STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
STIPULATIONS WITH REQUEST FOR AWARD

ADJ11815610
Case No.

Date of Injury 01/24/1994 to 12/06/2021
MM/DD/YYYY

562-78-4407
SSN (Numbers Only)

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

[X] 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 the Document Cover Sheet)

Applicant (Completion of this section is required)

GEORGE
First Name

MI

SOOHOO
Last Name

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

NEWPORT COAST
City

CA
State

92657
Zip Code

Employer #1 Information (Completion of this section is required)

[ ] Insured [ ] Self-Insured [X] Legally Uninsured [ ] Uninsured

CDCR, CALIFORNIA INSTITUTION FOR MEN
Employer Name (Please leave blank spaces between numbers, names or words)

PO BOX 128
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

CHINO
City

CA
State

91708
Zip Code

ADJUSTER: ROSA SHEPHERD RIVERSIDE - STATE CONTRACTS

Tracking Id: 32315354

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)

SCIF STATE EMPLOYEES RIVERSIDE
Name (Please leave blank spaces between numbers, names or words)

PO BOX 65005
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

FRESNO | CA | 93650
City | State | Zip Code

Employer #2 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

Employer #3 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

Tracking Id: 32315354

Employer #4 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

The parties hereto stipulate to the issuance of an Award and/or Order, based upon the following facts, and waive the requirements of Labor Code section 5313:

1. GEORGE
Employees First Name

SOOHOO ,
Employees Last Name

birth date 11/28/1953 ,
MM/DD/YYYY

while employed at CHINO , CA
State

as a(n) SUPERVISING DENTIST, CF , 220 in
Occupation Group

Tracking Id: 32315354

☐ More than 4 Companion Cases

☐ Specific Injury

ADJ11815610
Case Number 1

☒ Cumulative Injury

01/24/1994
(Start Date: MM/DD/YYYY)

12/06/2021
(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: 120 EAR Body Part 3: 330 HAND

Body Part 4: 420 BACK Other Body Parts: 440 HIPS; 801 - CIRCULATORY SYSTEM ; 842 NERVOUS SYSTEM

☐ Specific Injury

ADJ14761989
Case Number 2

☒ Cumulative Injury

01/01/2015
(Start Date: MM/DD/YYYY)

06/10/2021
(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: 110 BRAIN Body Part 3: 800 BODY SYS

Body Part 4: 841 STRESS Other Body Parts:

☐ Specific Injury

ADJ14761987
Case Number 3

☒ Cumulative Injury

06/11/2020
(Start Date: MM/DD/YYYY)

06/11/2021
(End Date: MM/DD/YYYY)

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

Body Part 1: 145 TEETH Body Part 2: 810 DIGESTIVE Body Part 3: 820 EXCRETORY

Body Part 4: 842 PSYCH Other Body Parts: 850: RESPIRATORY SYS

☒ Specific Injury

ADJ15069801
Case Number 4

☐ Cumulative Injury

08/16/2021
(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 2: 841 STRESS Body Part 3: 880 BODY SMS

Body Part 4: 999 UNCLASS Other Body Parts:

by the employer(s) and their insurer(s) listed above and who sustained injury(ies) arising out of and in the course of employment to

THE PARTIES AGREE THAT ONLY THE FOLLOWING BODY PARTS ARE INDUSTRIAL FOR ADJ11815610 ONLY: BODY PART 801- HTN, BODY PART 420 – BACK, BODY PART 200 -NECK, BODY PART 450 – BILATERAL SHOULDERS, BODY PART 313 -BILATERAL ELBOWS, BODY PART 311-BILATERAL ARM AND BODY PART 330-BILATERAL HANDS (CARPAL TUNNEL).

(Please list all body parts injured)

2. The injury (ies) caused temporary disability for the period _____ through
MM/DD/YYYY

_____ for which indemnity has been paid at $ _____ per week.
MM/DD/YYYY Indemnity Paid

2(a).The injury(ies) caused additional temporary disability for the period _____
MM/DD/YYYY

through _____ at the rate of $ _____ in the amount of $ _____
MM/DD/YYYY Rate Indemnity Paid

3. The injury(ies) caused permanent disability of 41 % for which indemnity is payable at $ 290.00
Indemnity Rate

per week beginning 07/07/2022 in the sum of $ 60320.00 , less credit for such payments
MM/DD/YYYY

previously made. ☐ And a life pension of $ _____ per week thereafter.
Life Pension

An informal rating ☒ has / ☐ has not (Select one)been previously issued in case no(s) ADJ14761987 .

4.There ☒ is ☐ is Not a need for medical treatment to cure or relieve from the effects of said injury (ies).

5. Medical-legal expenses and/or liens are payable by defendant as follows:

DEFENDANT TO PAY ADJUST OR LITIGATE LIENS OF RECORD WITH JURISDICTION RESERVED BY THE WCAB. LIEN ADDENDUM TO BE INCORPORATED BY REFERENCE.

