Koruon Daldalyan M.D., Q.M.E
Board Certified, Internal Medicine
Internist Health Clinic
13320 Riverside Dr., Suite 104,
Sherman Oaks, California 91423
Tel: 818.574.6189 Fax: 818.574.6218
kdaldalyan@internisthc.com

June 7, 2023

Natalia Foley, Esq.
Workers Defenders Law Group
8018 E. Santa Ana Canyon Rd. Ste 100 215
Anaheim, CA 92808

PATIENT:	Arthur Israyelyan
DOB:	August 6, 1958
OUR FILE #:	2022-174
SSN:	XXX-XX-XXXX
EMPLOYER:	Door to Door Valet Cleaners 9843 S. Santa Monica Blvd Beverly Hills, CA 90212
WCAB #:	ADJ17187099
CLAIM#:	***
DATE OF INJURY:	March 12, 2022
DATE OF 1ST VISIT:	March 22, 2023
INSURER:	AmTrust Concord P.O Box 89404 Cleveland, OH 44101
ADJUSTOR:	Iona Collier
PHONE #:	(415) 777-5557

Primary Treating Physician's Progress Report

Dear Ms. Foley,

The patient had a telehealth conference on June 7, 2023, for reevaluation. The evaluation was performed via telehealth given the current pandemic with COVID-19. A consent for this telehealth was obtained and the patient is agreeable to this evaluation. The patient does not report any changes to his current health status.

Current Medications:

The patient currently takes Sildenafil 20mg QD, Baby aspirin 81mg TID, Atorvastatin 40mg QD,

Physical Examination:

The patient is a 64-year-old alert, cooperative and oriented Armenian American male, in no acute distress.

Subjective Complaints:

1. Shortness of Breath
2. Erectile Dysfunction
3. Dizziness
4. Wheezing
5. Sexual Dysfunction
6. Lightheadedness
7. Eye Pain
8. Anxiety
9. Visual Difficulty
10. Depression
11. Difficulty Concentrating
12. Sinus Problems
13. Difficulty Sleeping
14. Sinus Congestion
15. Difficulty Making Decisions
16. Forgetfulness
17. Hair Loss
18. Postnasal Drip
19. Skin Issues
20. Jaw Pain
21. Intolerance to Heat/Cold
22. Jaw Clenching
23. Urinary Frequency

Objective Findings:

1. Tenderness noted to the paravertebral of the cervical spine and lumbar spine
2. Distal amputation of the 3rd digit, right hand
3. Numbness noted of tips of all digits, both hands
4. Tremor noted of bilateral hands

5. A pulmonary function test is performed revealing an FVC of 2.78 L (53.8%) and an FEV 1 of 1.79 L (46.4%). There was a 13.0% increase in FVC after the administration of Albuterol.
6. A 12-lead electrocardiogram is performed revealing sinus arrythmia and a heart rate of 65 per minute.
7. A pulse oximetry test is performed and is recorded at 99%.
8. Jamar Test: Rt. 1. 7.9kg 2. 9.2kg 3. 11.3kg Lft. 1. 8.3kg 2. 6.0kg 3. 6.7kg
9. Vision Test with glasses: OU: 20/25 OD: 20/30 OS: 20/30
10. An audiogram is performed and reveals the following:

	1,000 Hz	2,000 Hz	3,000 Hz	4,000 Hz
Right:	15	15	15	40
Left:	15	15	15	30

11. A random blood sugar is performed and is recorded at 109 mg/dL.
12. A pulmonary function test is performed revealing an FVC of 1.91 L (37.0%) and an FEV 1 of 1.34 L (34.8%). There was no change after the administration of Albuterol.
13. A pulse oximetry test is performed and is recorded at 98%.

Diagnoses:

1. CERVICAL SPINE STRAIN/SPRAIN
2. THORACIC SPINE STRAIN/SPRAIN
3. LUMBAR SPINE STRAIN/SPRAIN
4. RIGHT SHOULDER STRAIN/SPRAIN
5. LEFT SHOULDER STRAIN/SPRAIN
6. RIGHT WRIST STRAIN/SPRAIN
7. LEFT WRIST STRAIN/SPRAIN
8. RIGHT HAND STRAIN/SPRAIN
9. LEFT HAND STRAIN/SPRAIN
10. GANGRENE INFECTION OF THIRD DIGIT, RIGHT HAND, RESULTING IN PARTIAL DISTAL AMPUTATION
11. PARESTHESIA OF DISTAL ENDS OF ALL DIGITS, BOTH HANDS
12. RAYNAUD'S PHENOMENON
13. BRUXISM
14. SHORTNESS OF BREATH
15. ERECTILE DYSFUNCTION
16. DIZZINESS
17. WHEEZING
18. SEXUAL DYSFUNCTION
19. LIGHTHEADEDNESS
20. EYE PAIN

