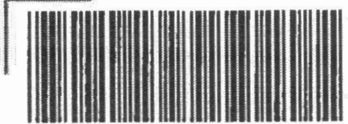
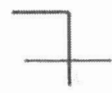


STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
COMPROMISE AND RELEASE



ADJ11924494
Case Number 1

Case Number 4

ADJ11924493
Case Number 2

Case Number 5

Case Number 3

559-79-2503
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)

DEBRA
First Name — MI

SANCHEZ
Last Name

6025 CLARA STREET
Address/PO Box (Please leave blank spaces between numbers, names or words)

BELL GARDENS — CA — 90201
City — State — Zip Code

Employer Information (Completion of this section is required)

☐ Insured ☑ Self-Insured ☐ Legally Uninsured ☐ Uninsured

UNIVERSITY OF SOUTHERN CALIFORNIA
Employer Name (Please leave blank spaces between numbers, names or words)

3434 S GRAND AVENUE CAL 120
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

LOS ANGELES — CA — 90089
City — State — Zip Code

Applicant's Attorney or Authorized Representative:

☑ Law Firm/Attorney ☐ Non Attorney Representative

NATALIA
First Name

FOLEY
Last Name

11964930
Law Firm Number

NATALIA FOLEY ANAHEIM
Law Firm Name

5753 E SANTA ANA CANYON RD STE G 616
Address/PO Box (Please leave blank spaces between numbers, names or words)

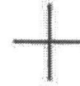
ANAHEIM
City

CA
State

92807
Zip Code

Defendant's Attorney or Authorized Representative:

☑ Law Firm/Attorney ☐ Non Attorney Representative



SHELLEY
First Name

WHEATLEY
Last Name

4885689
Law Firm Number

ROBERT WHEATLEY TUSTIN
Law Firm Name

14661 FRANKLIN AVENUE SUITE 100
Address/PO Box (Please leave blank spaces between numbers, names or words)

TUSTIN
City

CA
State

92780
Zip Code

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

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

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

City

State

Zip Code

Claims Administrator Information (if known and if applicable)

BROADSPIRE BREA
Name (Please leave blank spaces between numbers, names or words)

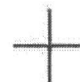
PO BOX 14352
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

LEXINGTON
City

KY
State

40512
Zip Code

IT IS CLAIMED THAT:



1. The injured employee, born 05/29/1966 (DATE OF BIRTH: MM/DD/YYYY), alleges that while employed as a(n)

OFFICE ASSISTANT (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

ADJ11924494
Case Number 1

☑ Cumulative Injury

01/20/2018 (Start Date: MM/DD/YYYY)

02/01/2019 (End Date: MM/DD/YYYY)

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

Body Part 1: 841 STRESS

Body Part 2: ______

Body Part 3: ______

Body Part 4: ______

Other Body Parts: ______

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

LOS ANGELES
City

CA
State

90089
Zip Code

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

ADJ11924493
Case Number 2

☐ Specific Injury

☑ Cumulative Injury

02/08/2018 (Start Date: MM/DD/YYYY)
02/07/2019 (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 200 NECK Body Part 2: 300 UPPER EXT Body Part 3: 420 BACK

Body Part 4: 450 SHOULDER Other Body Parts: 500 LOWER EXT; 320 WRISTS; 340 FINGERS/THUMBS

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

LOS ANGELES (City), CA (State) 90089 (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 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 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 $ 682.24

TEMPORARY DISABILITY INDEMNITY PAID 0.00 Weekly Rate $ ____________

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

PERMANENT DISABILITY INDEMNITY PAID 0.00 Weekly Rate $ ____________

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

TOTAL MEDICAL BILLS PAID $ ____________ Total Unpaid Medical Expense to be Paid By: SEE 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

$ 40,000.00
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.

$ ______________ payable to ______________

$ ______________ payable to ______________

$ ______________ payable to ______________

$ ______________ payable to ______________

$ $6,000.00 requested as applicant's attorney's fee.

LEAVING A BALANCE OF $ $34,000.00, 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):

DEFENDANTS WILL ADJUST OR LITIGATE ALL LIENS OF RECORDS, JURISDICTION TO REMAIN WITH THE WORKERS' COMPENSATION APPEALS BOARD.

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 THE APPLICANT OR HIS/HER REPRESENTATIVE AND DEFENDANTS OR THEIR REPRESENTATIVES ARE INCLUDED WITHIN THIS SETTLEMENT.

Applicant	Defendant	
[initials]	SW	earnings
[initials]	SW	temporary disability
		jurisdiction
[initials]	SW	apportionment
		employment
[initials]	SW	injury AOE/COE
[initials]	SW	serious and willful misconduct
[initials]	SW	discrimination (Labor Code §132a)
		statute of limitations
[initials]	SW	future medical treatment
[initials]	SW	other SEE ADDENDUM A
[initials]	SW	permanent disability
[initials]	SW	self-procured medical treatment, except as provided in Paragraph 7
[initials]	SW	vocational rehabilitation benefits/supplemental job displacement benefits AOE/COE AT ISSUE. POST TERMINATION DEFENSE.

COMMENTS:

APPLICANTS CLAIMS WERE DENIED BASED ON A POST TERMINATION DEFENSE. APPLICANT DESIRES TO AVOID THE HAZARDS AND UNCERTAINTY OF LITIGATION AND DESIRES TO SETTLE HER CLAIM AND UNDERSTANDS THAT IF THE MATTER PROCEEDED TO TRIAL, SHE COULD TAKE NOTHING.

PLEASE SEE ADDENDUM "A" AND "B" ATTACHED HERETO.