6. Applicant's attorney requests a fee of $ 9,048.00

☒ Fees to be commuted as follows:

FROM THE FAR END OF THE AWARD IF APPLICABLE

7. Liens Against compensation are payable as follows:

NONE

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

9.Other stipulations:

A. CASE NUMBER 5 NOT LISTED IN PAGE 5: ADJ15510614 SPEC INJURY ON 12/06/2021 BODY PART NUMBER 1-300: UPPER EXT BODY PART NUMBER 2- 450: SHOULDERS
B. BOTH PARTIES AGREE THAT THIS STIPULATION RESOLVES ALL ISSUES REGARDING COMPENSATION OF MEDICAL TEMP DIS, TEMP PART DIS AND PERM DIS THROUGH THE DATE OF APPROVAL OF AWARD.
C.CLAIMANT HAS NOT LOST ANY TIME FROM WORK AND THEREFORE NOT ELIGIBLE FOR THE SJDB VOUCHER.
D. FOR ADJADJ11815610 APPLICANT AGREES TO DISMISS CLAIM FOR: EAR BODY PART 120, HIPS BODY PART 440, NERVOUS SYSTEM BODY PART 842 AND HEAD BODY PART 100 WITH PREJUDICE.
E. APPLICANT AGREES NO RETRO IDL OR TD IS DUE.
F. APPLICANT AGREES TO DISMISS ADJ14761989 – 01/10/2015-06/10/2021 DOI, ADJ14761987 – 06/11/2020-06/11/2021 DOI, ADJ15069801 – 08/16/2021 DOI AND ADJ15510614 – 12/06/2021 DOI WITH PREJUDICE.
G. APPLICANT AGREES TO DISMISS CLAIM FOR KIDNEY CANCER AND PSYCH FROM ALLEGED ASSAULT WITH PREJUDICE.
H.ADDENDUM CONTINUATION OF PARAGRAPH 9 TO BE INCORPORATED BY REFERENCE.

Dated 07-27-2023
MM/DD/YYYY

Applicant

Applicant's Attorney or Authorized Representative:

[X] Law Firm/Attorney [ ] Non Attorney Representative

NATALIA
First Name

FOLEY
Last Name

13792552
Firm Number

WORKERS DEFENDERS ANAHEIM
Law Firm name

751 S WEIR CANYON RD, STE 157-455
Address/PO Box (Please leave blank spaces between numbers, names or words)

ANAHEIM
City

CA
State

92808
Zip Code

Dated 7/31/2023
MM/DD/YYYY

Applicant Attorney Signature

Tracking Id: 32315354

Defendant's Attorney or Authorized Representative:

[X] Law Firm/Attorney [ ] Non Attorney Representative

MIKE
First Name

VOLLMER
Last Name

4956144
Firm Number

SCIF INSURED ANAHEIM
Law Firm Name

PO BOX 65005
Address/PO Box (Please leave blank spaces between numbers, names or words)

FRESNO
City

CA
State

93650
Zip Code

Dated 08/18/2023
MM/DD/YYYY

Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

[ ] Law Firm/Attorney [ ] Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

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

City

State

Zip Code

Dated
MM/DD/YYYY

Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

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

City State Zip Code

Dated MM/DD/YYYY

Defense Attorney Signature

Interpreter Licence Number:

Interpreter Name

Interpreter License Number

APPLICANT: GEORGE SOOHOO
WCAB CASE NUMBER(S): ADJ11815610
SCIF CLAIM NUMBER(S): 06380832

CONTINUATION OF PARAGRAPH 9

I. APPLICANT AGREES TO CHANGE ADJ11815610 CT PERIOD FROM 08/01/2015-07/06/2018 TO 01/24/1994 THROUGH 12/06/2021.

J. APPLICANT AGREES THAT PD MONIES PAID UNDER ADJ15069801 TO BE CREDITED AGAINST PD MONIES DUE UNDER ADJ11815610 AND FROM THE FRONT END OF THE AWARD.

K. ORTHO PD RATING IS BASED ON THE 7/7/2022 REPORT OF DR. KOURAN DALDALYAN, M.D. AND WHICH RATES AS FOLLOWS:
Cervical – 80%(15.01.01.00-8-11-220E-10-13)10
Lumbar – 80%(15.03.01.00-8-11-220E-10-13)10
Left Arm –80%(16.01.02.02-3-4-220H-6-8)6
Right Arm – 80%(16.01.02.02-3-4-220H-6-8)6
Left Shoulder –80%(16.02.01.00-2-3-220F-3-4)3
Right Shoulder – 80%(16.02.01.00-2-3-220F-3-4)3
Left Elbow/forearm –80%(16.03.02.00-1-1-220H-2-3)2
Right Elbow/forearm - 80%(16.03.02.00-1-1-220H-2-3)2

L. HTN RATING IS BASED ON THE 03/03/2022 INTERNAL PQME REPORT OF DR. STEWART LONKY, M.D. AND WHICH RATES AS FOLLOWS: 15%(04.01.00.00-30-42-220G-45-55)8

M. NO CHANGES, DELETIONS OR AMENDMENTS ARE VALID UNLESS DISCLOSED AND INITIALED BY BOTH PARTIES OR THEIR ATTORNEYS.

N. PENALTIES AND INTEREST WAIVED IF THE PAYABLE PORTION OF THE AWARD IS PAID WITHIN 30 DAYS OF DEFENDANT'S RECEIPT OF APPROVAL.

APPLICANT Gloria Mae Scaffor DATE 07-27-2023

APPLICANT'S ATTORNEY [signature] DATE 7/31/2023

DEFENDANT'S ATTORNEY [signature] DATE 08/18/2023