21. ANXIETY DISORDER
22. VISION DISORDER
23. DEPRESSIVE DISORDER
24. DIFFICULTY CONCENTRATING
25. SINUS PROBLEMS AND CONGESTION
26. DIFFICULTY MAKING DECISIONS
27. FORGETFULNESS
28. ALOPECIA
29. POSTNASAL DRIP
30. SKIN ISSUES
31. TMJ SYNDROME
32. INTOLERANCE TO HEAT/COLD
33. JAW CLENCHING
34. URINARY FREQUENCY

Discussion:

The patient has filed a specific trauma claim dated 3/12/2022. The patient states he worked as a tailor for Door-to-Door Valet Cleaners. He mentions that his job duties included being seated at a sewing machine and assisting customers with their tailoring needs. He mentions that on this specific dated of 3/12/2022, he accidentally punctured the posterior aspect of his right 3rd digit just above his nail with the sewing machine. He states that this caused bleeding, however, he was able to use peroxide to cleanse his finger and continue his work.
The patient states that over the course of the next few months, he began to develop discoloration of the distal end of the 3rd digit, right hand. He states that in August of 2022, he presented to the hospital given the discoloration and numbness. He was diagnosed with gangrene of the distal digit and was told he required an amputation. The patient states he underwent antibiotic therapy and took various medications which helped slowly improve the fingers condition. He mentions that he eventually underwent a wound debris of the distal end of the digit which resulted in a partial amputation. He mentions that during his hospitalization he was also diagnosed with Raynaud's phenomenon. He complained of bilateral hand multi digit pain during his hospitalization. He was discharged and continued in treatment with a rheumatologist.
On March 21, 2022, the patient underwent an angiogram for evaluation of his upper extremity vessels. He was diagnosed with poor perfusion disorder; however, the final results are pending at this time. The patient states that given his condition, he began to develop severe stress, anxiety, and depression.

Please be advised that the listed diagnoses represent medical diagnoses and/or a differential diagnosis to a reasonable degree of medical probability based on the history provided to me by the patient and the findings of my examination. I believe that some of these diagnoses are industrial in origin and are either initiated or aggravated by the patient's employment and are, therefore, industrial in origin.

Some diagnoses are non-specific and will require further evaluation. I reserve the right to alter my opinions based upon receipt of additional information in the form of prior medical records or other documentary evidence that relates to this case. Please be advised that the denial of the claim by the employer will affect my ability to either confirm or reject any of the stated diagnoses, which will also affect my ability to provide evidentiary support for my opinions. Treatment authorization, if already approved, is appreciated. If treatment has not yet been approved, it is hereby requested.

The various diagnoses listed appear to be consistent with the type of work that would typically cause such abnormalities. I, therefore, believe that the diagnoses listed thus far are AOE/COE.

Disability Status:

The patient is to continue on temporary and total disability for a period of six weeks.

Treatment:

The patient is to continue with his current medications. He will be reevaluated in six weeks.

Attestation:

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

I further declare under penalty of perjury that I, Koruon Daldalyan, M.D., personally performed the evaluation of this patient and the cognitive services necessary to produce this report. The evaluation was performed at the above address. The time spent performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code.

The laboratory tests, if taken, were performed by Quest Diagnostics or Metro Lab in Encino, CA.

The history was obtained from the patient and the dictated report was transcribed by Adrine Madatyan, transcriptionist.

I further declare under penalty of perjury that I have not violated the provisions of California Labor Code Section 139.3 with regard to the evaluation of this patient or the preparation of this report. This attestation is effective as of January 1, 2020.

Based on Labor Code Statute 4628, a fee of $64.50 per page for a total of 6 pages has been added to cover reasonable costs of the clerical expense necessary to produce this report.

Should you have any questions or concerns regarding the evaluation or treatment provided to this patient or this report, please feel free to contact me.

