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

March 22, 2023

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

PATIENT:	Ivan Androsov
DOB:	April 25, 1981
OUR FILE #:	2022-173
SSN:	XXX-XX-0116
EMPLOYER:	Macy's Inc DBA Bloomingdales LLC. 14060 Riverside Dr. Sherman Oaks, CA 91423
WCAB #:	ADJ17289751
CLAIM#:	***
DATE OF INJURY:	CT: January 14, 2022 to January 3, 2023
DATE OF 1ST VISIT:	March 22, 2023
INSURER:	Sedgwick P.O Box 14522 Lexington, KY 40512
ADJUSTOR:	***
PHONE #:	***

Primary Treating Physician's Initial Evaluation Report

Dear Ms. Foley,

Thank you for referring Ivan Androsov, a 41-year-old Russian male, to my office for occupational/internal medicine consultation. The patient is specifically referred for evaluation and treatment of various musculoskeletal and other injuries that he sustained during the course of his employment with Macy's Inc DBA Bloomingdales LLC.

Job Description:

The patient began working as a sales associate in 2020. His work hours were 10:45 am to 7:00 pm per day, five days a week. In his job as a sales associate, he was required to provide customer service to guests and provide cosmetic consultations. Physically, the job required him to stand, walk, squat, stoop, bend, twist, and lift up to 30 pounds.

History of the Injury as Related by the Patient:

The patient has filed a continuous trauma claim dated 1/14/2022 to 1/3/2023. The patient states he worked as a sales associate in the cosmetics department at Macy's Inc DBA Bloomingdales LLC. The patient mentions that his job duties included standing on his feet for over 10 hours per day, carrying out various jobs including carrying boxes weighing over 40 pounds to perform stocking, applying cosmetics on customers, and performing checkout duties. Often, he would lift the boxes overhead or place them on the ground, twisting and turning his body, causing injuries and pain to his shoulders, back, both legs, neck, and hands. He mentions he would also perform typing duties which caused him numbness and pain in both hands.

Around December of 2022, the patient mentions he was falsely accused of stealing, for which he states around September 2022 they began an investigation at the workplace for missing items. He reports that he was coerced to admit to things he did not do including him having a suspension for three days. He mentions that this caused him to develop significant stress, anxiety, and insomnia as he discloses, he did not steal from his workplace.

The patient states that his anxiety levels were heightened from witnessing multiple robberies at his work. He mentions that individuals would enter the store threatening employees and grabbing items to run with, which would cause stress, depression, and anxiety for him. He reported his symptoms to his supervisor, however, he was instructed to continue working. The patient sought treatment on his own with Kaiser, where he underwent evaluation with a psychologist and psychiatrist, who prescribed him medications for his various disorders.

The patient complains of gastroesophageal reflux disease along with jaw clenching at this time.

Prior Treatment:

The patient has been examined by Dr. Gofnung.

Previous Work Descriptions:

Prior to working at Macy's Inc DBA Bloomingdales LLC, the patient worked at Neiman Marcus.

Occupational Exposure:

The patient was exposed to fumes, dust, and vapors during the course of his work. The patient was exposed to excessive noise during the course of his work. He was exposed to excessive heat or cold.

Past Medical History:

The patient was diagnosed with hypertension (2019) and hyperlipidemia (2022). He has a known allergy to mold. The patient underwent a varicocele in 2019. There is no other significant medical history.

Previous Workers' Compensation Injuries:

None

Social History:

The patient is married. He does not have any children. He does not smoke cigarettes, drink alcoholic beverages or use recreational drugs.

Family History:

The patient's parents are deceased. His mother died from breast cancer, and his father died from COVID-19. He does not have any brothers or sisters. There is no other significant family medical history.

Review of Systems:

The patient reports a complaint of headaches, shortness of breath, dizziness, wheezing, lightheadedness, eye pain, visual difficulty, sinus problems, sinus congestion, postnasal drip, jaw pain, jaw clenching, chest pain, heart palpitations. He denies a complaint of ear pain, hearing problems, cough, throat pain, dry mouth, hemoptysis or expectoration. The patient reports a complaint of abdominal pain or cramping, reflux symptoms, nausea, diarrhea, weight loss. He denies a complaint of burning symptoms, vomiting, constipation, weight gain. The patient reports genitourinary complaints including urinary frequency and urinary urgency. The patient's musculoskeletal complaints involve cervical spine pain 7/10, lumbar spine pain 8/10, right shoulder pain 7/10, left shoulder pain 7/10, right elbow pain 6/10, left elbow pain 6/10, right wrist pain 6/10, left wrist pain 6/10, right hand pain 6/10, left hand pain 4/10, right knee pain 7/10, left knee pain 7/10, right foot pain 6/10, left foot pain 6/10. There is no complaint of peripheral edema or swelling of the ankles. The patient's psychosocial complaints include anxiety, depression, difficulty concentrating, difficulty sleeping, and forgetfulness. There is hair loss and

