RECORDS

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Applicant/Plaintiff	Kevin Williams				
Case No.	SIF12524618				
Defendant	Wal-Mart Distribution				
Date of Injury File/Claim Num	09/09/2018 to 03/20/2019	Date Publis	hed 3/24/2	2021	
Records of Location Copied	Adelson, Testan and Brundo 31330 Oak Crest Drive Westlake Village, CA 91361				
Type of Records	Insurance Claims				
Records delivered to:		Control Num	22-5414-3	(128)	C1
1 Customer	Natalia Foley, Esq Workers Defenders Law Group 5753 E Santa Ana Cyn Rd Ste G #616 Anaheim, CA 92807 Attn: Natalia Foley, Esq.				

Med-Legal, LLC

955 Overland Ct, Suite 200, San Dimas, CA 91773 (800) 244-3495

Copy Service Paperwork

STATE OF CALIFORNIA DEPARTMENT OF INDUSTRIAL RELATIONS DIVISION OF WORKERS' COMPENSATION WORKERS' COMPENSATION APPEALS BOARD

Kevin Williams DOB: 02/17/64 AKA: File:

Claimant/Applicant,

vs.

Wal-Mart Distribution

Employer/Insurance Carrier/Defendant.

Case No. SIF12524618

(IF APPLICATION HAS BEEN FILED, CASE NUMBER MUST BE INDICATED REGARDLESS OF DATE OF INJURY)

SUBPOENA DUCES TECUM

(When records are mailed, identify them by using above case number or attaching a copy of subpoena)

Where no application has been filed for injuries on or after January 1, 1990 and before January 1, 1994, subpoena will be valid without a case number, but subpoena must be served on claimant and employer and/or insurance carrier.

See instructions below.*

The People of the State of California Send Greetings to: Adelson, Testan and Brundo WE COMMAND YOU to appear before <u>A Deposition Officer – Med-Legal, LLC</u>

at 955 Overland Ct, Suite 200, San Dimas, CA 91773, Phone 800-244-3495

on the <u>03/29/21</u> day of ______, at <u>10:00</u> o'clock_AM., to testify in the aboveentitled matter and to bring with you and produce the following described documents, papers, books and records. See Attachment for a list of records to be produced subject to this subpoena, to make available for

inspection and copying or transmit/transfer electronically.

(Do not produce X-rays unless specifically mentioned above.)

For failure to attend as required, you may be deemed guilty of a contempt and liable to pay to the parties aggrieved all losses and damages sustained thereby and forfeit one hundred dollars in addition thereto.

This subpoena is issued at the request of the person making the declaration on the reverse hereof, or on the copy which is served herewith.

Date 03/08/21

WORKERS' COMPENSATION APPEALS BOARD OF THE STATE OF CALIFORNIA

Secretary, Assistant Secretary, Workers' Compensation Judge



*FOR INJURIES OCCURING ON OR AFTER JANUARY 1, 1990, AND BEFORE JANUARY 1, 1994

If no Application for Adjudication of Claim has been filed, a declaration under penalty of perjury that the Employee's Claim for Workers' Compensation Benefits (Form DWC-1) has been filed pursuant to Labor Code Section 5401 must be executed properly.

SEE REVERSE SIDE [SUBPOENA INVALID WITHOUT DECLARATION]

You may fully comply with this subpoena by mailing the records described (or authenticated copies, Evid. Code 1561) to the person and place stated above within ten (10) days of the date of service of this subpoena.

This subpoena does not apply to any member of the Highway Patrol, Sheriff's Office or city Police Department unless accompanied by notice from this Board that deposit of the witness fee has been made in accordance with Government Code 68097.2, et seq.

DWC WCAB 32 (Side 1) (REV. 06/18)

HIPAA Compliant Request Control #: 22-5414-3 Do <u>not</u> appear! Simply call (800) 244-3495 and somebody will copy the records for you at your office.

ATB000002

DECLARATION FOR SUBPOENA DUCES TECUM

Case No. SIF12524618

STATE OF CALIFORNIA, County of Los Angeles

The undersigned states: That Med-Legal, LLC has been authorized to obtain records by

Natalia Foley, Esq Workers Defenders Law Group

That he /she is (one of) the attorney(s) of record / representative(s) for the applicant/defendant in the action captioned on the reverse hereof. That Adelson, Testan and Brundo

has in his/her possession or under his/her control the documents described on the reverse hereof. That said documents are material to the issues involved in the case for the following reasons:

Based on the information and belief to resolve any dispute in the above referenced case.

Declaration for Injuries on or After January 1, 1990 and Before January 1, 1994

That an Employee's Claim for Workers' Compensation Benefits (DWC Form 1) has been filed in accordance with Labor Code Section 5401 by the alleged injured worker whose records are sought, or if the worker is deceased, by the dependent(s) of the decedent, and that a true copy of the form filed is attached hereto. (Check box if applicable and part of declaration below. See instructions on front of subpoena.)

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

Executed on 03/08/21, at San Dimas, California.

955 Overland Court, Suite 200, San Dimas, CA 91773

(626) 653-5160

Telephone

Signature Victor Landero, Operations

DECLARATION OF SERVICE

STATE OF CALIFORNIA, County of Los Angeles

I, the undersigned, state that I served the foregoing subpoena by showing the original and delivering a true copy thereof, together with a copy of the Declaration in support thereof, to each of the following named persons, personally, at the date and place set forth opposite each name.

Address

Name of Person Served	Date	Place		
I declare under penalty of perjury that	the foregoing is true and correct			
ruectare under penany of perjury that	the foregoing is the and correct			
Executed on	, at	, California.		

Signature

Attachment

Re: Patient/Applicant: Kevin Williams AKA: Ordered By:

Social Security #: 000-00-0000

D.O.B.: 02/17/64

Ordered By: Natalia Foley, Esq Workers Defenders Law Group 5753 E Santa Ana Cyn Rd Ste G #616 Anaheim, CA 92807 Records to produce: Deponent's file #: Exclusions (if any):

Date Range (if any):

For each injury alleged by the Applicant named on the Subpoena, produce the following:

A signed "Declaration of Custodian of Records" must accompany the records.

Any and all non-privileged records, pertaining to Kevin Williams, in your possession and/or under your control.

Notice: For Subpoenas of claim files, you are to send the claim file directly to Med-Legal only. Sending the claim file to other than Med-Legal will be considered to be in non-compliance of the subpoena.

If any of the documents described above that are in your possession or control are <u>not</u> being produced then a detailed list of each withheld document must be included with the records production or listed on your declaration.

Where used, the terms "writing", "record", "document" and other words of similar meaning include (but are not limited to) electronically maintained image files, documents, notes, faxes, emails and other similar types of electronically held information. If the subpoenaed records exist in paper they are to be provided for inspection and copying. If the subpoenaed records exist electronically then they are to be provided either electronically through our Internet portal at upload.getrecords.com or on CD.

Case Name: Kevin Williams v. Wal-Mart Distribution

Case Number: SIF12524618

PROOF OF SERVICE BY MAIL

Notice of Copying, Deposition Notice

I declare that I am employed in the County of Los Angeles, over the age of 18 years and not a party to this action. My business address is: 955 Overland Court, Ste. 200 San Dimas, California 91773.

On 3/9/2021 I caused to be served, at my direction and following ordinary business practices, true copies of the document(s) referenced above for collection and mailing in a sealed envelope and addressed to the parties listed below. I am readily familiar with the business practices of Med-Legal, LLC for collection and processing of correspondence for mailing. The document was set for same day mail processing and collection, with postage fully paid, for delivery by the United States Postal Service or private delivery service following ordinary business practices.

SIBTF SACRAMENTO 1750 HOWE AVENUE STE 370 SACRAMENTO CA 95825

OD LEGAL LOS ANGELES 355 S GRAND AVE STE 1800 LOS ANGELES CA 90071

I declare under penalty under the penalty of perjury under the laws of the State of California, the foregoing is a true and correct statement. Executed on 3/9/2021 at San Dimas, California.

/s/ Roderic B. Davis Business Document Manager Med-Legal, LLC 22-5414-3

APPLICANT/PLAINTIFF/PETITIONER: Kevin Williams	CASE NUMBER:
DEFENDANT/RESPONDENT: Wal-Mart Distribution	SIF12524618
I served this Subpoena Duces Tecum by	/ delivering a copy to the person served as follows:
Personal Delivery Certified Mail Regular Ma	ail 📃 🗌 Via Facsimile
a. Person served (name): <u>Stacy Carr</u> b. Address where served: 31330 Oak Crest Drive, We	estlake Village,CA, 91361
c. Date of delivery: 03/09/2021	Time of delivery: 02:37 PM
d. Deposition date is: 03/29/2021	
e. (1) Vitness fees were paid. Amount: \$ <u>15</u> (2) Copying fees were paid. Amount: \$	Check Number: 3313279
f. Fee for service: \$	
 I received this subpoena for service on (date): 03/09/2021 Person serving: a. Not a registered California process server. b. California sheriff or marshal c. Registered California process server. d. Employee or independent contractor of a registered e. Exempt from registration under Business and Profe f. Registered professional photocopier. g. Exempt from registration under Business and Profe Name, address, telephone number, and, if applicable, county of registration for the professional photocopier.	ssions Code Section 22350(b). ssions Code section 22451.
Richard Woodard , LA – 7235	
955 Overland Ct, Suite 200, San Dimas, CA, 91773	
declare under penalty of perjury under the laws of the State of alifornia that the foregoing is true and correct.	(For California sheriff or marshal use only) I certify that the foregoing is true and correct.
ate: 03/09/2021	Date:
/S/ Richard Woodard	
	▶
(SIGNATURE)	(SIGNATURE)
32(a)(15.2) [Rev. January 2000] PROOF OF SI	ERVICE CS182Z
	Control Number: 22-5414-3

Records Order Form

Notice of Copying to:

OD LEGAL LOS ANGELES 355 S Grand Ave Ste 1800 LOS ANGELES, CA 90071 03/08/21

Case Information

Applicant: Kevin Williams Employer: Wal-Mart Distribution Case #: SIF12524618 DOI: 09/09/18 TO 03/20/19 SS#: 000-00-0000 Claim #: Not Supplied by Carrier Ordering party: Natalia Foley, Esq

Record Location:

Adelson, Testan and Brundo

Records of the Injured Worker are being produced at the above record location and delivered to the opposing party. You may receive copies of the records by selecting one of the following;

Title 8, CCR § 9982 Allowable Services. (A)... services for records relevant to an injured worker's claim, except services under a contract between the employer and the copy service provider.

Electronic Set per Billing Codes WC026 or WC027	Send records:				
Fees set by § 9983 Fees for Copy and Related Services (f)(2) Number of Sets					
CD Set per Billing Codes WC026 or WC027 Fees set by § 9983 Fees for Copy and Related Services (f)(2) Number of Sets					
	E-mail addresses required for the electronic sets:				
	@				
 Bill to My Office (Invoice will be sent Bill to the Insurance Carrier 	to the address on this notice.)				
(Print your i	name)				
(Sign your r (Signature required)	name) Control #: 22-5414-3				
Med-Leg	ty x-423/Los Angeles				
955 Overland Court, Suite 200, San Dimas, CA 9					

There was no violation of California Labor Code Section 139.32 with respect to the services described herein. ATB000007

Records Order Form

Notice of Copying to:

SIBTF SACRAMENTO 1750 Howe Avenue Ste 370 Sacramento, CA 95825 03/08/21

Case Information

Applicant: Kevin Williams Employer: Wal-Mart Distribution Case #: SIF12524618 DOI: 09/09/18 TO 03/20/19 SS#: 000-00-0000 Claim #: Not Supplied by Carrier Ordering party: Natalia Foley, Esq

Record Location:

Adelson, Testan and Brundo

Records of the Injured Worker are being produced at the above record location and delivered to the opposing party. You may receive copies of the records by selecting one of the following;

Title 8, CCR § 9982 Allowable Services. (A)... services for records relevant to an injured worker's claim, except services under a contract between the employer and the copy service provider.

Electronic Set per Billing Codes WC026 or WC027	Send records:				
Fees set by § 9983 Fees for Copy and Related Services (f)(2) Number of Sets					
CD Set per Billing Codes WC026 or WC027 Fees set by § 9983 Fees for Copy and Related Services (f)(2) Number of Sets					
	E-mail addresses required for the electronic sets:				
	@				
 Bill to My Office (Invoice will be sent Bill to the Insurance Carrier 	to the address on this notice.)				
(Print your r	name)				
(Sign your r (Signature required)	name) Control #: 22-5414-3				
Med-Leg	ty x-423/Los Angeles				
955 Overland Court, Suite 200, San Dimas, CA 9					

There was no violation of California Labor Code Section 139.32 with respect to the services described herein. ATB000008

1	1	Ϊ
1	PROOF OF SERVICE	
2	STATE OF CALIFORNIA, COUNTY OF SAN DIEGO	
3	I am employed in the County of San Diego, State of California. I am over the age of 18, and	
4	not a party to the within action. My business address: Testan Law, 7676 Hazard Center DR STE 500, San Diego, CA 92108.	
.5	On 1/19/20/9 I served the foregoing document(s) on the case of Williams Keyin v	
6	On UI 9/20/9, I served the foregoing document(s) on the case of Williams, Kevin v. Walmart Inc./WCAB Case No. ADJ12524635; ADJ12524618/Claim No. 8949558; 8949567 described as: WALKTHROUGH APPEARANCE SHEET; ORDER APPROVING	
7	COMPROMISE AND RELEASE AND FULLY EXECUTED COMPROMISE AND RELEASE AGREEMENT on the interested parties in this action by placing the original or a true	
.8	copy thereof enclosed in a sealed envelope addressed as follows:	1
9	Christine Leonard York Risk Services Group, Inc.	
10	PO Box 14731 Lexington, KY 40512	
11	Natalia Foley, Esg.	
12	Law Offices of Natalia Foley 8306 Wilshire Blvd., Suite 115	1
13	Beverly Hills, CA 90211	
14	I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with U.S. Postal Service on that same day	
15	with postage thereon fully prepaid at San Diego, California in the ordinary course of business. I am aware that on motion of party served, service is presumed invalid if postal cancellation date or	
16	postage meter date is more than one day after date of deposit for mailing affidavit.	ŀ
17	I declare under penalty of perjury under the laws of the State of California that the above is	
18	true and correct.	
19	Executed on 1 19 2019, at San Diego, CA.	
20	Anadallatt	
21	ANGELA ROSS	
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STATE OF CALIFORNIA DIVISION OF WORKERS' COMPENSATION WORKERS' COMPENSATION APPEALS BOARD WALK THROUGH APPEARANCE SHEET Keun Williams ADJ 12 524635 ADT12524418. Efiler: Yes No / Case set for hearing: Yes * No. Applicant, Walk through document: C&R -- STIP_WITH_AWARD 5710 DEPOSITION ATTORNEY'S FEES Walmart Inc PETITION TO COMPEL ATTENDANCE AT MEDICAL EVALUATION/DEPO · PETITION FOR STAY ORDER-PJ ONLY Defendants. APPEARANCES NOT PRESENT APPLICANT PRESENT APPLICANT REPRESENTED BY THEARING REP. ATTORNEY Daniel] HEARING REP. DEFENDANT REPRESENTED BY Testa~ Lun TORNEY OTHERS APPEARING THEARING REP. ATTORNEY INTERPRETER CERTIFICATION NO. DISPOSITION: DOTOC ORDER SUSPENDING ACTION ON CARISTIPS &R) STIPS APPROVED K. ORDER(s)/COMMENT(s); (UME MEDICAL EVALUATION/DEPO ☐ 30 DAYS TO SUBMIT REQUESTED DOC. PETITION DISAPPROVED. **7** SET FOR STATUS CONF. Dale: Judge Time: DATE: WORKERS' COMPENSATION JUDGE NOTICE TO:4 rsuant to Rule 10500, you are designated to serve this! mase document(s) on all interested parties including all llen claimants. [] Served on parties and lien claimants present Dala FOR WCAB USE ON JUDGE ASSIGNED RECEIVED NOV 1 8 2019 DWC SAN BERNARDINO

ATB000011

STATE OF CALIFORNIA DIVISION OF WORKERS' COMPENSATION WORKERS' COMPENSATION APPEALS BOARD

Kevin L	V. Miam	v 3	
	Appl	icant,	
	vs.		1
Walmart		Acc	American
Insurance co	Defe	ndant(s).

Case No(s). AnJ12524635 AnJ12524635 AnJ12524618 AnJ12743430

San Bernardino District Office

ORDER APPROVING COMPROMISE AND RELEASE

The parties to the above-entitled action have filed a Compromise and Release on $\frac{1/-18-2a_{13}}{1000}$ in the amount of S 105,000 For the reasons set forth in the Compromise and Release; incorporated herein by reference, and based upon review of the medical reports and other relevant documents, which are hereby received into evidence, this judge now finds that the settlement amount is adequate, is in the best interest of the parties, and should be approved.

The following provisions are applicable only if checked:

Address Record. Proof of svc. to be filed only if requested by WCAB.

Date: 11/18/19 By: 1/1/

Death Benefits: The parties have considered the release of death benefits in reaching their agreement.

Carter/Rodgers Finding: The parties have considered and included the release of claims for injuries in vocational rehabilitation in their settlement.

- Injury AOE/COE is seriously in issue as to A all body parts alleged D the following body parts:

			bas	ed on A dis	pute of law	and fact	🛛 statute	of limit	ations
I medical opinions	0[••• •		[] witness(e	s)	_			
							1.1	1.	

The parties have considered and included the release of any F-Labor Code Section 132a claim(s) A-serious & willful misconduct allegations (per Labor Code Section 4551 and/or 4553).

This agreement includes settlement of any claim for a Supplemental Job Displacement Benefit voucher.

THE COMPROMISE AND RELEASE IS ORDERED APPROVED.

AWARD IS MADE according to the terms of the Compromise and Release, with the following provisions: S Attorney's fees per the Compromise & Release are ordered:

D paid in the amount			Law Officerd	Natalin	Fully	•
🗆 paid S	0		and \$	to		per fee agreement.
E The amount of S		is ordered wi	thheld from the settler	ment by defend	ant until reso	lution of fee dispute between

applicant's current & former attorney(s) [] applicant & prior attorney(s) [] and further order of the court.
 All liens listed on the OAR as of this date have been resolved, per defendant's affidavit, withdrawn or dismissed by the judge.
 There remain unresolved liens. [] Any party/lien claimant may request a conf. by filing a Declaration of Readiness to Proceed.
 Defendant is ordered to comply with S CCR 10608(f) without violating LC 4903.6(d). Specifically, non-physician lien claimants are not entitled to medical information about an injured worker without prior written approval of the appeals board detailing what info is to be provided and a finding that such info is relevant to the proof of the matter for which it is sought.
 Lien claimants are now a parties per Rule 10205(an)(5) & are required to appear at all future hearings per Rule 10770.1(c).

I Niere are no liens of record in the Board's system as of this date. I The lien of the EDD has been resolved. If Depo fee of \$900.00 to be paid by A WAA outside of sest comment. Dated at San Bernardino, California: _______ D Filed and served by mail on all parties on the Official Address Record. MYRLE R. PETTY Notice to: ________ Net Hausters You are designated and ordered per Rule 10500 to serve this/these Workers' Compensation Administrative Law Judge documents within five (5) days on all parties as shown on the Official

			CALIFORNIA RICT OFFICE			
·]		DOCUMENT	COVER SHE	ET		ļ
Is this a new case	? Yes 🗌 No 🔽	Companion C	ases Exist	Walkthrough	Yes 🗸 No	
More than 15 Cor	npanion Cases					
11/18/2019 Date:(MM/DD/YY ADJ12524618	<u>m</u>	Specific Injury	09/09/2018	SSN:	03/20/2019	
Case Number 1		Cůmulative Injury	(Start Date: MM/DD/Y	<u>~~~</u>	(End Date: MM/DD/YY) as the specific date of Inj	
Body Part 1:		. <u>.</u>	- - -	Body Part 3:	·	
Body Part 2:		•		Body Part 4:		
Other Body Parts:	. <u></u>			_		
Please check unit t	o be filed on (check on	ly one box)				;
ADJ				NÍ (
Companion Cases		Specific Injury	10/01/2018		03/15/2019	
Case Number 2	<	Cumulative Injury	(Start Date: MM/DD/Y)	<u>rrn</u>	(End Date: MM/DD/YY the specific date of injur	
Body Part 1:	<u> </u>			Body Part 3:	<u></u>	
PI Body Part 2:		•		Body Part 4:		<u> </u>
C Other Body Parts:	·	· <u> </u>		_		
DWC-CA form 102	32.1 Rev. 11/2017- Page	1 of 8				I.

