

DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD

NOTICE OF APPLICATION

DATE OF SERVICE:*09/10/2019*

WCAB CASE NBR:*ADJ12524635*

DATE OF CLAIMED INJURY:*10/01/201803/15/2019*

EMPLOYEE:*KEVIN WILLIAMS*

EMPLOYER:*WAL-MART ASSOCIATES INC*

INSURER:

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: 09/09/2019*

WC04



Submission of this eform through EAMS constitutes service upon any internal DWC unit.

Batch ID: 31760014 Date: 09/09/2019 02:01:13 PM

OK

STATE OF CALIFORNIA
DWC DISTRICT OFFICE
E-COVER SHEET

REQUIRED FIELDS SHOWN BY "**"

Is this a new Case?*	Yes <input checked="" type="radio"/>	No <input type="radio"/>	Location:	<input type="text" value="CTL"/>
Companion Cases Exist	<input type="checkbox"/>	Walk Thru	Yes <input type="radio"/>	No <input checked="" type="radio"/>
More than 15 Companion Cases	<input type="checkbox"/>			
Date: (MM/DD/YYYY)	<input type="text" value="09/09/2019"/>			
Case Number:*	<input type="text"/>	SSN(Numbers Only)	<input type="text" value="551475680"/>	
<input type="radio"/> Specific Injury	(If Specific Injury, use the start date as the specific date of injury)			
<input checked="" type="radio"/> Cumulative Injury	<input type="text" value="10/01/2018"/> <small>(START DATE: MM/DD/YYYY)</small>	<input type="text" value="03/15/2018"/> <small>(END DATE: MM/DD/YYYY)</small>		
Body Part 1 :	<input type="text" value="841 NERVOUS SYSTEM"/>	Body Part 2 :	<input type="text"/>	
Body Part 3 :	<input type="text"/>	Body Part 4 :	<input type="text"/>	
Other Body Parts :	<input type="text"/>			

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

ADJ DEU SIF UEF SAU INT RSU

Companion Cases

Case 1:

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

Cumulative Injury

(START DATE: MM/DD/YYYY)
(END DATE: MM/DD/YYYY)

Body Part 1 :

Body Part 2 :

Body Part 3 :

Body Part 4 :

Other Body Parts :

Case 2:

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

Cumulative Injury

(START DATE: MM/DD/YYYY)
(END DATE: MM/DD/YYYY)

Body Part 1 :

Body Part 2 :

Body Part 3 :

Body Part 4 :

Other Body Parts :

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

Case Number	
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Amended Application

SSN	551475680
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****Venue Choice is based upon:***

- 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).)

* Enter the zipcode for the venue choice designated above, and then tab to Hearing Location Field and choose the corresponding Hearing Location Code

92807	AHM
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Injured Worker

First Name*	KEVIN
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MI	
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Last Name*	WILLIAMS
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Street Address 1 /PO Box*	2070 AVENIDA HACIENDA
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Street Address 2 /PO Box	
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International Address	
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City*	CHINO HILLS
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State*	CA
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Zip Code* (Numbers Only)	91709
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Applicant (If other than injured employee)

Insurance Carrier

Employer

Lien Claimant

Name	
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Street Address 1 /PO Box	
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Street Address 2 /PO Box	
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City	
------	--

State	
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Zip Code (Numbers Only)	
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Employer Information

Insured

Self-Insured

Legally Uninsured

Uninsured

Employer Name*	WAL-MART ASSOCIATES INC
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Employer Street Address/PO Box*	702 SW 8TH STREET
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City*	BENTONVILLE
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State*	AR
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Zip Code* (Numbers Only)	72716
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Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name	
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Street Address/PO Box	
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City	
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State	
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Zip Code (Numbers Only)	
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Claims Administrator Information (if known and if applicable)

Name	
------	--

Street Address/PO Box	
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City	
------	--

State	
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Zip Code (Numbers Only)	
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IT IS CLAIMED THAT :

1. The injured worker born* (Date of birth : MM/DD/YYYY)

, while employed as a(n)

(Occupation at the time of injury)

suffered a: (Choose only one)

specific injury on (DATE OF INJURY: MM/DD/YYYY)

cumulative trauma injury which began on

and ended on

(START DATE: MM/DD/YYYY)