dermatologic complaints. There is intolerance to excessive heat or cold. There is complaint of diaphoresis and lymphadenopathy.

Activities of Daily Living Affected by Workplace Injury:

The patient reports problems with sleeping, bathing, dressing, self-grooming, hobbies, climbing stairs, shopping, performing housework, and driving.

Review of Records:

Please note that if medical records have been received for review, they will be reviewed and commented upon in a subsequent communication.

Current Medications:

The patient currently takes Propranolol 10mg PRN, Milgamma Inj. 2ml PRN,

Physical Examination:

The patient is a 41-year-old alert, cooperative and oriented Russian, right-handed male, in no acute distress. The following vital signs and measurements are taken today on examination: Weight: 178 pounds. Blood Pressure: 118/77. Pulse: 73. Respiration: 17. Temperature: 98.5 degrees F.

Skin:

No abnormalities were detected.

Head:

The patient's head is normocephalic and atraumatic. The patient's facial muscles show good contour and symmetry. There is no scleral icterus and no tenderness of the skull noted on examination.

EENT:

Pupils are equally reactive to light and accommodation. Extraocular movements are intact. The throat is clear. Hearing appears to be uninvolved. The nasal passages are clear and the mucosa is normal in appearance. The patient's neck is overall supple with no evidence of lymphadenopathy, thyromegaly or bruits.

Thorax:

The patient exhibits good bilateral rib excursion during respiration. Lungs are clear during percussion and auscultation. The heart reveals a regular rate and rhythm and no murmurs are noted.

Abdomen:

The abdomen is globular, tender without organomegaly. Normoactive bowel sounds are present.

Genitalia and Rectal:

Examination is deferred.

Musculoskeletal Examination:

The patient is ambulatory. There are no grossly visible abnormalities of the upper or lower extremities or the axial skeleton. There are no deformities. There is tenderness or myospasm of the cervical, thoracic or lumbar paraspinal musculature.

Range of Motion Testing:

Cervical Spine:	Normal
Flexion	50/50
Extension	60/60
Right Rotation	80/80
Left Rotation	80/80
Right Lateral Flexion	45/45
Left Lateral Flexion	45/45

Thoracic Spine:

Flexion	60/60
Right Rotation	30/30
Left Rotation	30/30

Lumbo-Sacral Spine:

Flexion	60/60
Extension	25/25
Right Lateral Flexion	25/25
Left Lateral Flexion	25/25

Shoulder:	*Right*	*Left*
Flexion	180/180	180/180
Extension	50/50	50/50
Abduction	180/180	180/180
Adduction	50/50	50/50
Internal Rotation	90/90	90/90
External Rotation	90/90	90/90

Hips:	*Right*	*Left*
Flexion	140/140	140/140
Extension	0/0	0/0
Abduction	45/45	45/45
Adduction	30/30	30/30
Internal Rotation	45/45	45/45
External Rotation	45/45	45/45

Elbow:	*Right*	*Left*
Flexion	140/140	140/140

Forearm	*Right*	*Left:*
Pronation	80/80	80/80
Supination	80/80	80/80

Wrist:	*Right*	*Left*
Dorsiflexion	60/60	60/60
Palmar Flexion	60/60	60/60
Radial Deviation	20/20	20/20
Ulnar Deviation	30/30	30/30

Knee:	*Right*	*Left*
Flexion	130/130	130/130

Ankle/Foot:	*Right*	*Left*
Dorsiflexion	15/15	15/15
Plantar Flexion	40/40	40/40
Inversion	30/30	30/30
Eversion	20/20	20/20

Neurological Examination:

Cranial nerves 2-12 are intact. Deep tendon reflexes are 2+ bilaterally. Superficial reflexes are found to be within normal limits. There are no abnormal reflexes detected and there is no abnormality of sensation or coordination.