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ATB000013

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A DJ 1 UNASSIGNED Case Number 3	2743430		Specific Injury Cumulative Injury			(End Date: MM/DD/YYYY) the specific date of injury)
Body Part 1:	420		,			
Body Part 2:	<u> </u>		• 	Ę	Body Part 4:	
Other Body Parts:	<u>9</u>					
-			Specific Injury			
Case Number 4			Cumulative Injury	(Start Date: MM/DD/ (If Specific Injury,		(End Date: MM/DD/YYYY) a as the specific date of injury)
Body Part 1:	 				Body Part 3:	<u> </u>
Body Part 2:			_	l. E	Body Part 4:	
Other Body Parts:		- 100	•			
:			Specific Injury			
Case Number 5			Cumulative Injury			(End Date: MM/DD/YYYY) as the specific date of injury)
Body Part 1:	<u>.</u>		-	E	Body Part 3:	
Body Part 2:		_ <u>.</u> :	— :	Ë	ody Part 4;	· · · · · · · · · · · · · · · · · · ·
Other Body Parts:				 .		
DWC-CA form 1023	2.1 Rev. 11/2017- I	Page	2 of 8			·

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Product Delivery Unit	ADJ	
Document Type	LEGAL DOCS	
Document Title COMPROMISE AN	ID RELEASE	-
- Document Date	11/13/2019 MM/DD/YYYY	
Author	TESTAN LAW SAN DIEGO	
	Office Use Only	
Received Date	MM/DD/YYYY	
DWC-CA form 10232.2 Rev. 11/2017	Page 1	

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

ADJ12524635				
Case Number 1		Case Number 4	·	
ADJ12524618	-			
Case Number 2		Case Number 5		
6-massigned At	05 12443430	551-47	-5680	
Case Number 3		SSN (Numbers Only)	
Venue Choice is base	d upon: (Completion of	this section is required)		
County of residenc	e of employee (Labor Cod	le section 5501.5(a)(1) or (d).)		
County where injur	y occ irred (Labor Code s	ection 5501.5(a)(2) or (d).)		
County of principal	place of business of empl	loyee's attorney (Labor Code section	on 5501.5(a)(3) c	or (d).)
SBR				
	ode For Place/Venue of H	learing (From Document Cover Sh	eet)	
Employee(Completion	of this section is requir	red)		<u> </u>
KEVIN				
First Name			- MI	
T list value.			IAII	RECEIVED
WILLIAMS	•		-	
Last Name				NOV 1 8 2019
2070 AVENIDA HA	CIENDA			DWC SAN BERNARDINO
Address/PO Box (Pleas	se leave blank spaces bet	ween numbers, names or words)		
	•			
CHINO HILLS			CA.	91709
	(Completion of this sec		State	Zip Code
			—	
	Self-Insured	Legally Uninsured		sured
WALMART INC.	ł			
Employer Name (Pleas	e leave blank spaces betw	ween numbers, names or words)	<u> </u>	<u> </u>
6750 KIMBALL AV	E,			
	 • • • • • 	blank spaces belween numbers, na	ames or words)	
CUINIO				01700
CHINO			- CA	91708 Zip Code
Cily:	an a		State	
DWC-CA form 10214 (c) (Rev	. 11/2008) (Page 1 of 9) •			<u> </u>

		·
pplicant's Attorney or Authorized Representative:		
Law Firm/Attorney		
NATALIA		
First Name		
FOLEY		
Last Name		
Law Firm Number		
LAW OFFICES OF NATALIA FOLEY		
Law Firm Name		
8018 E SANTA ANA CYN RD STE 100-215		
Address/PO Box (Please leave blank spaces between numbers, names or words)		
	C 1	0000
ANAHEIM City	- CA State	92808 Zip Code
	01816	
Defendant's Attorney or Authorized Representative:		
Law Firm/Attorney	•	
DANIEL	'n	•
First Name		
HAWKES		
Last Name		
4970955		
Law Firm Number		
TESTAN LAW		
Law Firm Name	··	
7676 HAZARD CENTER DR STE 500 Address/PO Box (Please leave blank spaces between numbers, names or words)		
· · · · · · · · · · · · · · · · · · ·		
SAN DIEGO	CA	92108
	State	Zip Code
surance Carrier Information (if known and if applicable - include even if carri	ier is adjusted by	claims administrato
· · · · · · · · · · · · · · · · · · ·		an an ann tha an tha an
ACE AMERICAN INSURANCE CO.	<u> </u>	
nsurance Carrier Name (Please leave blank spaces between numbers, names or words)		
Po Bux 1473 nsurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, nar		<u></u>
usulance Gamer Street Address/PU box thease leave plank spaces between numbers. Nat	nies ur worus)	
	Ky	Y0512
Lexington	- Ky State	YOSIL Zlp Code

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YORK RISK SERVICES GROUP,	INC.					
Name (Please leave blank spaces between		words)	<u> </u>		<u> </u>	
PO BOX 14731	•					
Street Address/PO Box (Please leave blank	spaces between nu	mbers, name	es or words)			
LEXINGTON				KY State	40512 Zip Code	
City						
IT IS CLAIMED THAT:						ŀ
1. The injured employee, born 02/17/1	964. OF BIRTH: MM/DD/YY	, al	eges that while e	mployed as a(n) —	
	ų.					alaad in
0)	CCUPATION AT THE	TIME OF INJ	JRY)	WI	, sus	tained in
arising out of and in the course of emplo	and the second second second second second			ted below:		
(State with specificity the date(s) of ir					eing settled.)	
	pecific Injury			•		
ADJ12524635	•		01/2018		63/15/2	
Case Number 1	umulative injury	(Start D	Date: MM/DD/YYYY) c Injury, use the stat		(End Date: MM/D	
		(ii specifi	c mjury, use trie sta	n aute as me spe	care date of hijdry	14:
Body Part 1: 841	Body Part 2:		,	Body Part 3:		
Body Part 1: 841	Body Part 2: _		I	Body Part 3:	<u>-</u>	
Body Part 1: 84	· · · · · · · · · · · · · · · · · ·	s:	I			
Body Part 4:	- Other Body Part					
Body Part 4:	ー Other Body Part SW・& ^{ナト} S	7	<u> </u>			
Body Part 4: The injury occurred at 702 3 (Street Add	Other Body Part	H leave blank s	paces between numb			
Body Part 4: The injury occurred at 702 3 (Street Add	Other Body Part	H leave blank s	paces between numb			
Body Part 4: The injury occurred at 702 S (Street Add Bentonnic City	Other Body Part $SW \cdot S^{+h} S$ dress/PO Box - Please A St	ieave blank s K ate 2	paces between numb	ers, names or wor	ds) —	
Body Part 4: The injury occurred at 702 3 (Street Add	Other Body Part $SW \cdot S^{+h} S$ dress/PO Box - Please A St	ieave blank s K ate 2	paces between numb	ers, names or wor	ds) —	
Body Part 4: The injury occurred at 702 S (Street Add Bentonnic City	Other Body Part $SW \cdot S^{+h} S$ dress/PO Box - Please A St	ieave blank s K ate 2	paces between numb	ers, names or wor	ds) —	
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Body Part 4: The injury occurred at 702 S (Street Add Bentonnic City	Other Body Part $SW \cdot S^{+h} S$ dress/PO Box - Please A St	ieave blank s K ate 2	paces between numb	ers, names or wor	ds) —	

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 .	Specific Injury			
ADJ12524618 Case Number 2	Cumulative Injury	09/09/2	2018 <u>77777)</u> the start date as the spe	13720/2019
		(If Specific Injury, use)	the start date as the spe	cific date of injury)
ody Part 1: 200				
ody Part 4: <u>Y</u> 5-0	Other Body Par	ts:5~00		<u></u>
ne injury occurred at	02 SW 8th	5+		
				ds)
Bentonville	, <u>A</u>	<u>R</u> 727	16	
Body parts, condition	ז and systems may not b	e incorporated by refe	rence to medical repo	orts.
ADJ12743430	Specific Injury		- * - *	
(2hessight) ase Number 3	Cumulative Injury	0//22/20 (Start Date: MM/DD/Y	<u> </u>	(End Date; MM/DD/YYYY)
		(If Specific Injury, use t	he start date as the spec	ific date of injury)
ody Part 1: <u> </u>	Body Part 2:		Body Part 3:	- <u></u>
	Other Body Part			
ne injury occurred at0				
		2.5 A.S. A.S. A.S. A.S. A.S. A.S. A.S. A.		(s)
Bentonville	, <u>A</u>	<u>R 72116</u>		
City				-:
Body parts, con litio	ns and systems <u>may not b</u>	e incorporated by refe	rence to medical repo	orts.
	Specific Injury			
ase Number 4	Cumulative Injury	(Start Date: MM/DD/Y) (II Specific Injury, use ti	YYY) he start date as the spec	(End Date: MM/DD/YYYY) ffic date of injury)
ody Part 1:	Body Part 2:	<u> </u>	Body Part 3:	
ody Part 4:	Other Body Part	S <u>:</u>		
	•	-		
ne injury occurred at(Street Address/FO Box - Please	leave blank spaces betwee	n numbers, names or wor	3)
		te Zin Code	÷.	
City	is and systems <u>may not be</u>	12		rt o

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	Specific Injury			
Case Number 5	Cumulative Inju	Iry (Start Date: MM/DI (If Specific Injury, us	SAYYAY) e the start date as the sp	(End Date: MM/DD/YYYY) ecific date of injury)
Body Part 1:	Body Part 2	2:	Body Part 3:	<u>. </u>
Body Part 4:	Other Body	Parts:		<u> </u>
The Injury occurred at	(Street Address/PO Box - F	Please leave blank spaces betw	een numbers, names or wo	ords)
City	······································	State Zip Code	<u></u>	
Body parts, conditions	s and systems may no	t be incorporated by refer	rence to medical repo	rts.
2. Upon approval of this compro administrative law judge and pa discharges the above-named er or ascertained or which may he liability of the employer(s) and t representatives, administrators the scope of the workers' componential compensation law, unless other	ayment in accordance of mployer(s) and insurar reafter arise or develop he insurance carrier(s) or assigns of the empl ensation law or claims	with the provisions hereof ace carrier(s) from all clair p as a result of the above and each of them to the oyee. Execution of this fo that are not subject to the	, the employee releas ns and causes of action- referenced injury(ies) dependents, heirs, ex rm has no effect on cl	es and forever on, whether now known), including any and all ecutors, aims that are not within
 This agreement is limited to s Paragraph No. 1 and further exp any addendum. Unless otherwise expressives DEPENDENTS TO DEATH BEI AGREEMENT. The parties have duplicating this language pursue 	plained in Paragraph N tated, approval of this NEFITS RELATING TO e considered the releas	lo. 9 despite any languag agreement RELEASES A D THE INJURY OR INJUI se of these benefits in arr	e to the contrary elsev NY AND ALL CLAIMS RIES COVERED BY T iving at the sum in Pa	where in this document or S OF APPLICANT'S THIS COMPROMISE ragraph 7. Any addendum
5. Unless otherwise expressiv o administrative law judge, approv rehabilitation benefits or supple	val of this agreement d	oes not release any claim		
6. The parties represent that the Paragraph No. 9.)	e following facts are tru	e: (If facts are disputed, s	tate what each party	contends under
EARNINGS AT TIME OF INJU	RY\$ 700)		. <u>.</u>
TEMPORARY DISABILITY INC		Ø	Weekly Rate \$	466.67
Period(s) Paid(Start Date: I	мм/DD/YYYY)	(End Date: MM/DD/YYY	Y)	
PERMANENT DISABILITY INI		_Ø	Weekly Rate \$	290.00
Period(s) Pald(Start Dat	te: MM/DD/YYYY)	End date(End	Date: MM/DD/YYYY)	<u>-</u> -
TOTAL MEDICAL BILLS PAID \$	1843.42	Total Unpaid Medical E:	xpense to be Paid By:	Defendant
Unless otherwise specified here	in, the employer will pa	ay no medical expenses li	ncurred after approval	of this agreement.
DWC-CA form 10214 (c) (Rev. 11/2008)	(Page 5 of 9)			

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15,00	
	nent Amount unts are to be deducted from the settlement amount:
	for permanent disability advances through
	for temporary disability indemnity overpayment, if any.
	payable to
1,20	50^{2} requested as applicant's attorney's fee. ANCE OF \$ $12,750^{2}$, after deducting the amounts set forth above and le
fana : a al	ns set for h herein are paid within 30 days after the date of approval of this agreement.
De fenda valid l Spoussa of the Defendant	uned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary): Int will pay, adjust, liksats or other wise resolve all liens off neord with the exception of any child support or I support liens, such liens remain the sole responsibility i opplicant. will pay applicant atturneys LC 5710 depu for full. If depute the amount of \$900.
Defendant Valid I Spoussa of the Defendant	uned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary): Int will pay, adjust, lingate or other wise resolve all lens of neord with the exception of any child support or I support liens, such liens remain the sole responsibility - applicant. Will pay applicant attorneys LC 5710 depu for the
De fenda valid 1 Spoussa of the Defendant	uned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary): Int will pay, adjust, lingate or other wise resolve all lens of neord with the exception of any child support or I support liens, such liens remain the sole responsibility - applicant. Will pay applicant attorneys LC 5710 depu for the
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Defendant Valid I Spoussa of the Defendant	uned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary): Int will pay, adjust, lingate or other wise resolve all lens of neord with the exception of any child support or I support liens, such liens remain the sole responsibility - applicant. Will pay applicant attorneys LC 5710 depu for the
Defendant Valid I Spoussa of the Defendant	uned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary): Int will pay, adjust, lingate or other wise resolve all lens of neord with the exception of any child support or I support liens, such liens remain the sole responsibility - applicant. Will pay applicant attorneys LC 5710 depu for the

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9. The partles 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 I	Defendant	
KEW	OH	earnings
KEW	017	temporary disability
KEW	DH	jurisdiction
KEW	DH	apportionment
KEW	DH	employment
KEW	DH	Injury AOE/COE
KEW	D#	sericus and willful misconduct
KEW	DH	discumination (Labor Code §132a)
KEW	UU	statute of limitations
KEN	<u>h</u>	future medical treatment
KEW	DH	other Mackey Milestys/out of pucket expenses
KEW	DH	pern anent disability
KEN	OH	self-;)rocured medical treatment, except as provided in Paragraph 7
KEN	01-1	vocational rehabilitation benefits/supplemental job displacement benefits
COMMEN	TS:	
E. the	party	may appear ex parte for the purpose of obtaining approves of
this	5=+16	mail Penalhes and interest warred if payment is made
-		days of OACR, Case is denied, post termination notice of
Injor	Υ.	
Se	e adden	dumi A and B.

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 filling of this document is the filling 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.

DWC-CA form 10214 (c) (Rev. 11/2008) (Page 7 of 9)

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.

has had any questions hersne	nay have had about this agreeme	In answered to mismer satisfaction.	11 2 CA
Witness the signature hereof th	is 13 day of NOVCLUL	618, 74/4 an K201	lands CA
Alicia Tor,	(02 11/13/2019	1 Ande	= 11/13/19
 Witness 1	(Date)	Applicant (Employee) KEVIN WILLIAMS	(Baie) 11/13/187
Wilness 2	(Date)	Altomovitor Applicant NATALES FOLES ESO	(Date)
Interpreter	(Date)	Attorney for Defendant	(Date)
	1 .		
		Attorney for Defendant	(Date)
	•		
		Attorney for Defendant	(Date)

Attorney for Defendant

(Date)

DWC-CA form 10214 (c) (Rev.11/2008) (Page 8 of 9)

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	ACKNOWLEDGMENT	
State of California		
On	before me, (insert name and title of the officer)	
personally appeared	· · · · · · · · · · · · · · · · · · ·	
subscribed to the with his/her/their authorize	e basis of satisfactory evidence to be the person(s) whose name(s) is instrument and acknowledged to me that he/she/they executed the s capacity(ies), and that by his/her/their signature(s) on the instrument upon behalf of which the person(s) acted, executed the instrument.	ame i
subscribed to the with his/her/their authorize person(s), or the entit	instrument and acknowledged to me that he/she/they executed the s capacity(ies), and that by his/her/their signature(s) on the instrument upon behalf of which the person(s) acted, executed the instrument. Y OF PERJURY under the laws of the State of California that the fore	ame i he
subscribed to the with his/her/their authorize person(s), or the entit I certify under PENAL	instrument and acknowledged to me that he/she/they executed the s capacity(ies), and that by his/her/their signature(s) on the instrument upon behalf of which the person(s) acted, executed the instrument. Y OF PERJURY under the laws of the State of California that the fore orrect.	ame i he

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Williams, Kevin v. Walmart Inc. WCAB CASE NO. ADJ12524635; ADJ12524618

12.

ADDENDUM TO COMPROMISE AND RELEASE

ADDITIONAL SETTLEMENT PROVISIONS

Applicant warrants and represents, and the parties stipulate, that Applicant did not sustain any compensable injury as a result of Applicant's employment by defendant other than the alleged injuries listed in this Compromise and Release, and that as a result of said alleged injuries Applicant did not sustain injury to any body part, system, or condition not listed in this Compromise and Release.

Defendant shall be responsible for only unpaid medical expense incurred through the date of Applicant's execution of this Compromise and Release and only as specified in paragraph 8. Applicant shall be responsible for all medical expense incurred after the date of Applicant's execution of this Compromise and Release.

Applicant warrants and represents that Applicant is not eligible for Social Security or Medicare benefits, has not applied for Social Security benefits, and does not intend to apply for Social Security benefits at any time within the next 30 months.

It is not the intention of Defendant to shift liability for future medical treatment to the Federal Government. The parties have considered the interests of Medicare; Applicant accepts full and sole liability for dealing with and satisfying any future claims by Medicare out of the proceeds of this settlement. Neither Applicant's Attorney nor Defendant will have any obligation to respond to or reimburse Medicare for any benefit deemed received by Applicant.

All permanent disability advances, including any not listed in paragraph 7, are to be deducted from the settlement amount.

Any and all claims and petitions alleging violation of Labor Code section 132a and/or 4553 by defendant employer are herewith dismissed with prejudice. The parties stipulate that defendant employer has not violated Labor Code sections 132a or 4553.

This settlement includes all claims for interest pursuant to Labor Code section 5800, penalties pursuant to Labor Code sections 4650 and 5814, Attorney's fees pursuant to Labor Code sections 4607 and 5814.5, and costs, attorney's fees and sanctions pursuant to Labor Code section 5813, from the date(s) of injury herein through the 30th day after service of the Order Approving Compromise and Release.

Provided that the defendant employer inaintains a medical provide network, the following is hereby stipulated to by the applicant: The defendant has complied with all statutes and regulations regarding the medical provider network; the defendant has had at all times since the date(s) of injury the right to medical provider network control; the defendant provided all required medical provider network notices to the applicant on a timely basis; and, the applicant received ail required medical provider network notices on a timely basis.

The defendant disputes all medical bills and lien claims relating to treatment provided by any person or entity not within the medical provider network. The defendant reserves the right to litigate the issue of reasonableness and necessity of all cosis, treatment, and services procured outside the medical provider network, and the defendant expressly reserves to itself all statutory and regulatory defenses, whether expressly or implicitly set forth in the Labor Code and all applicable regulatory sections.

DATED: _// DATED: 11/13/69

Williams.

Natalia Foley, ATTORNEY FOR APPLICANT

RECEIVED NOV 1 8 2019 SAN BERNAHDINO

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Addendon B

Employee: • Employer: Claim Number: Date of Injury:

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RE:

Kevin Williams Walmart Inc. 8949558; 8949567 10/01/2018 - 03/15/2019; 09/09/2018 - 03/20/2019

AFFIDAVIT OF WAIVER OF OME PROCESS

I, Kevin Williams, was advised in writing on that I have the right to disagree with my primary treating physician's findings and conclusions, and be afforded the opportunity to request a comprehensive medical evaluation from a physician selected from a panel of Qualified Medical Evaluator's assigned by the Division of Worker's Compensation Medical Unit

I have-read-the-report-by-my-treating-physician, -dated -, and agree with the doctor's history, exan-ination-and-description-of-my-condition. I choose to settle my case basedupon the findings of and not exercise my right to a qualified medical evaluation, from a physician selected from a panel.

ь: Ģ

ployee Signature

RECEIVED

NOV 1 8 2019

DWC SAN BERNAHDINO

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STATE OF CALIFORNIA WORKERS' COMPENSATION APPEALS BOARD

Kevin Williams	Case No.
<i>Applicant,</i> • v.	AFFIDAVIT OF DEFENDANT RE: RESOLUTION OF LIENS
Walmart Inc; Ace American Insurance Co. Defendants.	
I. <u>Daniel Hawkes</u> for defendant <u>Ace American Incurance</u> I have made the following good faith eff List ALL lien claims below, use supplemental p	orts to resolve each of the liens in this case.
	URE & DATE RESULT ESOLUTION EFFORTS
No Known lien Claimants	·
· · · · · · · · · · · · · · · · · · ·	······································

I declare under penalty of perjury that the foregoing is true and correct and that this affidavit was executed at San Diego California on 11 j 15 j 2019.

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NOV 1 8 2019

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Durla

ATB000027

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



Estado de Collfórnia Deparlámento de Relaciones Industriales DIVISION DE CUMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC H

Employee: Complete the "Employee" section and give the form to your employee: Keep a copy and mark it "Employee's "Emporary 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 work, ers' 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.

Anymerspinatin	mellatenzamsath	hemadeunvilinowingly failse
		annatestal arcpresentation for
the murpuse of a	maining or denving a	vonkens' compensation bene-
	isoguilly of a fiction year	an talan an a
unexemplear memore	CANTER AND A CANCER OF A CANCE	Sector Contractor Contractor Contractor Contractor Contractor

Empleador: Complete la sección "Empleado" y entregue la forma a su empleador. Quedese con la copia designada "Recibo Temporal del

PETTTION DEL EMPLICADO PARA DE COMPENSACIÓN DEL: TRABAJADOR (DWC 1)

Empléada^w hasto que Ud, recibu la copia firmada y fechada de su empleador. Ud, puede flamar o la División de Compensación al Trabajador al (800) 736-7401 para où información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabjador.

Ud. también deberín haber recibido de su empleador un folleio describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerios.

Todal aquellal personal que a propósito haga o cause que se produzea cualquier declaración o representación material faisa o fraudulenta con ef fin de obtener o negar beneficios o pagos de compensación a trabajadores lestonudos es culpuble de un crimen mayor "felonia" a trabajadores

	Employee-complete this section and see note above Empleado-complete esta sección y note la notación arriba.
	1. Name, Nombre, KEVIN &- WILLAMS_Today's Date, Fecha de Hay, 09 03 2019
	2. Home Address, Dirección Residencial. 2010 AVENIDA UPCEVIDA
	3. City. Cindad
4	A. Date of Injury. Fecha de la lesión (accidente). PN/214 Low 2204 Fine of mjury. Flora en que ocarrio. 03 19 f.m. p.m.
5	$\alpha_1, \alpha_2, \alpha_3, \alpha_3, \alpha_4, \alpha_3, \alpha_4, \alpha_5, \alpha_5, \alpha_5, \alpha_5, \alpha_5, \alpha_5, \alpha_5, \alpha_5$
6	Describe injury and part of body affected. Describe to lesión y parte dal cuerpo aféctada. Stress and strain due to repetitive movement over period of time LOWER Dack NECKSHOLDER HELDER
	movement over period of time concerned concerned the provide of the period of time concerned to the period of the
7.	
8.	Signature of employee. Firmia del empleado.
E	mployer-complete this section and see note below. Empleador-complete esta sección y note la notación abajo.
9.	Naine of employer. Nombre del empleador.
10	
Н.	
12.	Date claim form was provided to employee. Fecha en que se le entregó al empleado la pétición
13.	Date employer received claim form. Fecha en que el empledad devolvio la pención de empledad.
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 Séguro,
16.	Signature of employer representative, Firma del representante del empledador.
J7.	Title. Thulo:18. Telephone. Telephone.
your or rej	loyer: You are required to date this form and provide copies to historer or claims administrator and to the employee, dependent presentative who filed the claim within one working day of pt of the form from the employee.
SIGN	ING THIS FORM IS NOT AN ADMISSION OF LIABILITY ELFIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD
] Em	player copy/Copia del Empleadar 🔄 l'amplayee copy/ Copia del Empleado 📮 Chainas Administraton/Admini
71/0	14 Rev.

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 I)

Employee: Complete the "Employee" section and give the torm to your employer. Keep a copy and mark it "Employee's Temporary Receipt" until you receive the signed and dated copy from your em-ployer. 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.

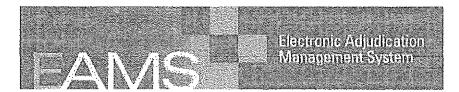
You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them,

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

Empleudir: Complete la sección "Empleudo" y envegue la forma a su empleador. Quédese com la copia designada "Recibo Temporal del Empleado" hosta-que l'il reciba la copia firmada y fechada de su empleador. Ud. piecele llamar a la Division de Compressactón al Trabajador al (800) 736-7401 para nir información gravada. En la hoja rubierta de esta forma esta la explicitión de los hénéficios de compensación al trabjador.

Ud, también delicría haber recibido de su empleador un fólleto 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 bene fits or payments is guilty of a felony, the purpose of each part of a	Todal, aquella, persona, que, ab propósito, haga o cause que, se produzea cualquier declaración o representación material faisa o fraudulenta con el fin de obtence o negat beneficios o pagos de compensación a trabajadores lestonados es culpable de un crimen mayor "felonía" se
 Nume: Nonihre: KEVIU & UIIIIAHAS Home Address: Dirección Residencial. 2010 AVE City. Ciudad. CHINO HILLS SI Date of Injury. Fecha de la lesión (accidente). OCTOBEL Address and description of where injury happened. Dirección/lugat HIND CA-91108 	-complete esta sección y note la notación arriba. Today's Date. Fecha de Hoy
 Employer—complete this section and see note below. Empleador— 9. Name of employer. Nombre del empleador	complete esta sección y note la notación abajo. o por primera vez de la lesión o accidente. egó al empleado la petición: nivió la petición al empleador.
17. Tide. Thulo 18.	mpleador Felephone, Teléfono,
your insurer or claims administrator and to the employee, dependent or representative who filed the claim within <u>one working day</u> of meaning the form from the purployee.	Empleador: Se requiere que Ud. feche está forma y-que provéa copias a su com- pañía de seguros, administrador de reclamos, o dependiente/representante de recla- nos y al empleado que hayan presentado esta polición dentro del plazo de <u>un día</u> <u>hábil</u> desde el momento de haber sido revibida la forma del empleado. EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD
7/1/04 Rev.	



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

Batch ID: 31759735 Date: 09/09/2019 01:38:04 PM

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STATE OF CALIFORNIA DWC DISTRICT OFFICE E-COVER SHEET

Is this a new Case?*	Yes 💿 🛛 No 🔿	Location: CTL
Companion Cases E More than 15 Comp		Walk Thru Yes 🔿 No 💿
Date: (MM/DD/YYYY)	09/09/2019	
Case Number:*		SSN(Numbers Only) 551475680
OSpecific Injury	(If Specific Injury, use the star	t date as the specific date of injury)
 Cumulative Injury 	09/09/2018 (START DATE: MM/DD/YYYY)	03/20/2019 (END DATE: MM/DD/YYYY)
Body Part 1 :	420 BACK - INCLUDING	Body Part 2 : 450 SHOULDERS - SCA
Body Part 3 :	300 UPPER EXTREMITI	E Body Part 4 : 200 NECK
Other Body Parts :	500 LOWER EXTREMIT	
 ADJ O DEL 	e filed on (check only one b \bigcirc SIF \bigcirc	
Companion Cases		
Case 1:		
1447 1241 Tel 167 1 1		
Oase 1. ○Specific Injury	(If Specific Injury, use the start	t date as the specific date of injury)
OSpecific Injury	(If Specific Injury, use the start (START DATE: MM/DD/YYYY)	t date as the specific date of injury) (END DATE: MM/DD/YYYY) Body Part 2 :
⊖Specific Injury		(END DATE: MM/DD/YYYY)
 ○Specific Injury ○Cumulative Injury Body Part 1 : Body Part 3 : 		(END DATE: MM/DD/YYYY) Body Part 2 :
 Specific Injury Cumulative Injury Body Part 1 : 		(END DATE: MM/DD/YYYY) Body Part 2 :
 ○Specific Injury ○Cumulative Injury Body Part 1 : Body Part 3 : Other Body Parts : 	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YYYY) Body Part 2 :
 ○Specific Injury ○Cumulative Injury Body Part 1 : Body Part 3 : Other Body Parts : Case 2: ○Specific Injury 	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YYYY) Body Part 2 : Body Part 4 : t date as the specific date of injury)
 ○Specific Injury ○Cumulative Injury Body Part 1 : Body Part 3 : Other Body Parts : Case 2: ○Specific Injury ○Cumulative Injury 	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YYYY) Body Part 2 : Body Part 4 : date as the specific date of injury) (END DATE: MM/DD/YYYY)
 ○Specific Injury ○Cumulative Injury Body Part 1 : Body Part 3 : Other Body Parts : Case 2: ○Specific Injury ○Cumulative Injury Body Part 1 : 	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YYYY) Body Part 2 : Body Part 4 : t date as the specific date of injury) (END DATE: MM/DD/YYYY) Body Part 2 :
 ○Specific Injury ○Cumulative Injury Body Part 1 : Body Part 3 : Other Body Parts : Case 2: ○Specific Injury ○Cumulative Injury 	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YYYY) Body Part 2 : Body Part 4 : date as the specific date of injury) (END DATE: MM/DD/YYYY)

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

Case Number	Amended Application	
SSN	551475680	
*Venue Choi	ce is based upon:	
County of r	esidence of employee (Labor Code section 5501.5(a)(1) or (d).)	
OCounty whe	ere injury occurred (Labor Code section 5501.5(a)(2) or (d).)	
County of p	rincipal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)	
	pcode for the venue choice designated above, and then tab to ation Field and choose the corresponding Hearing Location Code	N

Injured Worker		
First Name*	KEVIN	
MI		
Last Name*	WILLIAMS	
Street Address 1 /PO Box* 20	70 AVENIDA HACIENDA	
Street Address 2 /PO Box		
=++		
International Address		I
	CHINO HILLS	
International Address City* State*	CHINO HILLS CA	

○Insurance Carrier	○ Employer	 Lien Claimant 		
Name				
Street Address 1 /PO Box				
Street Address 2 /PO Box				
City				
State				
Zip Code (Numbers Only)				
L		27-79.455.655.651.651.651.651.651.651.651.651.6		
Employer Information				
	-Insured O Legally Uninsured	 Uninsured 		
Insured Self		 Uninsured 		
○Insured ○ Self Employer Name*		 Uninsured 		
○Insured ○ Self Employer Name*	OCIATES INC	 Uninsured 		
 Insured Self Employer Name* WAL-MART ASS Employer Street Address/PC 	OCIATES INC	Uninsured		

claims administrator)	
Insurance Carrier Name	
Street Address/PO Box	· · · · · · · · · · · · · · · · · · ·
City	
State	
Zip Code (Numbers Only)	

Name	 	
Street Address/PO Box	 	
City	 	
State	 	
Zip Code (Numbers Only)	 	

	~~~~				
IT IS CLAIMED THAT :					
1. The injured worker born* 02/17/1964 (Date of birth : MM/DD/YYYY)					
, while employed as a(n) RECORD PR					
suffered a: ( Choose only one ) (Occupation at the time of injury)					
Ospecific injury on (DATE OF INJURY: MM/DD/YYYY)					
cumulative trauma injury which began on					
09/09/2018 and ended on 03/20/2019					
(START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)					
The injury occured at* 6150 KIMBALL AVE (Street Address/PO Box - Please leave blank spaces between numbers, names or words)					
	Box - Plea	r	baces between nu	f	or words)
CHINO (City)*		'CA		91708	\ /#
(City) (State which par	ts of the b	•	ate)* :d)	(Zip Code	)
Body Part 1 : 420 BACK - INCLUDING		י ר	450 SHOULI	DERS - SCAP	PULA AND
Body Part 3 : 300 UPPER EXTREMITI	ES - NO	_ ]Body Part 4 :	200 NECK		
Other Body Parts : 500 LOWER EXTRI	EMITIES	- NOT SPECI	FIED		
2. The injury occurred as follows:			•/////		
(Explain What The Worker Was Doing Field size limited to 325 characters	At The Ti	me Of Injury A	nd How The li	njury Occured	1)
STRESS AND STRAIN DUE TO REPI	ETITIVE	MOVEMENT	OVER PERIO	O OF TIME A	ND DUE
TO LIFTING HEAVY BOXES, INJURE	D LOWE	R BACK, NEO	CK, SHOULDE	RS, LOWER	
EXTREMITIES, REPORTED TO THE	SUPER	ISOR, SENT	TO INDUSTRI	AL CLINIC	
		W ( ) been generatives de  ) en seus comme en estere			
3. Actual earnings at the time of injury	<i>~</i> ~~ • •			···· • •	
Rate of Pay \$	⊖Mo		•	Hourly	⊖Monthly
State value of tips, meals, lodging or oth received \$	ner advar	ntages regular	ly		⊖Weekly
Number of hours worked per week.					⊖Hourly
4. The injury caused disability as follow	VS				
Last day off work due to injury :					
	(MM/DD/Y Start dat		End d	ate	·····
First Period of Disability:	JIAN UA	(MM/DD/Y	I I		
Second Period of Disability:	Start dat		End d	· · · · · · · · · · · · · · · · · · ·	
Geother ende of Disability.	Juirud	MM/DD/M)	İ		
1		·····= =··		<b>,</b>	,

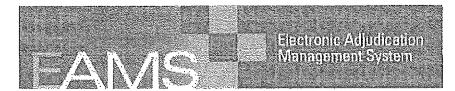
5. Compensation Compensation was paid :	⊖Yes ⊚No		
Total paid:			
Weekly rate(s):			
Date of last payment:			
	(MM/DD/YYYY) y unemployment insurance benefits an fits (state disability) since the date of in		nployment
⊖ Yes			
7. Medical treatment			
Medical treatment was receive	d :	$\bigcirc$ Yes	⊖No
All treatment was furnished by	the Employer or Insurance Carrier :	⊖ Yes	⊖No
Date of last treatment	(MM/DD/YYY)		
	PROVIDING OR PAYING FOR MEDICAL CAR		
Did Medi-Cal pay for any healt Names and addresses of docto out that were not provided or p	h care related to this claim ? : or(s)/hospital(s)/clinic(s) that treated or aid for by the employer or insurance car	○ Yes examined for	⊖No • this injury,
Did Medi-Cal pay for any healt Names and addresses of docto but that were not provided or p	h care related to this claim ? : or(s)/hospital(s)/clinic(s) that treated or aid for by the employer or insurance car	○ Yes examined for	
Did Medi-Cal pay for any healt Names and addresses of docto out that were not provided or p	c 2.	○ Yes examined for	·
Did Medi-Cal pay for any healt Names and addresses of doctor out that were not provided or p Name of Doctor/Hospital/Clini Field size limited to 80 charact	c 2.	Yes examined for arrier.	·
Did Medi-Cal pay for any healt Names and addresses of doctor out that were not provided or p Name of Doctor/Hospital/Clini Field size limited to 80 charact	c 2.	Yes examined for arrier.	·
Did Medi-Cal pay for any heal Names and addresses of docto out that were not provided or p Name of Doctor/Hospital/Clini Field size limited to 80 charact Name of Doctor/Hospital/Clini Field size limited to 80 charact	c 2.	Yes examined for arrier.	
Did Medi-Cal pay for any healt Names and addresses of doctor out that were not provided or p Name of Doctor/Hospital/Clini Field size limited to 80 charact Name of Doctor/Hospital/Clini Field size limited to 80 charact 8. Other cases have been file Case Number 1	c 2.	Yes examined for arrier.	

9. This application is filed because of a di	sagreement 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) ALL OTHER BEVEF	ITS
	○No if "No", applicant is to sign and date below. mplete the following and is to sign and date below ○Non Attorney Representative
Law Firm/Attorney     Law Firm or Company Name(If Applicable	
NATALIA FOLEY BEVERLY HILLS	/
	11004020
Law Firm Number (If Applicable)	11964930
Attorney/Rep First Name	NATALIA
Attorney/Rep MI	
Attorney/Rep Last Name	FOLEY
Street Address/PO Box 8306 WILSHIRE	BLVD STE 115
City	BEVERLY HILLS
State	CA
Zip Code (Numbers Only)	90211
Applicant Attorney / Representative S NAT	ALIA FOLEY
Applicant Signature	

Dated at BEVERLY HILLS , California Date 09/09/2019

City

(MM/DD/YYYY)



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

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

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## STATE OF CALIFORNIA DWC DISTRICT OFFICE E-COVER SHEET

Is this a new Case?*	Yes 🕘 🛛 No 🔿	Location: CTL
Companion Cases E More than 15 Comp	<u> </u>	Walk Thru Yes 🔿 No 🤄
Date: ( MM/DD/YYYY)	09/09/2019	
Case Number:*		SSN(Numbers Only) 551475680
OSpecific Injury	(If Specific Injury, use the start of	date as the specific date of injury)
Cumulative Injury	10/01/2018	03/15/2018
0	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YYYY)
Body Part 1 :	841 NERVOUS SYSTEM	Body Part 2 :
Body Part 3 :		Body Part 4 :
Other Body Parts :		
	J () SIF () U	IEF () SAU () INT () RSU
Companion Cases	J () SIF () U	IEF () SAU () INT () RSU
Companion Cases		IEF O SAU O INT O RSU
Companion Cases Case 1: OSpecific Injury		]
Companion Cases Case 1: Ospecific Injury Ocumulative Injury		date as the specific date of injury)
Companion Cases Case 1: OSpecific Injury	(If Specific Injury, use the start o	date as the specific date of injury)
Companion Cases Case 1: Ospecific Injury Ocumulative Injury	(If Specific Injury, use the start o	date as the specific date of injury)
Companion Cases Case 1: OSpecific Injury OCumulative Injury Body Part 1 : Body Part 3 :	(If Specific Injury, use the start o	date as the specific date of injury) (END DATE: MM/DD/YYYY) Body Part 2 :
Companion Cases Case 1: OSpecific Injury OCumulative Injury Body Part 1 : Body Part 3 :	(If Specific Injury, use the start o	date as the specific date of injury) (END DATE: MM/DD/YYYY) Body Part 2 :
Case 1: Specific Injury Cumulative Injury Body Part 1 : Body Part 3 : Other Body Parts : Case 2:	(If Specific Injury, use the start of (START DATE: MM/DD/YYYY)	date as the specific date of injury) (END DATE: MM/DD/YYYY) Body Part 2 :
Companion Cases Case 1: Specific Injury Cumulative Injury Body Part 1 : Body Part 3 : Other Body Parts : Case 2: Specific Injury	(If Specific Injury, use the start of (START DATE: MM/DD/YYYY)	date as the specific date of injury)   (END DATE: MM/DD/YYYY)   Body Part 2 :   Body Part 4 :
Companion Cases Case 1: Specific Injury Cumulative Injury Body Part 1 : Body Part 3 : Other Body Parts : Case 2:	(If Specific Injury, use the start of (START DATE: MM/DD/YYYY)	date as the specific date of injury)   (END DATE: MM/DD/YYYY)   Body Part 2 :   Body Part 4 :
Companion Cases Case 1: Specific Injury Cumulative Injury Body Part 1 : Body Part 3 : Other Body Parts : Case 2: Specific Injury	(If Specific Injury, use the start of (START DATE: MM/DD/YYYY)	date as the specific date of injury) (END DATE: MM/DD/YYYY) Body Part 2 : Body Part 4 : date as the specific date of injury)
Companion Cases Case 1: Specific Injury Cumulative Injury Body Part 1 : Body Part 3 : Other Body Parts : Case 2: Specific Injury Cumulative Injury	(If Specific Injury, use the start of (START DATE: MM/DD/YYYY)	date as the specific date of injury) (END DATE: MM/DD/YYYY) Body Part 2 : Body Part 4 : date as the specific date of injury) (END DATE: MM/DD/YYYY)

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

Case Number	· · · · · · · · · · · · · · · · · · ·	Ar	nended Application	
SSN	551475680			
*Venue Choice	e is based upon:			
County of re	sidence of employee (Labor Code section 5	5501.5(a)(1) or (d).)		
Ocounty wher	e injury occurred (Labor Code section 550	1.5(a)(2) or (d).)		
<ul> <li>County of prior</li> </ul>	incipal place of business of employee's atto	orney (Labor Code section 5	501.5(a)(3) or (d).)	
1 1	code for the venue choice designated a ion Field and choose the corresponding	•	92807 AF	łM ]

•

Injured Worker		
First Name*	KEVIN	
MI		
Last Name*	WILLIAMS	
Street Address 1 /PO Box* 20	70 AVENIDA HACIENDA	
Street Address 2 /PO Box		
International Address		
City*	CHINO HILLS	
State*	СА	
Zip Code* (Numbers Only)	91709	

⊖Insuranc	e Carrier	○ Employer	<ul> <li>Lien Claimant</li> </ul>
Name		······································	
Street Addr	ress 1 /PO Box		
Street Addr	ress 2 /PO Box		
City			
State			
Zip Code (1	Numbers Only)		
Zip Code (î	Numbers Only)		
Zip Code (1	Numbers Only)		
Zip Code (î Employer Inf	la.		
Employer Inf	formation	sured O Legally Uninsured	<ul> <li>Uninsured</li> </ul>
Employer Inf	formation		<ul> <li>Uninsured</li> </ul>
Employer In OInsured Employer Name*	formation Self-Ins WAL-MART ASSOC		<ul> <li>Uninsured</li> </ul>
Employer In OInsured Employer Name*	formation Self-Ins WAL-MART ASSOC	CIATES INC	Uninsured
Employer Inf Insured Employer Name* Employer S	formation Self-Ins WAL-MART ASSOC	OIATES INC	Uninsured

,

isurance Carrier Information (if known and if applicable - include even if carrier is adjusted by aims administrator)	
nsurance arrier Name	]
treet Address/PO Box	_
ity	]
itate	]
Zip Code (Numbers Only)	]
laims Administrator Information (if known and if applicable)	

Name	 
Street Address/PO Box	
City	
State	
Zip Code (Numbers Only)	

•

.

IT IS CLAIMED THAT :				
1. The injured worker born* 02/17/196	34	(Date of birth : MM	/DD/YYYY)	
, while employed as a(n) RECORD P	ROCESSO	<b>A</b>		
suffered a: ( Choose only one )	(Occupation	at the time of injury	()	
⊖specific injury on			(DATE OF INJU	RY: MM/DD/YYYY)
cumulative trauma injury which beg	an on			
10/01/2018	and end	led on 03/15/2	2018	
(START DATE: MM/DD/YYYY)	I	(E	ND DATE: MM/DD	/YYYY)
The injury occured at* 6150 KIMBALL	AVE		ан на н	
	Box - Please	leave blank spaces	s between numbers	, names or words)
CHINO		CA	917	08
(City) [₩]	and the state of t	(State)*	(	(Zip Code)*
		dy were injured)		
Body Part 1 : 841 NERVOUS SYSTEM	I-SIRE			
Body Part 3 :	][	Body Part 4 :		
Other Body Parts :				······
2. The injury occurred as follows:				
(Explain What The Worker Was Doing	At The Tim	e Of Injury And I	How The Injury (	Occured )
Field size limited to 325 characters				DASSMENIT
BINESS DOE TO HOSTILE WORKT			U OLNOAL HA	INAGOIMENT
	•			·
				arren 1 a 4, a 4, b 4, a , a 4 a , a 4 a , a 4
3. Actual earnings at the time of injury	!	· · · · · · · · · · · · · · · · · · ·		
Rate of Pay \$	⊖Mont	ihly ()Weekl	ly 🔿 Hou	rly
State value of tips, meals, lodging or o	her advanta	ages regularly		OMonthly
received \$				⊖Weekly
Number of hours worked per week.				⊖Hourly
	f			
4. The injury caused disability as follo	ws			
Last day off work due to injury :				
Last day on work due to injury .	(MM/DD/YYY	] ]		
First Period of Disability:	Start date		End date	
				(MM/DD/YYYY)
Second Period of Disability:	Start date		End date	
-	l			

5. Compensation Compensation was paid :		
Total paid:		
Weekly rate(s):		
Date of last payment: (MM/DD/YYYY)		
3. Has the worker received any unemployment insurance benefits ar compensation disability benefits (state disability) since the date of it		nployment
7. Medical treatment		
Medical treatment was received :	$\bigcirc$ 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:		
Other treatment was provided/paid by: NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CAI	RE)	
NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CA Did Medi-Cal pay for any health care related to this claim ? : Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or	○ Yes r examined for	⊖No ∙ this injury,
Did Medi-Cal pay for any health care related to this claim ? :	○ Yes r examined for	
NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CA Did Medi-Cal pay for any health care related to this claim ? : Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or	○ Yes r examined for	
NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CA Did Medi-Cal pay for any health care related to this claim ? : Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated of put that were not provided or paid for by the employer or insurance of Name of Doctor/Hospital/Clinic 1.	○ Yes r examined for	
NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CAL         Did Medi-Cal pay for any health care related to this claim ? :         Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or         Dut that were not provided or paid for by the employer or insurance of         Name of Doctor/Hospital/Clinic 1.         Field size limited to 80 characters         Name of Doctor/Hospital/Clinic 2.	○ Yes r examined for carrier:	
NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CAL         Did Medi-Cal pay for any health care related to this claim ? :         Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or         Dut that were not provided or paid for by the employer or insurance of         Name of Doctor/Hospital/Clinic 1.         Field size limited to 80 characters         Name of Doctor/Hospital/Clinic 2.         Field size limited to 80 characters	○ Yes r examined for carrier:	
Did Medi-Cal pay for any health care related to this claim ? : Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated of but that were not provided or paid for by the employer or insurance of Name of Doctor/Hospital/Clinic 1. Field size limited to 80 characters Name of Doctor/Hospital/Clinic 2. Field size limited to 80 characters 3. Other cases have been filed for industrial injuries by this employed	○ Yes r examined for carrier:	
NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CAL         Did Medi-Cal pay for any health care related to this claim ? :         Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or         out that were not provided or paid for by the employer or insurance of         Name of Doctor/Hospital/Clinic 1.         Field size limited to 80 characters         Name of Doctor/Hospital/Clinic 2.         Field size limited to 80 characters         B. Other cases have been filed for industrial injuries by this employed         Case Number 1	○ Yes r examined for carrier:	

9. This application is filed because of a dist	agreement 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) ALL OTHER BENEFI	TS
Is the Applicant Represented?: <ul> <li>Yes</li> <li>if "Yes", applicant's representative is to com</li> </ul>	○No if "No", applicant is to sign and date below. Inplete 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
Attorney/Rep First Name	NATALIA
Attorney/Rep MI	
Attorney/Rep Last Name	FOLEY
Street Address/PO Box 8306 WILSHIRE I	BLVD STE 115
City	BEVERLY HILLS
State	CA
Zip Code (Numbers Only)	90211
Applicant Attorney / Representative S NATA	LIA FOLEY
Applicant Signature	
Dated at BEVERLY HILLS	, California Date 09/09/2019

(MM/DD/YYYY)

Sinte of California Department of Iodustrial Relations Division of Workers'), ompeasatori

#### FEE DISCLOSURE STATEMENT

If you choose to be represented by an attorney, your attorney's fires 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 (epresenting 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 your 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.

9/8/2019

Date

Call this toll-free number: 1-80

Employee's Signature

Employee's Name

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

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 Signa	Únré	AU	 Date	9/8/2019	
		The second se			
Attorney's name	in •		·		
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.

9/8/2019 Date:

Signed by Applicant

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



200000000

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

#### PRÍTITÓN 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.

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

You should also have received a paniphlet from your employer describing workers' compensation benefits and the procedures to obtain them. Empleudo: Complete la sección "Empleudo" y eniregue la forma a su empleudor. Quedese con la copia designada "Racibo Temporal del Empleudo" lasta 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 oir información gravada. En la hoja cubierta de esta forma esta la coplicatión de los benéficios de compensación al trabajador.

Ud. lambién deberla hober recibida de su empleador un falleto describieñdo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Any person who mines of eauses to be mide any knowingly fills or frandulent material statement or material representation for the purpose of obtaining or denying workers? compensation bene fits or payments is guilty of a felony.	CURLINITIAN DECEMBER OF AN AND A CONTRACT
Employcecomplete this section and see note above Emplead	lo-complete esta sevelón y note la notación arriba.
1. Name Nombre, KEVIU & MINI DAAS	Terdante Data Rechardedtan D9/05/10
2. Home Address: Dirección Residencial. 2010 AV	Elytha UMICIAN
3. City Ciudad, CHINO HIVS	State Felado CH - Tin Calibia Partal 91709
4. Date of Injury, Fecha de la lesión (accidente). OCTODE	Today's Date. Fechu de Hoy. $D9/D8/19$ E/4 100 HPC/EUCov State. Estado. $B115170197$ ; D. Cáligó Postal. 91709 J018 Time of Injury! Hora en que ocurrióa.mp.m. par dónde occurió él accidente. $G150$ KIMball AVE
5. Address and description of where injury happened. Direction/hug	par dónde occurió el accidence (07.50 KIABAILAVE
MIND CA.91708	
6. Describe injury and part of body affected. Describa la lesión y pa	urte del cuerpo afectada. Stress due to hostile work environment
7. Social Security Number. Número de Seguro Social del Empleado	551-47-5680
8. Signature of employee. Finna del empleado. X	42enci
	t dia da la contra la contra de
Employer-complete this section and see note below. Empleador-	-complete esta sección y noie la notación abajo.
9. Name of employer. Nombre del empleador.	
10. Address. Dirección.	
11. But an international sector of the sector of the sector of an and a sector of	ipo por primera vez de la lesión o accidente.
The second s	ntreas al empleado la petición.
12. Date chain hain was provided to emproyee, I could be que as a	volvió la petición al empleador.
13. Date employer received chann torm, a contract of querey Namb	re y dirección de la compañía de seguros o agencia adminstradora de seguros.
The second secon	l empleador.
15. Insurance Policy Number. Ist mimero de la polizi de la sancastanta de	l empleador.
16. Signature of employer representative, <i>rima del representative</i>	Telephone, Teléfono,
17. Title. Thulo.	
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 <u>one working day</u> of receipt of the form from the employee.	Empleador: Se requiere que Ud. feche esta forma y que provéa copias a su com- pañía de seguros, administrador de reclamos, o dependientelrepresentante de recla- mos y al empleado que hayan presentado esta petición dentro del plazo de <u>un día</u> <u>hábil</u> desde el momento de háber sido recibida la forma del empleado.
SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY	RI, FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD
🗇 Employer vopy/Capia del Empleador 👘 🗔 Employee vopy/ Capia del Empleado	Chahusi Administrator/Administrador de Rechamiss 🔲 Tomporouy RecouptRecibo del Empleado
7/1/04 Rev.	

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



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

#### WORKERS' COMPENSATION CLAIM FORM (DWC 1)

Employee: Complete the "Employee" section and give the form to your employer. Keep a copy and mark it "Employee's Temporary Receipt" infil 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 work ers' compensation benefits is included as the cover sheet of this form.

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

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Empleudo: Complete la sección "Empleudo" y entregue la forma a su compleudor. Quédexe con la copia designada "Recibo Temporal del Empleudo" hasta que Ud, recibu la copia firmúila y fechada de su empleador. Ud, puede llamar a la División de Compensaición al Trabajador al (800) 736-7401 para dir Información gravadà. En la hojo cubierta de esta

PETITIÓN DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC B

Ud. también debevía haber revibida de su empleador un folleio describiendo los benfícios de compensación al trabajador lesionado y los provedimientos para optenerlos.

forma esta la explicatión de los lieneficios de compensación al trabjador.

Todas aquella" persona, que a propósito haga o cause que se produzea cualquier declaración o representación material faisa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia" accesso as produzea p

Employee—complete this	s section and see note above L Emple	ado—complete esta sección y note la notación arriba.
1. Name, Nombre.	(EVING-WILLIAM	15 Today's Date, Fecha de Hoy, 09 03 2019
2. Home Address. Direct	ción Residencial 2010 A	NEIVIJA HACevida
3. City, Ciudad.	MIND CD	State, Estado, CIA Zip, Cálico Postal, 917,09 Luna Duc (Gime & Hjury, Hara on gur ochritik, OB 119 20019 p.m.
4. Date of Injury. Fecha	de la lesión (accidente), 2019	LUNELINC Kime & mury Hora on que activités OB 119 2019 p.m.
5. Address and description	n of where injuty happened, Dirección/	lugar dónde occürió el accidente. 65150 Kimball AVE
6. Describe injury and part	rt of body affected. Describa la lesión y	parte dal cuerpo afectada. Stress and strain due to repetitive
movement over	r period of time LOWEL	ack weekstlanden Henth
7. Social Security Numbe	r. Número de Seguro Social del Emplea	10/ <u>- 551 4F1 - 5(05)</u>
8. Signature of employee.	Firma del empleado, 🛛 📈 🖉	K - C - 2
Employer _ complete this :	ention and see note below Funnlande	r-complete esta sección y note la notación abujo.
Employer—complete this s	echon and see note score Empresa	Teomphere essusseement y new a new contraction and you
9. Name of employer, Non	bre del empleador.	
	<u></u>	
		supo por primera vez de la lesión o accidente.
		ntregó al empleado la petición.
13. Date employer received	claim form. Fecha en que el empleado a	evolvió la petición al empleador.
14. Name and address of inst	urance carrier or adjusting agency. Nom	bre y dirección de la compañía de seguros o agencia adminstrudora de seguros.
15 Insurance Policy Number	r. El número de la póliza de Seguro.	
	presentativo. Firma del representante de	
10. Signature to chiphoyer rej	nesentariye, r maa aar representatise av	Telephone. Teléfono.
	anne an	
your insurer or claims administ	date this form and provide copies to rater and to the employee, dependent claim within <u>one working day</u> of ployee.	Empleador: Se requileré que Ud, feche está formá y que provéa copias a su com- pañía de seguvos, administrador de reclamos, o dependiente/representante de recla- mas y al empleado que hayar presentado esta petición dentro del plazo de <u>un día</u> <u>hábil</u> desde el momento de haber sido recibida la forma del empleado.