DEFENDANT CAN GO EX-PARTE TO OBTAIN ORDER.

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 ________ day of ______________, ______________ at ______________________

Violet Cabral 3-26-20
Witness 1 (Date)

P. Castellanos 3-26-20
Witness 2 (Date)

Interpreter (Date)

3/26/20
Applicant (Employee) (Date)

3/26/20
Attorney for Applicant (Date)

Attorney for Defendant (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 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)**

ADDENDUM A

STATE OF CALIFORNIA
WORKERS' COMPENSATION APPEALS BOARD

DEBRA SANCHEZ Applicant, VS. **USC PSI admin by BROADSPIRE** Defendant.	**CASE NO.: ADJ11924494; ADJ11924493** **AFFIDAVIT OF APPLICANT/DEFENDANT RE: LIENS, MEDICAL PROVIDERS AND MISCELLANEOUS BILLS**

I am the attorney or representative for applicant/defendant in the above entitled matter. I have reviewed my file and have identified the following liens, billing for medical providers, interpreters, transportation, and photocopy services, as well as liens against compensation (L.C. 4903) listed below:

MEDICAL PROVIDER/ LIEN CLAIMANT & ADDRESS	**NATURE AND DATE OF LIEN RESOLUTION EFFORTS**
NO KNOW LIENS OF RECORDS	
DCSS	Clear per TF at DCSS on 3/23/2020
EDD	Zero balance per 3/23/2020 phone call to EDD. EDD previously reimbursed for 2019 disability claim.

____

Law Offices of Robert Wheatley

RE: DEBRA SANCHEZ vs. USC
WCAB CASE NO. : ADJ11924494; ADJ11924493

ADDENDUM "B"

1. Defendants desire to buy their peace. Applicant desires to control future medical expenses. All parties desire to settle the hazards, risks and delays of litigation for a lump sum certain. All parties agree that the Compromise and Release herein is fair and reasonable.

2. It is expressly agreed between the parties that this Compromise and Release is to cover any and all aspects of the applicant's alleged injury, including all disability the applicant may have sustained as a result of any and all employment by the defendant herein, and any and all parts of the body demonstrated by the medical record or claimed in applicant's deposition which are hereby incorporated by reference. This is a full and final release which includes, but is not limited to, all known injuries of whatever nature, resulting from the applicant's employment by the defendant.

3. Applicant agrees to waive penalty or interest on award if award is paid within 30 days of receipt by defense counsel.

4. Applicant has been advised that by agreeing to this Compromise and Release, she is giving up any rights her dependents may have to death benefits as indicated in paragraph 4 of this Agreement. The parties have considered the release of these benefits in arriving at the settlement figure contained in paragraph 2 of this Agreement, and the attention of the Appeals Board is directed to this release of benefits.

5. The Compromise and Release includes resolves, waives and forever settles any and all claims that applicant may have to retroactive benefits, penalties and sanctions of any kind. This settlement specifically resolves any claims for temporary disability.

6. This settlement specifically resolves any claim that applicant may have to reimbursement, to date of Order Approving including, but not limited to, prescriptions, mileage, treatment and all other out-of-pocket expenses, penalties, sanctions and attorney fees pursuant to Labor Code §5710.

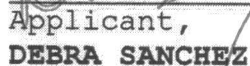
RE: **DEBR SANCHEZ** vs. **USC**
WCAB CASE NO. : **ADJ11924494; ADJ11924493**

ADDENDUM "B" (continued)

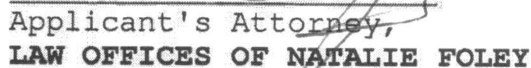
The parties stipulate that all periods of temporary disability have been adequately compensated by settlement of this case.

7. If applicant has filed a claim alleging that the employer has committed serious and willful misconduct and/or discrimination under Labor Code §132(a), then applicant hereby admits and stipulates that applicant cannot sustain any burden of proof imposed by Labor Code §3202.5 to prevail on any such claim. Additionally, in further consideration of this Compromise and Release, applicant hereby agrees to dismiss any such claim with the employer and specifically agrees to a dismissal for said claims with prejudice.

8. Applicant stipulates as a condition to this settlement that applicant is not receiving Social Security or Medicare Benefits, and has no reasonable expectation of receipt or eligibility of these benefits within 30 months of the settlement date.



Applicant, **DEBRA SANCHEZ** — Date: 3/26/20



Applicant's Attorney, **LAW OFFICES OF NATALIE FOLEY** — Date: 3/26/20

STATE OF CALIFORNIA

DIVISION OF WORKERS COMPENSATION

Debra Sanchez

Injured Worker

ADJ

WCAB File Number(s)

559-79-2503

Social Security Number

Date of Birth

DECLARATION RE CHILD SUPPORT

I have contacted the County of San Diego Department of Child Support Services (DCSS) regarding the WCAB file(s) referenced above. DCSS has represented that:

- ☒ DCSS is not currently enforcing an order for child and/or spousal support against this injured worker. Clear, per phone call to DCSS 3/23/20
- ☐ DCSS is enforcing an order for child and/or spousal support against this injured worker, but, DCSS is not currently asserting a lien in the above noted workers' compensation case(s).
- ☐ DCSS is asserting a lien for unpaid support and a settlement has been reached. Please see the attached Compromise and Release or Stipulation with Request for Award.

I declare under penalty of perjury under the laws of the State of California this declaration is true and correct and was executed on 3/23/20 at San Diego, California.

Attorney or Hearing Representative

TF

DCSS Rep Initial