Special Diagnostic Testing:

An abdominal ultrasound is performed today revealing a normal liver, normal gallbladder, and normal right kidney

An ultrasound of the right wrist is performed today, evaluation of the median nerve reveals a circumference of 1.85 cm and an area of .19 cm^2

An ultrasound of the left wrist is performed today, evaluation of the median nerve reveals a circumference of 1.44 cm and an area of .10 cm^2

A pulmonary function test is performed revealing an FVC of 3.55 L (67.3%) and an FEV 1 of 3.22 L (77.0%). There was no change after the administration of Albuterol.

A 12-lead electrocardiogram is performed revealing sinus rhythm and a heart rate of 61 per minute.

A pulse oximetry test is performed today and is recorded at 97%.

Jamar Test: Rt. 1. 9.6kg 2. 6.3kg 3. 6.0kg Lft. 1. 6.3kg 2. 5.5kg 3. 7.2kg

Vision Test without glasses: OU: 20/20 OD: 20/20 OS: 20/25

An audiogram is performed today and reveals the following:

	1,000 Hz	2,000 Hz	3,000 Hz	4,000 Hz
Right:	45	40	40	40
Left:	45	40	45	45

Laboratory Testing:

A random blood sugar is performed today and is recorded at 99 mg/dL.

Subjective Complaints:

1. Headaches
2. Shortness of Breath

3. Dizziness
4. Wheezing
5. Lightheadedness
6. Eye Pain
7. Anxiety
8. Visual Difficulty
9. Abdominal Pain
10. Depression
11. Difficulty Concentrating
12. Sinus Problems
13. Reflux Symptoms
14. Difficulty Sleeping
15. Sinus Congestion
16. Nausea
17. Difficulty Making Decisions
18. Forgetfulness
19. Diarrhea
20. Hair Loss
21. Postnasal Drip
22. Skin Issues
23. Jaw Pain
24. Intolerance to Heat/Cold
25. Jaw Clenching
26. Weight Loss
27. Urinary Frequency
28. Chest Pain
29. Urinary Urgency
30. Diaphoresis
31. Heart Palpitations
32. Lymphadenopathy

Objective Findings:

1. Tenderness noted to the paravertebral of the cervical spine and lumbar spine
2. Tenderness noted of the left shoulder
3. Tenderness noted of the right bicep
4. Tenderness noted of bilateral wrists/hands
5. Tenderness noted of bilateral knees
6. Tenderness noted of bilateral ankles
7. Tenderness noted to the epigastric region of the abdomen
8. Bilateral TMJ tenderness
9. An abdominal ultrasound is performed revealing a normal liver, normal gallbladder, and normal right kidney

10. An ultrasound of the right wrist is performed, evaluation of the median nerve reveals a circumference of 1.85 cm and an area of .19 cm^2
11. An ultrasound of the left wrist is performed, evaluation of the median nerve reveals a circumference of 1.44 cm and an area of .10 cm^2
12. A pulmonary function test is performed revealing an FVC of 3.55 L (67.3%) and an FEV 1 of 3.22 L (77.0%). There was no change after the administration of Albuterol.
13. A 12-lead electrocardiogram is performed revealing sinus rhythm and a heart rate of 61 per minute.
14. A pulse oximetry test is performed and is recorded at 97%.
15. Jamar Test: Rt. 1. 9.6kg 2. 6.3kg 3. 6.0kg Lft. 1. 6.3kg 2. 5.5kg 3. 7.2kg
16. Vision Test without glasses: OU: 20/20 OD: 20/20 OS: 20/25
17. An audiogram is performed and reveals the following:

	1,000 Hz	2,000 Hz	3,000 Hz	4,000 Hz
Right:	45	40	40	40
Left:	45	40	45	45

18. A random blood sugar is performed and is recorded at 99 mg/dL.

Diagnoses:

1. CERVICAL SPINE STRAIN/SPRAIN
2. RIGHT SHOULDER STRAIN/SPRAIN
3. LEFT SHOULDER STRAIN/SPRAIN
4. RIGHT ELBOW STRAIN/SPRAIN
5. LEFT ELBOW STRAIN/SPRAIN
6. RIGHT WRIST STRAIN/SPRAIN
7. LEFT WRIST STRAIN/SPRAIN
8. RIGHT HAND STRAIN/SPRAIN
9. LEFT HAND STRAIN/SPRAIN
10. RIGHT KNEE STRAIN/SPRAIN
11. LEFT KNEE STRAIN/SPRAIN
12. RIGHT FOOT STRAIN/SPRAIN
13. LEFT FOOT STRAIN/SPRAIN
14. MYOSPASMS OF RIGHT BICEP
15. TENDINOSIS OF LEFT SHOULDER
16. LUMBAR SPINE STRAIN/SPRAIN
17. CARPAL TUNNEL SYNDROME, RIGHT HAND
18. GASTROESOPHAGEAL REFLUX DISEASE
19. TMJ SYNDROME
20. BRUXISM
21. TENSION HEADACHES