(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)

Field size limited to 325 characters

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:	
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Weekly rate(s):	
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Date of last payment:	
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(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	
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(MM/DD/YYYY)

Other treatment was provided/paid by:
(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

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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. Field size limited to 80 characters	

Name of Doctor/Hospital/Clinic 2. Field size limited to 80 characters	

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

Case Number 1	
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Case Number 2	
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Case Number 3	
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Case Number 4	
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9. This application is filed because of a disagreement regarding liability for:

- | | |
|---|--|
| <input checked="" type="checkbox"/> Temporary disability indemnity | <input checked="" type="checkbox"/> Permanent disability indemnity |
| <input checked="" type="checkbox"/> Reimbursement for medical expense | <input type="checkbox"/> Rehabilitation |
| <input checked="" type="checkbox"/> Medical treatment | <input checked="" type="checkbox"/> Supplemental Job Displacement/Return to Work |
| <input checked="" type="checkbox"/> Compensation at proper rate | |
| <input checked="" type="checkbox"/> Other (Specify) | <input type="text" value="ALL OTHER BENEFITS"/> |

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)
NATALIA FOLEY BEVERLY HILLS

Law Firm Number (If Applicable)	11964930
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Attorney/Rep First Name	NATALIA
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Attorney/Rep MI	
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Attorney/Rep Last Name	FOLEY
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Street Address/PO Box	8306 WILSHIRE BLVD STE 115
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City	BEVERLY HILLS
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State	CA
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Zip Code (Numbers Only)	90211
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Applicant Attorney / Representative Signature	S NATALIA FOLEY
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Applicant Signature	
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Dated at , California Date

City (MM/DD/YYYY)

E-Filed: NATALIA FOLEY, ESQ
UAN: NATALIA FOLEY BEVERLY HILLS
EAMS #: 11964930
Address: LAW OFFICES OF NATALIA FOLEY
8306 WILSHIRE BLVD STE 115, BEVERLY HILLS CA 90211
Tel 310 707 8098; Fax 310 626 9632; Email: nfoleylaw@gmail.com

PROOF OF SERVICE

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 years and not a party to the within action; my business address is:
8306 WILSHIRE BLVD STE 115
BEVERLY HILLS CA 90211

I am readily familiar with the firm's business practice of processing correspondence for mailing. In the ordinary course of business, the correspondence would be deposited with the United States Postal Service on that same day with postage thereon fully prepaid at my business address above. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after the date of deposit for mailing as listed.

On 9/9/2019 I served the foregoing documents described as:

**APPLICATION FOR ADJUDICATION; DECLARATION 4906; VENUE
AUTHORIZATION; FEE DISCLOSURE; APPLICATION VERIFICATION ;
FORM DWC1**

on the interested parties in this action, by placing a true copy thereof in a sealed envelope with postage thereon fully prepaid, in the United States Mail at my address stated above, addressed as follows:

WCAB (AHM)
1065 N PACIFIC CENTER DR
STE 170
ANAHEIM CA 92806


KEVIN WILLIAMS
2070 AVENIDA HACIENDA
CHINO HILLS CA 91709

WAL-MART ASSOCIATES INC
6150 KIMBALL AVE
CHINO, CA 91708

WAL-MART ASSOCIATES INC
702 SW 8TH STREET
BENTONVILLE AR 72716-0135

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

Executed on: 9/9/2019 at Los Angeles, CA


By IRINA PALEES,
Legal Assistant to Attorney
Natalia Foley, Esq

FEE DISCLOSURE STATEMENT

If you choose to be represented by an attorney, your attorney's fees will be deducted from your benefits. The fee will be approved by the Workers' Compensation Appeals Board with consideration given to the: (1) responsibility assumed by the attorney; (2) care exercised in representing you; (3) time involved; and, (4) results obtained.

Attorney's fees normally range from 9% to 15% of the benefits awarded.

There are certain circumstances where your employer (or his/her insurer) may be liable to pay your attorney's fees. For example, if the employer disputes a permanent disability evaluation obtained when you were not represented by an attorney, your employer may be liable for any attorney fees you incur because of the dispute.