Sincerely,

Koruon Daldalyan, M.D.
Board Certified, Internal Medicine

Internist Health Clinic
13320 Riverside Drive
Suite 104
SHERMAN OAKS, CA 91423

PLEASE SELECT THE CHECK BOX INDICATING PAYMENT METHOD			
☐ mastercard ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS ☐ $			
CARD NUMBER		CVC	AMOUNT
SIGNATURE		ZIP CODE	EXP . DATE
ACCOUNT #	STATEMENT DATE	DUE UPON RECEIPT	SHOW AMOUNT PAID
8431687	06/27/2023	$0.00	

Israyelyan, Arthur
11515 Rochester Ave Apt. 204
LOS ANGELES, CA 90025

Internist Health Clinic
13320 Riverside Drive
Suite 104
SHERMAN OAKS, CA 91423

ACCOUNT #	CHART #	PATIENT NAME	STATEMENT DATE	CASE	DUE UPON RECEIPT
8431687	2022-174	Israyelyan, Arthur	06/27/2023	Workers' Compensation	$0.00

DATE	DESCRIPTION	CHARGES	PATIENT PAYMENTS	ADJ.	INSURANCE PAYMENTS	PENDING INSURANCE	PATIENT BALANCE
06/07/23	99215 OFFICE O/P EST HI 40-54 MIN DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A MODIFIERS: 95	700.00	0.00	0.00	0.00	700.00	0.00
	Place Of Service: Internist Health Clinic						
	Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00						
	Provider: Daldalyan, Koruon						
	YOUR BALANCE						0.00
05/03/23	ML201 Comprehensive Medical-Legal Evaluation DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A MODIFIERS: 92	2015.00	0.00	0.00	0.00	2015.00	0.00
	Place Of Service: Internist Health Clinic						
	Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00						
05/03/23	94060 EVALUATION OF WHEEZING DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A	250.00	0.00	0.00	0.00	250.00	0.00
	Place Of Service: Internist Health Clinic						
	Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00						
05/03/23	94664 EVALUATE PT USE OF INHALER DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A	75.00	0.00	0.00	0.00	75.00	0.00
	Place Of Service: Internist Health Clinic						
	Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00						
	Provider: Daldalyan, Koruon						
	YOUR BALANCE						0.00
03/22/23	99205 OFFICE O/P NEW HI 60-74 MIN DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A	1500.00	0.00	0.00	0.00	1500.00	0.00
	Place Of Service: Internist Health Clinic						

DATE	DESCRIPTION	CHARGES	PATIENT PAYMENTS	ADJ.	INSURANCE PAYMENTS	PENDING INSURANCE	PATIENT BALANCE
	Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00						
03/22/23	97750 PHYSICAL PERFORMANCE TEST DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A	600.00	0.00	0.00	0.00	600.00	0.00
	Place Of Service: Internist Health Clinic						
	Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00						
03/22/23	97535 SELF CARE MNGMENT TRAINING DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A	150.00	0.00	0.00	0.00	150.00	0.00
	Place Of Service: Internist Health Clinic						
	Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00						
03/22/23	99483 ASSMT & CARE PLN PT COG IMP DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A	800.00	0.00	0.00	0.00	800.00	0.00
	Place Of Service: Internist Health Clinic						
	Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00						
03/22/23	94060 EVALUATION OF WHEEZING DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A	250.00	0.00	0.00	0.00	250.00	0.00
	Place Of Service: Internist Health Clinic						
	Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00						
03/22/23	94664 EVALUATE PT USE OF INHALER DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A	75.00	0.00	0.00	0.00	75.00	0.00
	Place Of Service: Internist Health Clinic						
	Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00						
03/22/23	93000 ELECTROCARDIOGRAM COMPLETE DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A	215.00	0.00	0.00	0.00	215.00	0.00
	Place Of Service: Internist Health Clinic						
	Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00						
03/22/23	94760 MEASURE BLOOD OXYGEN LEVEL DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A	125.00	0.00	0.00	0.00	125.00	0.00
	Place Of Service: Internist Health Clinic						
	Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00						
03/22/23	99173 VISUAL ACUITY SCREEN DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A	50.00	0.00	0.00	0.00	50.00	0.00
	Place Of Service: Internist Health Clinic						
	Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00						
03/22/23	92557 COMPREHENSIVE HEARING TEST DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A	250.00	0.00	0.00	0.00	250.00	0.00
	Place Of Service: Internist Health Clinic						
	Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00						
03/22/23	82962 GLUCOSE BLOOD TEST DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A	65.00	0.00	0.00	0.00	65.00	0.00
	Place Of Service: Internist Health Clinic						
	Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00						
03/22/23	36415 ROUTINE VENIPUNCTURE DIAGNOSIS: S13.4XXA S23.9XXA S33.5XXA S43.401A	65.00	0.00	0.00	0.00	65.00	0.00
	Place Of Service: Internist Health Clinic						
	Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00						
	Provider: Daldalyan, Koruon						
	YOUR BALANCE						0.00
		7185.00	0.00	0.00	0.00	7185.00	0.00

DATE	DESCRIPTION	CHARGES	PATIENT PAYMENTS	ADJ.	INSURANCE PAYMENTS	PENDING INSURANCE	PATIENT BALANCE
	Total						

MESSAGES

SSN: 611-49-3637
D.O.I.: March 12, 2022 / TAX ID: 86-2448871

BALANCE DUE UPON RECEIPT **$ 0.00**

AVAILABLE PATIENT FUND **$ 0.00**

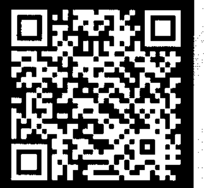
AGING INFORMATION

0 - 30	31 - 60	61 - 90	91 - 120	> 120
$0.00	$0.00	$0.00	$0.00	$0.00

PLEASE DETACH AND RETURN THE TOP PORTION WITH YOUR PAYMENT

Pay Online

Scan QR code or use below link to make a secure online payment:
www.rxnt.com/patientbillpay



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

AmTrust 89404
P.O. BOX 89404
CLEVELAND OH 44101-6400

PICA — CARRIER

1. MEDICARE (Medicare#) [ ] MEDICAID (Medicaid#) [ ] TRICARE (ID#/DoD#) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (ID#) [ ] FECA BLK LUNG (ID#) [ ] OTHER (ID#) [X]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 611403637

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Israyelyan Arthur

3. PATIENT'S BIRTH DATE (MM DD YY): 08 06 1958 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 11515 Rochester Ave Apt. 204

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: LOS ANGELES STATE: CA

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 90025 TELEPHONE (Include Area Code): (310) 498-9087

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Israyelyan Arthur

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 611403637

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE: CLEVELAND OH 441016400

d. INSURANCE PLAN NAME OR PROGRAM NAME: AmTrust 89404

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) [X] YES [ ] NO

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

c. OTHER ACCIDENT? [ ] YES [X] NO

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER: 611-40-3637

a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M [ ] F [ ]

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME: AmTrust 89404

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO *If yes, complete items 9, 9a, and 9d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Koruon Daldalyan DATE 6/7/2023

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Koruon Daldalyan

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. 439 MM DD YY 03 12 2022

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. S13.4XXA B. S23.9XXA C. S33.5XXA D. S43.401A
E. S43.402A F. S63.501A G. S63.502A H. S63.91XA
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06 07 23		11		99215	95	ABCD	700 00	1.0		NPI	1679937643
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 862448871 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 13040031

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 700 00

29. AMOUNT PAID: $ 0 00

30. Rsvd for NUCC Use: 700 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Koruon Daldalyan SIGNED 06/26/2023 DATE

32. SERVICE FACILITY LOCATION INFORMATION
Internist Health Clinic
13320 Riverside Drive Suite 104
SHERMAN OAKS CA 91423-2502
a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )
Koruon Daldalyan
13320 Riverside Drive Suite 104
SHERMAN OAKS CA 91423
a. 1679937643 b.

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
Koruon Daldalyan M.D. Inc.

2 Business name/disregarded entity name, if different from above
Koruon Daldalyan M.D. Inc../ Internist Health Clinic

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☑ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ ________

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) ________

Exemption from FATCA reporting code (if any) ________

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.
13320 Riverside Drive, Suite 104

Requester's name and address (optional)

6 City, state, and ZIP code
Sherman Oaks, CA 91423

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number
___ – __ – ____

or

Employer identification number
86 – 2448871

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here Signature of U.S. person ▶ [signature] Date ▶ 12/01/2022

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Re: Arthur Israyelyan
Claim No: Pending
WCAB No: ADJ17187099
Chart No: 2022-174

PROOF OF SERVICE BY MAIL
(1013a, 2015.5 C.C.P.)
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 and not a party to the within action. My business address is 13320 Riverside Drive, Suite 104, Sherman Oaks, CA 91423.

On June 27, 2023, I served the foregoing document described as:

- Progress Report (06-07-23)
- Itemized Bill (06-27-23)
- 1500 CMS Claim (06-26-23)
- W-9 Form (12-01-22)

On all interested parties in this action by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid in the United States mailed at Sherman Oaks, California addressed as follows:

Workers' Defenders Law Group
751 South Weir Canyon Road, Suite 157-455
Anaheim, CA 92808

Law Offices of Llarena, Murdock, Lopez & Azizad
505 East Colorado Boulevard, Suite 200
Pasadena, CA 91101

AmTrust Services
P.O. Box 89404
Cleveland, OH 44101

Executed on June 27, 2023, in Sherman Oaks, California.

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

Eliza Perez
Eliza Perez