22. SHORTNESS OF BREATH
23. DIZZINESS
24. WHEEZING
25. LIGHTHEADEDNESS
26. EYE PAIN
27. ANXIETY DISORDER
28. VISION DISORDER
29. DEPRESSIVE DISORDER
30. DIFFICULTY CONCENTRATING
31. SINUS PROBLEMS AND CONGESTION
32. INSOMNIA
33. NAUSEA
34. DIFFICULTY MAKING DECISIONS
35. FORGETFULNESS
36. DIARRHEA
37. ALOPECIA
38. POSTNASAL DRIP
39. SKIN ISSUES
40. INTOLERANCE TO HEAT/COLD
41. JAW CLENCHING
42. WEIGHT LOSS
43. URINARY FREQUENCY AND URGENCY
44. CHEST PAIN
45. DIAPHORESIS
46. HEART PALPITATIONS
47. LYMPHADENOPATHY

Discussion:

The patient has filed a continuous trauma claim dated 1/14/2022 to 1/3/2023. The patient states he worked as a sales associate in the cosmetics department at Macy's Inc DBA Bloomingdales LLC. The patient mentions that his job duties included standing on his feet for over 10 hours per day, carrying out various jobs including carrying boxes weighing over 40 pounds to perform stocking, applying cosmetics on customers, and performing checkout duties. Often, he would lift the boxes overhead or place them on the ground, twisting and turning his body, causing injuries and pain to his shoulders, back, both legs, neck, and hands. He mentions he would also perform typing duties which caused him numbness and pain in both hands.

Around December of 2022, the patient mentions he was falsely accused of stealing, for which he states around September 2022 they began an investigation at the workplace for missing items. He reports that he was coerced to admit to things he did not do including him having a suspension for three days. He mentions that this caused him to develop significant stress, anxiety, and insomnia as he discloses, he did not steal from his workplace.

The patient states that his anxiety levels were heightened from witnessing multiple robberies at his work. He mentions that individuals would enter the store threatening employees and grabbing items to run with, which would cause stress, depression, and anxiety for him. He reported his symptoms to his supervisor, however, he was instructed to continue working. The patient sought treatment on his own with Kaiser, where he underwent evaluation with a psychologist and psychiatrist, who prescribed him medications for his various disorders.
The patient complains of gastroesophageal reflux disease along with jaw clenching at this time.

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 is prescribed Hydroxyzine HCl 25 mg tablet at bedtime, Celebrex 200 mg daily, and Lansoprazole 15 mg every morning. An RFA will be submitted for a Med-Legal Consultation for the purpose of discussing causation of the diseases in relation to the work-related injuries. A RFA is submitted to request an evaluation with Dr. Schames given his TMJ syndrome. 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.

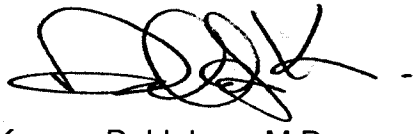
The history was obtained from the patient and the dictated report was transcribed by Adrine Madatyan, transcriptionist.

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 12 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**
8431673	04/14/2023	$0.00	

Androsov, Ivan
1300 Larrabee St. Apt. 2
W HOLLYWOOD, CA 90069

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

ACCOUNT #	CHART #	PATIENT NAME	STATEMENT DATE	CASE	DUE UPON RECEIPT
8431673	2022-173	Androsov, Ivan	04/14/2023	Workers Compensation	$0.00