If at any time you no longer wish to be represented by the attorney, you may withdraw from representation by notifying the attorney. If you withdraw from representation, the fee amount found by a workers' compensation judge to be the fair value of any work the attorney did in your case will be deducted from your award.

Your case is being filed at the Division of Workers' Compensation at the following location:

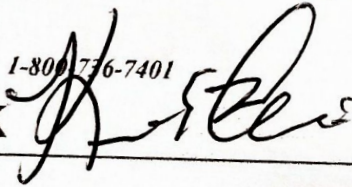
Anaheim - AHM

The employee has been advised of the district office at which his or her case will be filed and that he or she may be required to attend conferences or hearings at this location at his or her own expense.

An Information and Assistance Officer may be able to answer your questions concerning your workers' compensation benefits at no charge to you. The Officer may be able to resolve your problems without the need for litigation.

Call this toll-free number: 1-800-776-7401

Employee's Signature

X 

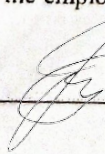
Date 9/8/2019

Employee's Name _____

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 worker's compensation benefits or payments is guilty of a felony.

I hereby declare under penalty of perjury that I am the attorney representing the above-named employee, or am an attorney licensed by the State Bar of California regularly employed by the firm by which the employee will be represented, and have advised the employee of their rights as set forth above and in Labor Code section 4906(e) and (g)(1).

Attorney's Signature



Date 9/8/2019

Attorney's name _____

Address _____

Phone No. () _____


APPLICATION VERIFICATION

I, the undersigned, say that I am the Applicant in this action.

I have read the foregoing Application for Adjudication in regard to my worker compensation case, and I verify that I know the contents thereof, and that the same is true of my own knowledge, except as to the matters which are therein stated upon my information or belief, and as to those matters that I believe to be true.

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

Date: 9/8/2019

X 

Signed by Applicant



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.

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 División de Compensación al Trabajador al (800) 736-7401 para oír información grabada. En la hoja cubierta de esta forma esta la explicación de los beneficios de compensación al trabajador.

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

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios 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.

- Name. *Nombre.* KEVIN E WILLIAMS Today's Date. *Fecha de Hoy.* 09/08/19
- Home Address. *Dirección Residencial.* 2070 AV. ENLIDA HERRERA
- City. *Ciudad.* CHINO HILLS State. *Estado.* CA Zip. *Código Postal.* 91709
- Date of Injury. *Fecha de la lesión (accidente).* October 2018 ← 05/15/2019 Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
- Address and description of where injury happened. *Dirección/lugar dónde ocurrió el accidente.* 6750 Kimball AVE
CHINO CA 91708
- Describe injury and part of body affected. *Describe la lesión y parte del cuerpo afectada.* Stress due to hostile work environment
- Social Security Number. *Número de Seguro Social del Empleado.* 551-47-5680
- Signature of employee. *Firma del empleado.* X Kevin E Williams

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

- Name of employer. *Nombre del empleador.* _____
- Address. *Dirección.* _____
- Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
- Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
- Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
- Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* _____
- Insurance Policy Number. *El número de la póliza de Seguro.* _____
- Signature of employer representative. *Firma del representante del empleador.* _____
- Title. *Título.* _____
- 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.

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.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

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

VENUE AUTHORIZATION

I HEREBY AUTHORIZE MY WORKERS' COMPENSATION CASE(S) FOR
INJURY(IES) DATED _____ TO BE
FILED AT THE AHM WORKERS'
COMPENSATION APPEALS BOARD.

DATED: 9/8/2019

X


APPLICANT

APPLICANT'S ATTORNEY:



DECLARATION PURSUANT TO LABOR CODE SECTION 4906(g)

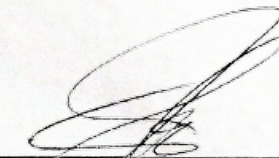
Pursuant to Labor Code Section 4906(g), I declare under penalty of perjury that I have not violated Section 139.3 and I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

Dated: 9/8/2019

X 

Signature

Dated: 9/8/2019



Signature

Before signing this form, you should be aware that: "Any person who makes or causes to be made any knowingly false or fraudulent material statement or representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony."