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

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

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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

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

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

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

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

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

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

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

1. Name. *Nombre.* EVAN DISNEY Today's Date. *Fecha de Hoy.* 03/12/2018
2. Home Address. *Dirección Residencial.* 1611 S HIGHLAND AVE # M
3. City. *Ciudad.* FULLERTON State. *Estado.* CA Zip. *Código Postal.* 92832
4. Date of Injury. *Fecha de la lesión (accidente).* 03/12/2017 - 03/12/2018 Time of Injury. *Hora en que ocurrió.* ______ a.m. ______ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* JOB SITE
300 W 2ND ST, SANTA ANA, CA 92701
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* STRESS AND ANXIETY DUE TO FALSE DEFAMATORY STATEMENTS, DISCRIMINATION, HARASSMENT AND HOSTILE WORK ENVIRONMENT
7. Social Security Number. *Número de Seguro Social del Empleado.* 517 - 13 - 7948
8. Signature of employee. *Firma del empleado.* X [signature]

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

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

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

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

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

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

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

7/1/04 Rev.

DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD

NOTICE OF APPLICATION

DATE OF SERVICE:*03/13/2018*

WCAB CASE NBR:*ADJ11231848*

DATE OF CLAIMED INJURY:*06/05/201503/12/2018*

EMPLOYEE:*EVAN DISNEY*

EMPLOYER:*ADVANCES MANAGEMENT COMPANY*

INSURER:*BERKSHIRE HATHAWAY PASADENA*

COMMENT(S)/REMARK(S):

AN APPLICATION FOR ADJUDICATION OF CLAIM HAS BEEN FILED WITH THE WORKERS COMPENSATION APPEALS BOARD FOR THE ABOVE CLAIMED INJURY. PLEASE REFERENCE THE ABOVE WCAB ID NUMBER ON ALL CORRESPONDENCE TO THE WCAB.
THIS NOTICE CONSTITUTES A CONFORMED COPY OF THE APPLICATION.
DATE APPLICATION FILED: 03/12/2018

WC04

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET

Is this a new case? Yes [X] No [ ] Companion Cases Exist [X] Walkthrough Yes [ ] No [ ]

More than 15 Companion Cases [ ]

6/18/2018
Date:(MM/DD/YYYY)

SSN: 517137948

[ ] Specific Injury

Case Number 1

[X] Cumulative Injury 06/05/2015 (Start Date: MM/DD/YYYY) 06/18/2018 (End Date: MM/DD/YYYY)

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

Body Part 1: 840 NERVOUS SYSTEM - NOT SPECIFIED

Body Part 3:

Body Part 2:

Body Part 4:

Other Body Parts:

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

[X] ADJ [ ] DEU [ ] SIF [ ] UEF [ ] VOC [ ] INT [ ] RSU

Companion Cases

[X] Specific Injury

ADJ11231848
Case Number 2

[ ] Cumulative Injury 02/14/2018 (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: 420 BACK

Body Part 3:

Body Part 2:

Body Part 4:

Other Body Parts:

ADJ11231848

Case Number 3

[X] Specific Injury

[ ] Cumulative Injury

06/05/2015 (Start Date: MM/DD/YYYY)

03/12/2018 (End Date: MM/DD/YYYY)

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

Body Part 1: 100 HEAD

Body Part 2: 420 BACK

Body Part 3: 500 LOWER extremities

Body Part 4: 300 UPPER extremities

Other Body Parts:

Case Number 4

[ ] Specific Injury

[ ] 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:

Case Number 5

[ ] Specific Injury

[ ] 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:

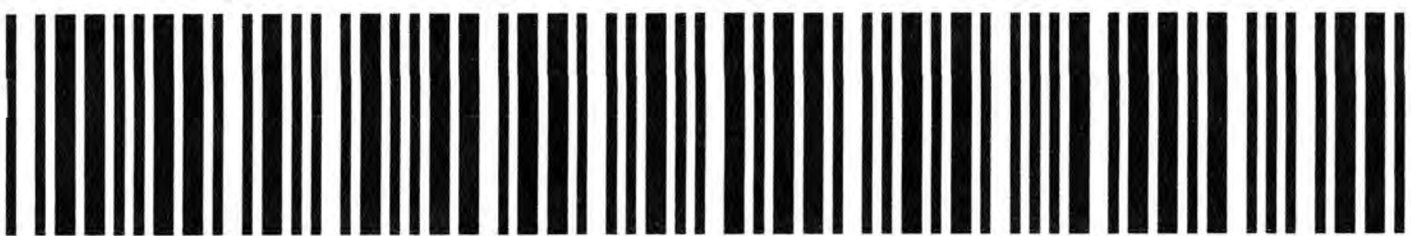
Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

DOCUMENT SEPARATOR SHEET



Product Delivery Unit: ADJ

Document Type: LEGAL DOCUMENT

Document Title: APPLICATION FOR ADJUDICATION

Document Date: 06/18/2018
MM/DD/YYYY

Author: NATALIA FOLEY BEVERLY HILLS

Office Use Only

Received Date: ______
MM/DD/YYYY

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

☐ Amended Application

Case No.

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).)

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

Injured Worker (Completion of this section is required)

First Name   MI

Last Name

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

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

International Address (Please leave blank spaces between numbers, names or words)

City   State   Zip Code

Applicant (If other than Injured Worker)

☐ Insurance Carrier   ☐ Employer   ☐ Lien Claimant

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

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

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

City   State   Zip Code

Employer Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

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

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

City State 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)

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

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

City State Zip Code

IT IS CLAIMED THAT (Complete all relevant information):

1. The injured worker, born ______ (DATE OF BIRTH: MM/DD/YYYY), while employed as a(n) ______ (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

suffered a :

☐ specific injury ______ (Date of injury: MM/DD/YYYY)

☐ cumulative injury which began on ______ (Start Date: MM/DD/YYYY) and ended on ______ (End Date: MM/DD/YYYY)

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

City , State Zip Code .

(State which parts of the body were injured)

Body Part 1: ____

Body Part 2: ____

Body Part 3: ____

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)

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

____
Name of Doctor/Hospital/Clinic 2 (Please leave blank spaces between numbers, names or words)

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

Case Number 1	Case Number 3
Case Number 2	Case Number 4

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

☐ Temporary disability indemnity	☐ Permanent disability indemnity
☐ Reimbursement for medical expense	☐ Rehabilitation
☐ Medical treatment	☐ Supplemental Job Displacement/Return to Work
☐ Compensation at proper rate	☐ Other (Specify) ______________

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)

Law Firm Number (If Applicable)

Attorney/Representative First Name MI

Attorney/Representative Last Name

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

City State Zip Code

Applicant Attorney/Representative Signature Applicant Signature

Dated at ______________________________, California
City

Date ______________
MM/DD/YYYY

DOCUMENT SEPARATOR SHEET

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Document Date: 06/18/2018
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Author: NATALIA FOLEY BEVERLY HILLS

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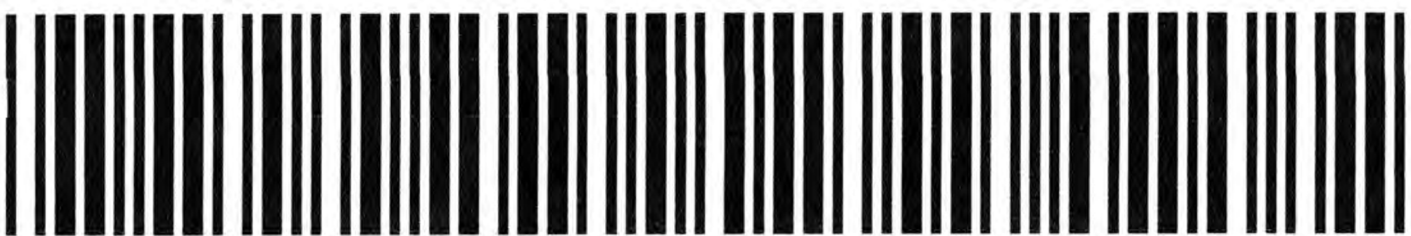

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Document Title: VENUE AUTHORIZATION

Document Date: 06/18/2018
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Author: NATALIA FOLEY BEVERLY HILLS