DATE	DESCRIPTION	CHARGES	PATIENT PAYMENTS	ADJ.	INSURANCE PAYMENTS	PENDING INSURANCE	PATIENT BALANCE
03/22/23	99205 OFFICE O/P NEW HI 60-74 MIN DIAGNOSIS: S13.4XXA S43.401A S43.402A S53.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	1500.00	0.00	0.00	0.00	1500.00	0.00
03/22/23	97750 PHYSICAL PERFORMANCE TEST DIAGNOSIS: S13.4XXA S43.401A S43.402A S53.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	600.00	0.00	0.00	0.00	600.00	0.00
03/22/23	97535 SELF CARE MNGMENT TRAINING DIAGNOSIS: S13.4XXA S43.401A S43.402A S53.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	150.00	0.00	0.00	0.00	150.00	0.00
03/22/23	99483 ASSMT & CARE PLN PT COG IMP DIAGNOSIS: S13.4XXA S43.401A S43.402A S53.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	800.00	0.00	0.00	0.00	800.00	0.00
03/22/23	76700 US EXAM ABDOM COMPLETE DIAGNOSIS: S13.4XXA S43.401A S43.402A S53.401A Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	700.00	0.00	0.00	0.00	700.00	0.00
03/22/23	76881 US COMPL JOINT R-T W/IMG DIAGNOSIS: S13.4XXA S43.401A S43.402A S53.401A MODIFIERS: RT Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	400.00	0.00	0.00	0.00	400.00	0.00
03/22/23	76881 US COMPL JOINT R-T W/IMG DIAGNOSIS: S13.4XXA S43.401A S43.402A S53.401A MODIFIERS: LT Place Of Service: Internist Health Clinic Copay: 0.00 Deductible: 0.00 Co-insurance: 0.00	400.00	0.00	0.00	0.00	400.00	0.00
03/22/23	94060 EVALUATION OF WHEEZING	250.00	0.00	0.00	0.00	250.00	0.00

DATE	DESCRIPTION	CHARGES	PATIENT PAYMENTS	ADJ.	INSURANCE PAYMENTS	PENDING INSURANCE	PATIENT BALANCE
	DIAGNOSIS: S13.4XXA S43.401A S43.402A S53.401A						
	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 S43.401A S43.402A S53.401A	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	94760 MEASURE BLOOD OXYGEN LEVEL DIAGNOSIS: S13.4XXA S43.401A S43.402A S53.401A	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	93000 ELECTROCARDIOGRAM COMPLETE DIAGNOSIS: S13.4XXA S43.401A S43.402A S53.401A	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	99173 VISUAL ACUITY SCREEN DIAGNOSIS: S13.4XXA S43.401A S43.402A S53.401A	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 S43.401A S43.402A S53.401A	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 S43.401A S43.402A S53.401A	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 S43.401A S43.402A S53.401A	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
	Total	**5645.00**	**0.00**	**0.00**	**0.00**	**5645.00**	**0.00**

MESSAGES

SSN: 023-27-0116
DOI: CT: January 14, 2022 to January 3, 2023
Claim: Pending / 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

PICA

Sedgwick 14522
P.O. Box 14522
LEXINGTON KY 40512-4522

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
[ ] (Medicare#) [ ] (Medicaid#) [ ] (ID#/DoD#) [ ] (Member ID#) [ ] (ID#) [ ] (ID#) [X] (ID#)	023270116
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Androsov Ivan	3. PATIENT'S BIRTH DATE MM DD YY: 04 25 1981 SEX: M [X] F [ ]
5. PATIENT'S ADDRESS (No., Street): 1300 Larrabee St. Apt. 2	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
CITY: W HOLLYWOOD STATE: CA	8. RESERVED FOR NUCC USE
ZIP CODE: 90069 TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [X] YES [ ] NO
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER
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: Sedgwick 14522
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] 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 03/22/2023

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. 439 MM DD YY 01 14 2022	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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. S43.401A	C. S43.402A	D. S53.401A
E. S53.402A	F. S63.501A	G. S63.502A	H. S83.91XA
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. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	03 22 23	11		99205		ABCD	1500 00	1.0		NPI	1679937643
2	03 22 23	11		97750		ABCD	600 00	4.0		NPI	1679937643
3	03 22 23	11		97535		ABCD	150 00	1.0		NPI	1679937643
4	03 22 23	11		99483		ABCD	800 00	1.0		NPI	1679937643
5	03 22 23	11		76700		ABCD	700 00	1.0		NPI	1679937643
6	03 22 23	11		76881	RT	ABCD	400 00	1.0		NPI	1679937643

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
862448871 [ ] [X]	11927717	[X] YES [ ] NO	$ 5645 00	$ 0 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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
Koruon Daldalyan 04/14/2023 SIGNED DATE	Internist Health Clinic 13320 Riverside Drive Suite 104 SHERMAN OAKS CA 91423-2502 a. NPI b.	Koruon Daldalyan 13320 Riverside Drive Suite 104 SHERMAN OAKS CA 91423 a. 1679937643 b.

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

PICA

Sedgwick 14522
P.O. Box 14522
LEXINGTON KY 40512-4522

CARRIER

PICA

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): 023270116

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Androsov Ivan	04 25 1981 M X F	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1300 Larrabee St. Apt. 2	Self X Spouse Child Other	
CITY: W HOLLYWOOD / STATE: CA	8. RESERVED FOR NUCC USE	CITY / STATE
ZIP CODE: 90069 / TELEPHONE (Include Area Code): ( )		ZIP CODE / TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) X YES NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: Sedgwick 14522
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X 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 03/22/2023

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 01 DD 14 YY 2022	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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. S43.401A	C. S43.402A	D. S53.401A
E. S53.402A	F. S63.501A	G. S63.502A	H. S83.91XA
I.	J.	K.	L.

22. RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 03 22 23	11		76881	LT	ABCD	400 00	1.0		NPI	1679937643
2 03 22 23	11		94060		ABCD	250 00	1.0		NPI	1679937643
3 03 22 23	11		94664		ABCD	75 00	1.0		NPI	1679937643
4 03 22 23	11		94760		ABCD	125 00	1.0		NPI	1679937643
5 03 22 23	11		93000		ABCD	215 00	1.0		NPI	1679937643
6 03 22 23	11		99173		ABCD	50 00	1.0		NPI	1679937643

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
862448871		X	11927717	X YES NO	$ 5645 00	$ 0 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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
Koruon Daldalyan SIGNED 04/14/2023 DATE	Internist Health Clinic 13320 Riverside Drive Suite 104 SHERMAN OAKS CA 91423-2502 a. NPI b.	Koruon Daldalyan 13320 Riverside Drive Suite 104 SHERMAN OAKS CA 91423 a. 1679937643 b.

HEALTH INSURANCE CLAIM FORM

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

PICA

Sedgwick 14522
P.O. Box 14522
LEXINGTON KY 40512-4522

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
[ ] (Medicare#) [ ] (Medicaid#) [ ] (ID#/DoD#) [ ] (Member ID#) [ ] (ID#) [ ] (ID#) [X] (ID#)	023270116
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Androsov Ivan	3. PATIENT'S BIRTH DATE MM DD YY: 04 25 1981 SEX M [X] F [ ]
5. PATIENT'S ADDRESS (No., Street) 1300 Larrabee St. Apt. 2	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
CITY: W HOLLYWOOD — STATE: CA	8. RESERVED FOR NUCC USE
ZIP CODE: 90069 — TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [X] YES [ ] NO
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER
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: Sedgwick 14522
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] 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 03/22/2023

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY / QUAL.	15. OTHER DATE QUAL. 439 MM DD YY: 01 14 2022	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO
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. S43.401A C. S43.402A D. S53.401A E. S53.402A F. S63.501A G. S63.502A H. S83.91XA 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. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 03 22 23	11		92557		ABCD	250 00	1.0		NPI	1679937643
2 03 22 23	11		82962		ABCD	65 00	1.0		NPI	1679937643
3 03 22 23	11		36415		ABCD	65 00	1.0		NPI	1679937643
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
862448871 [ ] [X]	11927717	[X] YES [ ] NO	$ 5645 00	$ 0 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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
Koruon Daldalyan 04/14/2023 SIGNED DATE	Internist Health Clinic 13320 Riverside Drive Suite 104 SHERMAN OAKS CA 91423-2502 a. NPI b.	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
8 6 - 2 4 4 8 8 7 1

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: Ivan Androsov
Claim No: Pending
WCAB No: ADJ17289751
Chart No: 2022-173

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 April 17, 2023, I served the foregoing document described as:

- Initial Evaluation Report (03-22-23)
- Itemized Bill (04-14-23)
- 1500 CMS Claim (04-14-23)
- 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:

Natalia Foley, Esq.
Workers Defenders Law Group
751 South Weir Canyon Road, Suite 157-455
Anaheim, CA 92808

Sedgwick
P.O. Box 14522
Lexington, KY 40512

Executed on April 17, 2023, in Sherman Oaks, California.

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

Valerie Swartz

Valerie Swartz