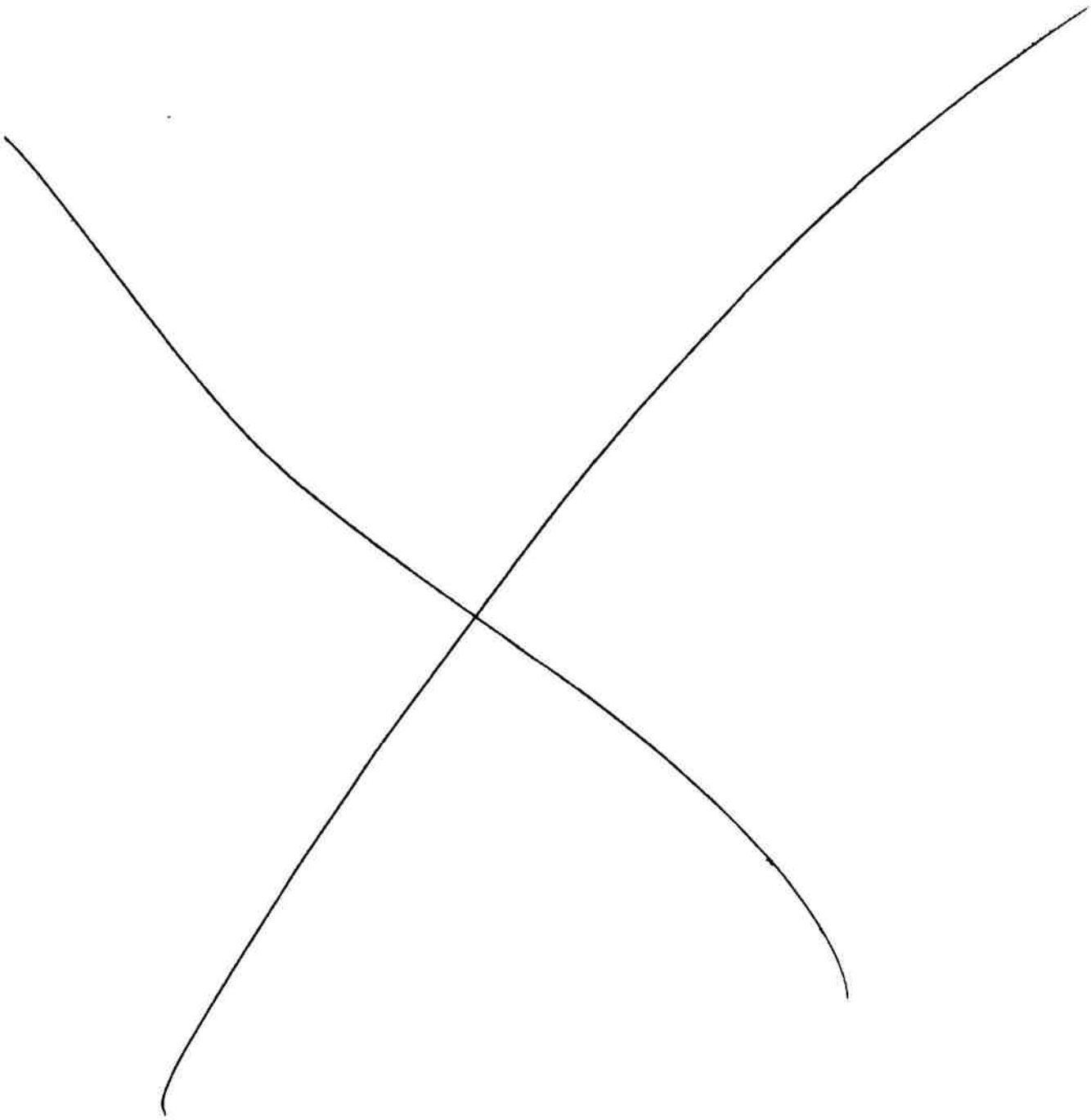
The injury occurred at _____

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

_____ _____ _____.

City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.