Office Use Only

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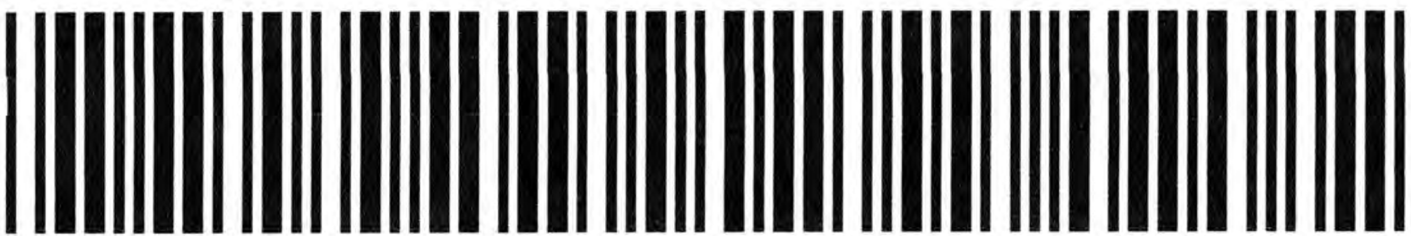

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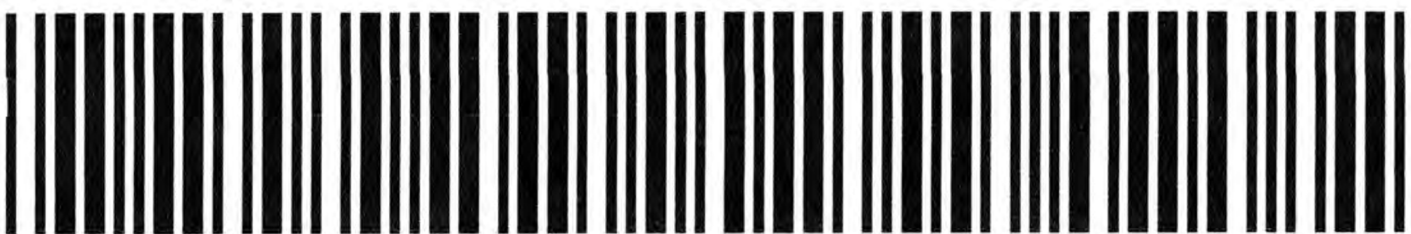

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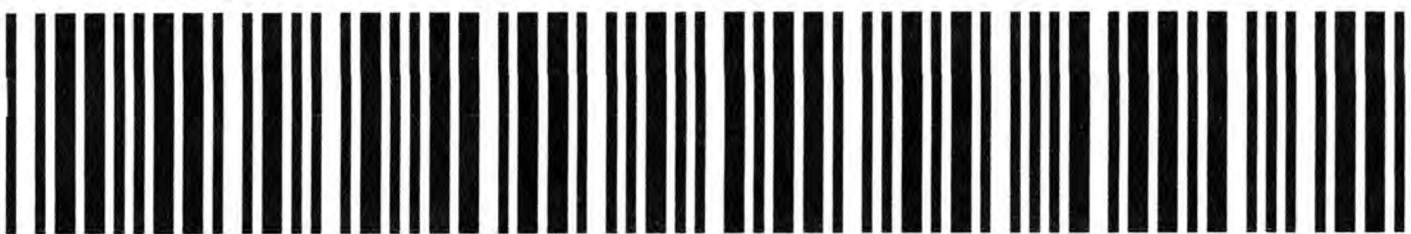

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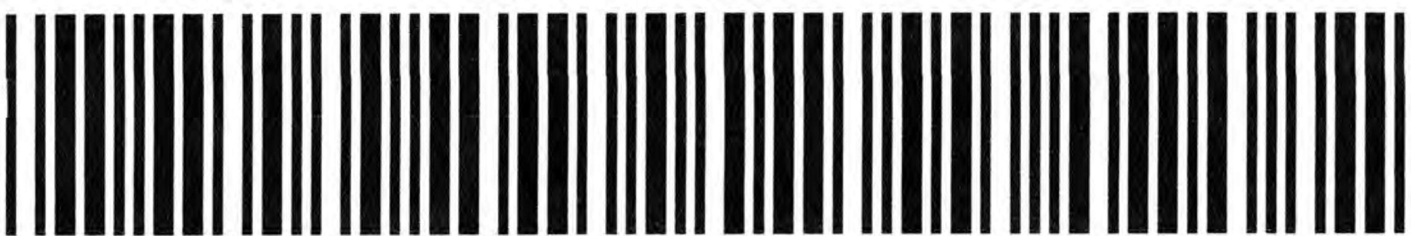

Product Delivery Unit: ADJ

Document Type: LEGAL DOCUMENT

Document Title: PROOF OF SERVICE

Document Date: 06/18/2018
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Author: NATALIA FOLEY BEVERLY HILLS

Office Use Only

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