☐ Specific Injury

Case Number 5 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

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

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The injury occurred at _____

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

_____ _____ _____

City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

2. Upon approval of this compromise agreement by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge and payment in accordance with the provisions hereof, the employee releases and forever discharges the above-named employer(s) and insurance carrier(s) from all claims and causes of action, whether now known or ascertained or which may hereafter arise or develop as a result of the above-referenced injury(ies), including any and all liability of the employer(s) and the insurance carrier(s) and each of them to the dependents, heirs, executors, representatives, administrators or assigns of the employee. Execution of this form has no effect on claims that are not within the scope of the workers' compensation law or claims that are not subject to the exclusivity provisions of the workers' compensation law, unless otherwise expressly stated.

3. This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury set forth in Paragraph No. 1 and further explained in Paragraph No. 9 despite any language to the contrary elsewhere in this document or any addendum.

4. Unless otherwise expressly stated, approval of this agreement RELEASES ANY AND ALL CLAIMS OF APPLICANT'S DEPENDENTS TO DEATH BENEFITS RELATING TO THE INJURY OR INJURIES COVERED BY THIS COMPROMISE AGREEMENT. The parties have considered the release of these benefits in arriving at the sum in Paragraph 7. Any addendum duplicating this language pursuant to Sumner v WCAB (1983) 48 CCC 369 is unnecessary and shall not be attached.

5. Unless otherwise expressly ordered by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge, approval of this agreement does not release any claim applicant may have for vocational rehabilitation benefits or supplemental job displacement benefits.

6. The parties represent that the following facts are true: (If facts are disputed, state what each party contends under Paragraph No. 9.)

EARNINGS AT TIME OF INJURY $ IN DISPUTE

TEMPORARY DISABILITY INDEMNITY PAID ADEQUATELY COMPENSATED Weekly Rate $ N/A

Period(s) Paid N/A (Start Date: MM/DD/YYYY) N/A (End Date: MM/DD/YYYY)

PERMANENT DISABILITY INDEMNITY PAID 0.00 Weekly Rate $ N/A

Period(s) Paid N/A (Start Date: MM/DD/YYYY) End date N/A (End Date: MM/DD/YYYY)

TOTAL MEDICAL BILLS PAID $ PER PROOF Total Unpaid Medical Expense to be Paid By: PER PARAGRAPH 8

Unless otherwise specified herein, the employer will pay no medical expenses incurred after approval of this agreement.

7. The parties agree to settle the above claim(s) on account of the injury(ies) by the payment of the SUM OF

$ 70,000.00
Settlement Amount

The following amounts are to be deducted from the settlement amount:

$ _____ for permanent disability advances through _____

$ _____ for temporary disability indemnity overpayment, if any.

$ 8,700.00 payable to EDD for benefits paid after MMI date 4/1/20 through 10/27/20

$ _____ payable to _____

$ _____ payable to _____

$ _____ payable to _____

$ 10,500.00 requested as applicant's attorney's fee.

LEAVING A BALANCE OF $ 50,800.00 , after deducting the amounts set forth above and less further permanent disability advances made after the date set forth above. Interest under Labor Code section 5800 is included if the sums set forth herein are paid within 30 days after the date of approval of this agreement.

8. Liens not mentioned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary):

ALL INDUSTRIAL LIENS OF RECORD TO BE NEGOTIATED, ADJUSTED OR PAID BY DEFENDANT. ALL LIENS ARE SUBJECT TO ALL AVAILABLE DEFENSES, AFFIRMATIVE OR OTHERWISE PROVIDED BY THE LABOR CODE.

NOTHING IN THIS SETTLEMENT SHALL BE CONSTRUED AS A WAIVER BY DEFENDANT OF ITS RIGHTS TO ASSERT APPLICABLE DEFENSES. APPLICANT IS RESPONSIBLE FOR ALL TREATMENT COSTS FROM DATE OF OACR. DEFENDANT DISPUTES LABILITY FOR NON-MPN TREATMENT PURSUANT TO LC 4605.

ALL PENALTIES AND INTEREST WAIVED IF AWARD PAID WITHIN 30 DAYS OF ORDER APPROVING. PARTIES STIPULATE THERE ARE NO OUTSTANDING PAYMENTS REGARDING TTD, TPD, PD, MILEAGE, OUT-OF-POCKET EXPENSES, PENALTIES & INTEREST, AND OR ATTORNEY FEES.

APPLICANT CONTENTS HE HAS BEEN ADEQUATELY PAID ALL TTD BENEFITS FROM 10/30/2019 THROUGH 4/1/2020 WHEN SHE WAS DECLARED MMI. APPLICANT WILL REIMBURSE EDD $8,700.00 FROM SETTLEMENT AMOUNT FOR PERIODS OF BENEFITS PAID BY EDD AFTER THE DATE SHE WAS MMI. ALTHOUGH THE RATE PAID BY EDD WAS $648/WEEK, EDD WILL ONLY SEEK REIMBURSENT AT THE PD RATE OF $290/WEEK.

DEFENDANT WILL HOLD HARMPLESS APPLICANT AGAINST PERIODS OF BENEFITS PAID BY EDD DURING TTD PERIOD DETERMINED BY DR. SCHWARZ. DEFENANT WILL NEGOTIATE AND REIMBURSE EDD AMOUNT PAID DURING SAID PERIOD.

9. The parties wish to settle these matters to avoid the costs, hazards and delays of further litigation, and agree that a serious dispute exists as to the following issues (initial only those that apply). ONLY ISSUES INITIALED BY APPLICANT OR HIS/HER REPRESENTATIVE AND DEFENDANTS, REPRESENTATIVES ARE INCLUDED WITHIN THIS SETTLEMENT.

Applicant	Defendant	
AG	NME	earnings
AG	NME	temporary disability
AG	NME	jurisdiction
AG	NME	apportionment
AG	NME	employment
AG	NME	injury AOE/COE
AG	NME	serious and willful misconduct
AG	NME	discrimination (Labor Code §132a)
AG	NME	statute of limitations
AG	NME	future medical treatment
AG	NME	other OUT OF POCKET COSTS, PENALTIES, 5710 FEES, INTEREST, MILEAGE
AG	NME	permanent disability PER PQME REPORT OF DR. SCHWARZ
AG	NME	self-procured medical treatment, except as provided in Paragraph 7
	NME	vocational rehabilitation benefits/supplemental job displacement benefits

COMMENTS:

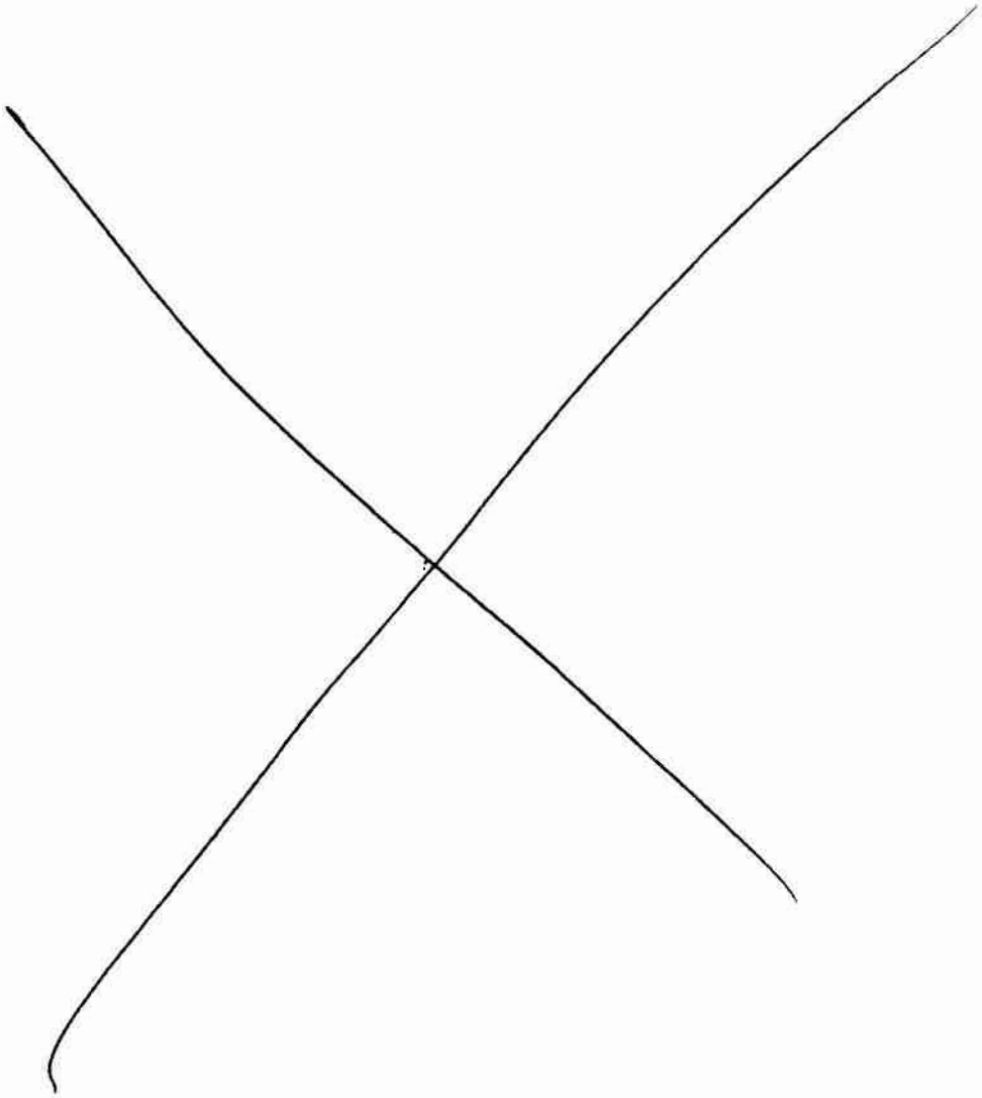
This agreement resolves all claims against the listed employer and insurance carrier. Applicant affirms she suffered no injuries other than those listed in this agreement while employed by the listed employer. Only accepted body parts are the cervical spine and bilateral upper extremities for ADJ12721933. All other body parts are denied, including ADJ12721676 is denied in its entirety based on the PQME findings of Dr. Yadegar (psyche PQME). Applicant's allegations of harassment stem from good faith personnel action. Therefore, defendant maintains denial of ADJ12721676 and parties stipulate that there is a good faith dispute as to AOE/COE which if resolved against defendant would lead to total bar against recovery.

~~Parties stipulate applicant is not a qualified injured worker and therefore not entitled to supplemental job displacement benefits/voucher~~.

Applicant acknowledges and agrees that she (a) is not a Medicare recipient at the time of this settlement, (b) has not at any time applied for social security benefits, and (c) does not reasonably expect to become a Medicare recipient within thirty (30) months of the date of this settlement.

Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

10. It is agreed by all parties hereto that the filing of this document is the filing of an application, and that the workers' compensation administrative law judge may in its discretion set the matter for hearing as a regular application, reserving to the parties the right to put in issue any of the facts admitted herein and that if hearing is held with this document used as an application, the defendants shall have available to them all defenses that were available as of the date of filing of this document, and that the workers' compensation administrative law judge may thereafter either approve this Compromise and Release or disapprove it and issue Findings and Award after hearing has been held and the matter regularly submitted for decision.



11. WARNING TO EMPLOYEE: SETTLEMENT OF YOUR WORKERS' COMPENSATION CLAIM BY COMPROMISE AND RELEASE MAY AFFECT OTHER BENEFITS YOU ARE RECEIVING TO WHICH YOU BECOME ENTITLED TO RECEIVE IN THE FUTURE FROM SOURCES OTHER THAN WORKERS' COMPENSATION, INCLUDING BUT NOT LIMITED TO SOCIAL SECURITY, MEDICARE AND LONG-TERM DISABILITY BENEFITS.

THE APPLICANT'S (EMPLOYEE'S) SIGNATURE MUST BE ATTESTED TO BY TWO DISINTERESTED PERSONS OR ACKNOWLEDGED BEFORE A NOTARY PUBLIC

By signing this agreement, applicant (employee) acknowledges that he/she has read and understands this agreement and has had any questions he/she may have had about this agreement answered to his/her satisfaction.

Witness the signature hereof this 25 day of March, 2021 at 3:38 p.m.

Witness	(Date) 3-26-21
Witness 2	(Date) 3-26-21
Interpreter	(Date)
Applicant (Employee)	(Date) 3/25/2
Attorney for Applicant	(Date) 3/28/21
Attorney for Defendant	(Date) 04/28/2021
Attorney for Defendant	(Date)
Attorney for Defendant	(Date)
Attorney for Defendant	(Date)

ACKNOWLEDGMENT

State of California
County of _____)

On _____ before me, _____
(insert name and title of the officer)

personally appeared _____
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ **(Seal)**

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) 04/28/2021

Case Number: ADJ12721933 SSN(Numbers Only)

○ 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 :

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

◉ ADJ ○ DEU ○ SIF ○ UEF ○ SAU ○ INT ○ RSU

Companion Cases

Case 1: ADJ12721676

○ 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
COMPROMISE AND RELEASE

Case No 1	ADJ12721933
Case No 2	ADJ12721676
Case No 3	
Case No 4	
Case No 5	
SSN (Numbers only)*	561256071

*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

Employee

First Name*	ANNETTE
MI	
Last Name*	GARNER
Address/PO Box*	1928 W 108 TH STR
City*	LOS ANGELES
State*	CA
Zip Code* (Numbers Only)	90047

Employer Information*

◉ Insured ◯ Self-Insured ◯ Legally Uninsured ◯ Uninsured

Employer Name*	MISSION SCHOOL TRANSPORTATION
Street Address/PO Box*	20 SOTELLO ST
City*	LOS ANGELES
State*	CA
Zipcode* (Numbers Only)	90012

Applicant's Attorney or Authorized Representative:

☑ Law Firm/Attorney ☐ Non Attorney Representative

First Name	NATALIA
Last Name	FOLEY
Law Firm Number	13792552
Law Firm Name	WORKERS DEFENDERS ANAHEIM
Address/PO Box	8018 E SANTA ANA CANYON RD
City	ANAHEIM
State	CA
Zipcode (Numbers Only)	92808

Defendant's Attorney or Authorized Representative:

☑ Law Firm/Attorney ☐ Non Attorney Representative

First Name	NADINE
Last Name	ELKHATTAT
Law Firm Number	6405254
Law Firm Name	MICHAEL SULLIVAN FULLERTON
Address/PO Box	PO BOX 85059
City	SAN DIEGO
State	CA
Zipcode (Numbers Only)	92186

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

Insurance Carrier Name	VANLINER INSURANCE COMPANY
Insurance Carrier Address/PO Box	ONE PREMIER DRIVE
City	FENTON
State	MO
Zip Code (Numbers Only)	63026

Claims Administrator Information (if known and if applicable)

Name	NATIONAL INTERSTATE RICHFIELD
Street Address/PO Box	PO BOX 521
City	RICHFIELD
State	OH
Zip Code (Numbers Only)	44286

IT IS CLAIMED THAT:

1. The injured employee, born * 11/15/1959 alleges that while employed
(DATE OF BIRTH: MM/DD/YYYY)

as a(n) _____
(OCCUPATION AT THE TIME OF INJURY)

sustained injury arising out of and in the course of employment at the locations and during the dates listed below:

(State with specificity the date(s) of injury(ies) and what part(s) of body, conditions or systems are being settled.)

Case Number 1: ADJ12721933

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

◉ Cumulative Injury 12/01/2018 (START DATE: MM/DD/YYYY) 11/01/2019 (END DATE: MM/DD/YYYY)

Body Part 1: 200 NECK
Body Part 2: 300 UPPER EXTREMITIES - NOT SPE
Body Part 3: 430 CHEST - INCLUDING RIBS,
Body Part 4: 450 SHOULDERS - SCAPULA AND C
Other Body Parts : 500 LOWER EXTREMITIES - NOT SPECIFIED

The injury occurred at :

Street Address: WORKPLACE
City:
State:
Zip Code (Numbers Only):

Body parts, conditions and systems may not be incorporated by reference to medical reports.

Case Number 2: ADJ12721676

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

◉ Cumulative Injury 01/01/2018 (START DATE: MM/DD/YYYY) 10/31/2019 (END DATE: MM/DD/YYYY)

Body Part 1: 841 NERVOUS SYSTEM - STRES Body Part 2:

Body Part 3: Body Part 4:

Other Body Parts:

The injury occurred at :

Street Address:

City:

State:

Zip Code (Numbers Only):

Body parts, conditions and systems may not be incorporated by reference to medical reports.

Case Number 3:

◯ 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:

The injury occurred at :

Street Address:

City:

State:

Zip Code(Numbers Only):

Body parts, conditions and systems may not be incorporated by reference to medical reports.

Case Number 4:

◯ 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

The injury occurred at :

Street Address

City

State

Zip Code(Numbers Only)

Body parts, conditions and systems may not be incorporated by reference to medical reports.

Case Number 5:

◯ 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

The injury occurred at :

Street Address

City

State

Zip Code(Numbers Only)

Body parts, conditions and systems may not be incorporated by reference to medical reports.

2. Upon approval of this compromise agreement by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge and payment in accordance with the provisions hereof, the employee releases and forever discharges the above-named employer(s) and insurance carrier(s) from all claims and causes of action, whether now known or ascertained or which may hereafter arise or develop as a result of the above-referenced injury(ies), including any and all liability of the employer(s) and the insurance carrier(s) and each of them to the dependents, heirs, executors, representatives, administrators or assigns of the employee. Execution of this form has no effect on claims that are not within the scope of the workers' compensation law or claims that are not subject to the exclusivity provisions of the workers' compensation law, unless otherwise expressly stated.

3. This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury set forth in Paragraph No. 1 and further explained in Paragraph No. 9 despite any language to the contrary elsewhere in this document or any addendum.

4. Unless otherwise expressly stated, approval of this agreement RELEASES ANY AND ALL CLAIMS OF APPLICANT'S DEPENDENTS TO DEATH BENEFITS RELATING TO THE INJURY OR INJURIES COVERED BY THIS COMPROMISE AGREEMENT. The parties have considered the release of these benefits in arriving at the sum in Paragraph No. 7. Any addendum duplicating this language pursuant to Sumner v WCAB, (1983) 48 CCC 369 , is unnecessary and shall not be attached.

5. Unless otherwise expressly ordered by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge, approval of this agreement does not release any claim applicant may have for vocational rehabilitation benefits or supplemental job displacement benefits.

6. The parties represent that the following facts are true: (If facts are disputed, state what each party contends under Paragraph No. 9.)

EARNINGS AT TIME OF INJURY$	
TEMPORARY DISABILITY INDEMNITY PAID$	
Weekly Rate$	
Period(s) Paid	(START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)
PERMANENT DISABILITY INDEMNITY PAID$	
Weekly Rate$	
Period(S) Paid	(START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)
Total Medical Bills Paid$	
Total Unpaid Medical Expense to be Paid By	

Unless otherwise specified herein, the employer will pay no medical expenses incurred after approval of this agreement.

7. The parties agree to settle the above claim(s) on account of the injury(ies) by the payment of the SUM OF *$ 70,000.00

Settlement Amount*

The following amounts are to be deducted from the settlement amount:

$		for permanent disability advances through	
$		for temporary disability indemnity overpayment , if any.	
$	8,700.00	payable to	EDD FOR BENEFITS PAID AFTER MMI...
$		payable to	
$		payable to	
$		payable to	
$	10,500.00	requested as applicant's attorney's fee.	

LEAVING A BALANCE OF $50,800.00 ,after deducting the amounts set forth above and less further permanent disability advances made after the date set forth above. Interest under Labor Code §5800 is included if the sums set forth herein are paid within 30 days after the date of approval of this agreement.

8. Liens not mentioned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary): Field size limited to 1673 characters

ALL INDUSTRIAL LIENS OF RECORD TO BE NEGOTIATED, ADJUSTED OR PAID BY DEFENDANT. ALL LIENS ARE SUBJECT TO ALL AVAILABLE DEFENSES, AFFIRMATIVE OR OTHERWISE PROVIDED BY THE LABOR CODE.

NOTHING IN THIS SETTLEMENT SHALL BE CONSTRUED AS A WAIVER BY DEFENDANT OF ITS RIGHTS TO ASSERT APPLICABLE DEFENSES. APPLICANT IS RESPONSIBLE FOR ALL TREATMENT COSTS FROM DATE OF OACR. DEFENDANT DISPUTES LABILITY FOR NON-MPN TREATMENT PURSUANT TO LC 4605.

ALL PENALTIES AND INTEREST WAIVED IF AWARD PAID WITHIN 30 DAYS OF ORDER APPROVING. PARTIES STIPULATE THERE ARE NO OUTSTANDING PAYMENTS REGARDING TTD, TPD, PD, MILEAGE, OUT-OF-POCKET EXPENSES, PENALTIES & INTEREST, AND OR ATTORNEY FEES.

APPLICANT CONTENTS HE HAS BEEN ADEQUATELY PAID ALL TTD BENEFITS FROM 10/30/2019 THROUGH 4/1/2020 WHEN SHE WAS DECLARED MMI. APPLICANT WILL REIMBURSE EDD $8,700.00 FROM SETTLEMENT AMOUNT FOR PERIODS OF BENEFITS PAID BY EDD AFTER THE DATE SHE WAS MMI. ALTHOUGH THE RATE PAID BY EDD WAS $648/WEEK, EDD WILL ONLY SEEK REIMBURSENT AT THE PD RATE OF $290/WEEK.

DEFENDANT WILL HOLD HARMPLESS APPLICANT AGAINST PERIODS OF BENEFITS PAID BY EDD DURING TTD PERIOD DETERMINED BY DR. SCHWARZ. DEFENANT WILL NEGOTIATE AND REIMBURSE EDD AMOUNT PAID DURING SAID PERIOD.

9. The parties wish to settle these matters to avoid the costs, hazards and delays of further litigation, and agree that a serious dispute exists as to the following issues (check only those that apply). ONLY ISSUES CHECKED BY APPLICANT AND HIS/HER REPRESENTATIVE AND DEFENDANTS, REPRESENTATIVES ARE INCLUDED WITHIN THIS SETTLEMENT.

Applicant	Defendant	
☑	☒	earnings
☑	☒	temporary disability
☑	☒	jurisdiction
☑	☒	apportionment
☑	☒	employment
☑	☒	injury AOE/COE
☑	☒	serious and willful misconduct
☑	☒	discrimination (Labor Code §132a)
☑	☒	statute of limitations
☑	☒	future medical treatment
☑	☒	other OUT OF POCKET COSTS, PENALTIES, 5710 FEES...
☑	☒	permanent disability PER PQME REPORT OF DR. SCHWARZ
☑	☒	self-procured medical treatment, except as provided in Paragraph 7
☐	☒	vocational rehabilitation benefits/supplemental job displacement benefits

Comment: Field size limited to 503 characters

THIS AGREEMENT RESOLVES ALL CLAIMS AGAINST THE LISTED EMPLOYER AND INSURANCE CARRIER. APPLICANT AFFIRMS SHE SUFFERED NO INJURIES OTHER THAN THOSE LISTED IN THIS AGREEMENT WHILE EMPLOYED BY THE LISTED EMPLOYER. ONLY ACCEPTED BODY PARTS ARE THE CERVICAL SPINE AND BILATERAL UPPER EXTREMITIES FOR ADJ12721933. ALL OTHER BODY PARTS ARE DENIED, INCLUDING ADJ12721676 IS DENIED IN ITS ENTIRETY BASED ON THE PQME FINDINGS OF DR. YADEGAR (PSYCHE PQME). APPLICANT'S ALLEGATIONS OF HARASSMENT STEM FROM...

Any accrued claims for Labor Code Section 5814 penalties are included in this settlement unless expressly excluded.

10. It is agreed by all parties hereto that the filing of this document is the filing of an application, and that the workers' compensation administrative law judge may in its discretion set the matter for hearing as a regular application, reserving to the parties the right to put in issue any of the facts admitted herein and that if hearing is held with this document used as an application, the defendants shall have available to them all defenses that were available as of the date of filing of this document, and that the workers' compensation administrative law judge may thereafter either approve this Compromise and Release or disapprove it and issue Findings and Award after hearing has been held and the matter regularly submitted for decision.

11. WARNING TO EMPLOYEE: SETTLEMENT OF YOUR WORKERS' COMPENSATION CLAIM BY COMPROMISE AND RELEASE MAY AFFECT OTHER BENEFITS YOU ARE RECEIVING TO WHICH YOU MAY BECOME ENTITLED TO RECEIVE IN THE FUTURE FROM SOURCES OTHER THAN WORKERS' COMPENSATION, INCLUDING BUT NOT LIMITED TO SOCIAL SECURITY, MEDICARE AND LONG-TERM DISABILITY BENEFITS.

THE APPLICANT'S (EMPLOYEE'S) SIGNATURE MUST BE ATTESTED TO BY TWO DISINTERESTED PERSONS OR ACKNOWLEDGED BEFORE A NOTARY PUBLIC

By signing this agreement, applicant (employee) acknowledges that he/she has read and understands this agreement and has had questions he/she may have had about this agreement answered to his/her satisfaction.

For this form to be legally binding, the filing party must attach to this electronic form a fully executed OCR form that is identical in content to this form and which contains all required signatures.

Witness the signature hereof this 25 (Day) day of 03 (Month) 2021 (Year)

at FULLERTON, CA

UNLEGIBLE Witness 1	03/26/2021 (Date)
INLEGIBLE Witness 2	03/26/2021 (Date)
Interpreter	(Date)
ANNETTE GARNER Applicant (Employee)	03/25/2021 (Date)
NATALIA FOLEY Attorney for Applicant	03/28/2021 (Date)
NADINE M. ELHATTAT Attorney for Defendant	04/28/2021 (Date)
Attorney for Defendant	(Date)
Attorney for Defendant	(Date)
Attorney for Defendant	(Date)

ACKNOWLEDGMENT

State of California

County of _____

On _____

before me, _____
(insert name and title of the officer)

personally appeared _____

who proved to me on the basis of satisfactory evidence to be the persons(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)

Nadine M. Elkhattat, State Bar No. 237408
Michael Sullivan & Associates LLP (UAN: MICHAEL SULLIVAN FULLERTON)
PO Box 85059
San Diego, CA 92186-5059
Tel (714) 202-3440 Fax (844) 910-1850

Attorneys for Defendants

WORKERS' COMPENSATION APPEALS BOARD

Annette Garner, Applicant, vs. Mission School Transportation; Insured by Vanliner Insurance Company; Administered by National Interstate Insurance Company, Defendant,	Case No: **ADJ12721933, ADJ12721676** **AFFIDAVIT OF DEFENDANT RE: RESOLUTIONS OF LIENS**

I, Nadine M. Elkhattat, am the attorney or representative for defendant Mission School Transportation in the above-entitled matter.

I have made the following good faith efforts to resolve each of the liens in this case. List ALL lien claims below. Use supplemental pages as necessary.

Lien Claimant	**Nature and Date of Lien Resolution Efforts**	**Result**
EDD	EDD lien is pending negotiations. Parties have a tentative agreement but awaiting EDD rep to forward lien agreement.	

I declare under penalty of perjury that the foregoing is true and correct and that this affidavit was executed at Fullerton, California on April 28, 2021.

DATE: April 28, 2021

MICHAEL SULLIVAN & ASSOCIATES LLP

NADINE M. ELKHATTAT
Attorney at Law

Mailing Address:
Michael Sullivan & Associates LLP
PO Box 85059
San Diego, CA 92186-9059

1780.0081 (Annette Garner), ADJ12721933, ADJ12721676/ Claim #(s): 1341863

PROOF OF SERVICE
STATE OF CALIFORNIA, COUNTY OF ORANGE

I am a resident of or employed in the County of Orange, State of California. I am over the age of eighteen years and not a party to the within entitled action. My business address is: 1440 N. Harbor Boulevard, Suite 500, Fullerton, California 92835.

On **April 28, 2021,** I served the foregoing document(s) described as **Proposed Compromise and Release, and Lien Affidavit** by causing to be placed a true copy thereof in (a) sealed envelope(s) addressed to:

Workers' Compensation Appeals Board
1065 N Link Ste 170
Anaheim, CA 92806
(E-Filed)

Diane McClellan
National Interstate Insurance Company
PO Box 521
Richfield OH 44286
(Sent via U.S. Mail and Email)

Workers Defenders
8018 E. Santa Ana Canyon Rd.,
Ste. 100-215
Anaheim, CA 92808

Melendrez Law Newport Beach
4695 Macarthur Ct., FL 11
Newport Beach, CA 92660

Annette Garner
1928 W 108th St.
Los Angeles CA 90047

Vanliner Insurance Fenton
One Premier Dr. Mail Stop Y 29
Fenton, MO 63026

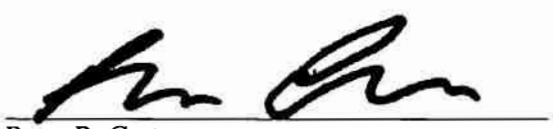
EDD SDI Santa Ana
PO Box 1466
Santa Ana, CA 92702
SSN# 561-25-6071

(X) (BY MAIL) I caused to be deposited such envelope(s) in first class mail in San Diego, California. The envelope was mailed with postage thereon fully paid.

(X) (AS FOLLOWS) I am "readily familiar" with the practice of collection and processing correspondence for mailing in the firm filing this document. Under that practice it would be deposited with the U.S. Postal Service on that same day with postage thereon, fully prepaid at San Diego, California in the ordinary course of business. I am aware that on motion of the parties 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 in affidavit.

Executed on **April 28, 2021** at Fullerton, California.

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



Ryan R. Carter
MICHAEL SULLIVAN & ASSOCIATES LLP