IGNING THIS FORM IS NO	I AN ADMISSION OF LIABILITY	EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD
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## VENUE AUTHORIZATION

NJURY(IES) DATED	ΑΤΤΆΛ	TO BE	
ILED AT THE	AHM	WORKERS'	
COMPENSATION APPEA	LS BOARD.	()	
DATED:	X A	ale in ant	·
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APPLICANT'S ATTORNEY:			
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## ATB000050

## 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.

9/8/2019 Х ignature 9/8/2019

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."

Signature

Dated:

Dated:

#### ATB000051

E-Filer:	NATALIA FOLEY, ESQ
UAN:	NATALIA FOLEY BEVERLY HILLS 11964930
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
	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

WAL-MART ASSOCIATES INC 6150 KIMBALL AVE CHINO, CA 91708 KEVIN WILLIAMS 2070 AVENIDA HACIENDA CHINO HILLS CA 91709

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

#### DIVISION OF WORKERS' COMPENSATION WORKERS' COMPENSATION APPEALS BOARD

# NOTICE OF APPLICATION

**DATE OF SERVICE:***09/10/2019* 

WCAB CASE NBR: ADJ12524618

DATE OF CLAIMED INJURY:09/09/201803/20/2019

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

file:///C:/Users/Life/Downloads/DWCADJWC04 - 2019-09-09T223133.657.html



DIVISION OF WORKERS' COMPENSATION WORKERS' COMPENSATION APPEALS BOARD

# **NOTICE OF APPLICATION**

**DATE OF SERVICE:** 09/10/2019

EAMS CASE NBR(s): ADJ12524635

DATE OF CLAIMED INJURY: 10/01/2018

EMPLOYEE: KEVIN WILLIAMS

EMPLOYER: WAL-MART ASSOCIATES INC

**INSURER:** 

VENUE: AHM-ADJ, 1065 N. PACIFICENTER DRIVE, #170, ANAHEIM, CA, 92806-2131

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 EAMS CASE NUMBER ON ALL CORRESPONDENCE TO THE WCAB. THIS NOTICE CONSTITUTES A CONFORMED COPY OF THE APPLICATION. DATE APPLICATION FILED: 09/09/2019

NOTICE TO PARTIES: Disability Accommodation is available upon request. Individuals with a disability requiring a reasonable accommodation (such as auxiliary aid or service or a modification of policies or procedures) to ensure effective communication and access to the programs of the Division of Workers' Compensation, should contact the Disability Accommodation Coordinator at the local District Office of the DWC, or the Statewide Disability Accommodation Coordinator at 1-866-681-1459 (toll free) or through the California Relay Service, by dialing 711 or 1-800-735-2929 (TTY) or 1-800-855-3000 (TTY-Spanish).

Accommodations can include reasonable modifications of procedures or the provision of auxiliary aids or services including, but not limited to, assistive listening devices (ALD), Computer-Aided Realtime Translation (CART), sign language interpreters, documents in alternative formats, magnifiers, and audio cassette recordings. Accommodation requests should be made as soon as possible and at least five (5) days before the hearing, especially for requests for an ALD, a sign language interpreter, or CART.

WC04



AHM-ADJ 1065 N. PACIFICENTER DRIVE #170 ANAHEIM CA 92806-2131

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

## STATE OF CALIFORNIA DWC DISTRICT OFFICE E-COVER SHEET

Companion Cases Exist More than 15 Companion Cases Date: ( MM/DD/YYYY) 10/11/2019	Location*: CTL Walk Thru Yes O No ④
Case Number*:       ADJ12524618         OSpecific Injury       (If Specific Injury, use the start date)	SSN(Numbers Only)
OCumulative Injury (START DATE: MM/DD/YYYY)*	(END DATE: MM/DD/YYYY)
Body Part 1 :	Body Part 2
Body Part 3 :	Body Part 4 :
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Cumulative Injury (START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YYYY)
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Body Part 1	Body Part 2 :
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Body Part 1   Body Part 3   Other Body Parts :     Case 2:	Body Part 2 : Body Part 4 :
Body Part 1	Body Part 2 : Body Part 4 :
Body Part 1	Body Part 2 : Body Part 4 : te as the specific date of injury) (END DATE: MM/DD/YYYY)

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

Case Number:	ADJ12524618	-	
(Choose only one)	)		
a specific injury	on		
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⊠a cumulative tra	uma injury which begar		
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Name(s) of Answe	ring Party(ies) WALM		E: MM/DD/YYYY)
			s between names, numbers or words)
<u> </u>	ر۳۱88 		
Injured Worker			
First Name*		KEVIN	
MI			
Last Name*		WILLIAMS	· · · · · · · · · · · · · · · · · · ·
		-	
Employer Informat	lion		
-			
<ul> <li>Insured</li> </ul>	⊖Self-Insured	CLegally Unin	sured
	O Self-Insured	CLegally Unin	sured OUninsured
· · · · · · · · · · · · · · · · · · ·	WALMART INC	CLegally Unin	
Employer Name	WALMART INC		
Employer Name Employer Street A	WALMART INC	6750 KIMBALL A	
Employer Name Employer Street A City	WALMART INC ddress/PO Box	6750 KIMBALL A	
Employer Name Employer Street A City State	WALMART INC ddress/PO Box	6750 KIMBALL A CHINO CA	
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Employer Name Employer Street A City State Zip Code (Number Insurance Carrier Insurance Carrier Name	WALMART INC ddress/PO Box rs Only) Information (if applicable	6750 KIMBALL A CHINO CA 91708 - include even if car	
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Claims Administrator Information	(if applicable)		
Claims Admin Name YORK EL	DORADO HILLS		
Claims Admin Str Addr/PO Box PO BOX 14731			
City	LEXINGTON		
State	KY		
Zip Code (Numbers Only)	40512	]	
ANSWERING DEFENDANTS de explanations as expressly set for DENIALS (Mark X if allegation is denied)		the application as indicated below with such r material allegations. EXPLAIN BELOW	
Employment			
Occupation		Field size limited to 129 characters Field size limited to 129 characters Field size limited to 129 characters	
⊠Injury	NATURE AND EX		
	(IF DENIAL IS BASED ON	Field size limited to 85 characters DATE OR PART OF BODY INJURED, EXPLAIN FULLY)	
⊠Insurance Coverage		Field size limited to 84 characters S BEEN NOTIFIED TO APPEAR AND DEFEND)	

Liability for self-procured treatment	· · · · · · · · · · · · · · · · · · ·	
		Field size limited to 129 characters
Liability for future medical treatment		
		Field size limited to 129 characters
Medical Legal Costs		
		Field size limited to 129 characters
Earnings	ACCORDING TO PROOF	
		Field size limited to 129 characters
⊠Periods of Disability	MARCH 15, 2019	
	(GIVE LAST DAY WORKED AND CORRECT DATE OF	Field size limited to 84 characters
Rehabilitation		
		Field size limited to 129 characters
Supplemental Job displacement / return to work		
		Field size limited to 129 characters
⊠Permanent disability		
	(IF APPORTIONMENT IS CLAIMED, SO STATE)	Field size limited to 126 characters

ATB000059

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IT IS FURTHER ALLEGED	ility indemnity in the total amount of \$ 0					
at the rate of \$ 466.67						
a week beginning	M/DD/YYYY MM/DD/YYYY					
plus						
2. Affirmative defenses and ot	her matters : (Field size limited to 448 characters)					
	HE LABOR CODE, INSURANCE CODE, CIVIL CODE AND CODE POST-TERMINATION NOTICE OF INJURY.					
	is being filed on behalf of ( Please check one only ) Insurance Carrier OBoth					
CEmployer	Insurance Carrier					
⊖Employer ( Defendant(s) do(es) not waive						
CEmployer ( Defendant(s) do(es) not waive of law and the Rules of Practic	Insurance Carrier Both the right to raise additional issues in accordance with the provisions					
⊖Employer ( Defendant(s) do(es) not waive	<ul> <li>Insurance Carrier</li> <li>Both</li> <li>the right to raise additional issues in accordance with the provisions ce and Procedure if other issues develop.</li> </ul>					
Cemployer ( Defendant(s) do(es) not waive of law and the Rules of Practic Dated: 10/11/2019	<ul> <li>Insurance Carrier</li> <li>Both</li> <li>the right to raise additional issues in accordance with the provisions ce and Procedure if other issues develop.</li> </ul>					
Employer ( Defendant(s) do(es) not waive of law and the Rules of Practic Dated: 10/11/2019 Date (MM/DD/	Insurance Carrier Both The right to raise additional issues in accordance with the provisions be and Procedure if other issues develop.					
Cemployer ( Defendant(s) do(es) not waive of law and the Rules of Practic Dated: 10/11/2019 Date (MM/DD/ S DANIEL HAWKES	Insurance Carrier Both the right to raise additional issues in accordance with the provisions be and Procedure if other issues develop. (YYY) Phone Number 6195439960					
Cemployer ( Defendant(s) do(es) not waive of law and the Rules of Practic Dated: 10/11/2019 Date (MM/DD/ S DANIEL HAWKES Signature	Insurance Carrier Both the right to raise additional issues in accordance with the provisions be and Procedure if other issues develop. (YYY) Phone Number 6195439960					
Cemployer ( Defendant(s) do(es) not waive of law and the Rules of Practic Dated: 10/11/2019 Date (MM/DD/ S DANIEL HAWKES Signature	Insurance Carrier Both the right to raise additional issues in accordance with the provisions ce and Procedure if other issues develop. YYYY) Phone Number 6195439960 N DIEGO					
Cemployer ( Defendant(s) do(es) not waive of law and the Rules of Practic Dated: 10/11/2019 Date (MM/DD/ S DANIEL HAWKES Signature Firm Name TESTAN LAW SAM Address/PO Box	Insurance Carrier Both the right to raise additional issues in accordance with the provisions be and Procedure if other issues develop. (YYYY) Phone Number 6195439960 N DIEGO 7676 HAZARD CENTER DRIVE SUITE 500					

RE: Williams, Kevin v. Walmart Inc. WCAB CASE NO.: ADJ12524635; ADJ12524618

### VERIFICATION

State of California, County of San Diego -- ss.

I, the undersigned say:

I am one of the attorneys for the Petitioner in the above entitled action. I have read the Answer to Application for Adjudication of Claim and know the contents thereof; and I certify that the same is true of my knowledge, except as to those matters which are therein stated upon my information and belief, and as to those matters I believe to be true.

I declare under penalty of perjury under the law of the State of California that the foregoing is true and correct. Executed on October 11, 2019 at San Diego, California.

mar Man

Daniel Hawkes Attorney for Defendants

#### ATB000061

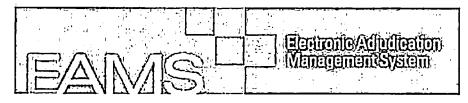
Ï	Ĩ.
1	TESTAN LAW SAN DIEGO 4970955
2	6195439960
3	angelolimpin@atblaw.net
	PROOF OF SERVICE
4	STATE OF CALIFORNIA, COUNTY OF SAN DIEGO
5	I am employed in the County of San Diego, State of California. I am over the age of 18, and
6	not a party to the within action. My business address: Testan Law, 7676 Hazard Center DR STE
7	500, San Diego, CA 92108.
8	On October 11, 2019, I served the foregoing document(s) on the case of Williams, Kevin v. Walmart Inc./WCAB Case No. ADJ12524635; ADJ12524618/Claim No. 8949558; 8949567
9	described as:
10	Answer to Application for Adjudication of Claim
11	on the interested parties in this action by placing the original or a true copy thereof enclosed in a
12	sealed envelope addressed as follows:
13	[X] BY ELECTRONIC TRANSMISSION I transmitted a PDF version of this document by electronic mail to the WCAB through EAMS.
	Workers' Compensation Appeals Board
14	1065 N Pacificenter DR STE 170 & 200 Anaheim, CA 92806
15	
16	Christine Leonard York Risk Services Group, Inc.
17	PO Box 14731 Lexington, KY 40512
18	
19	Law Offices of Natalia Foley 8306 Wilshire BLVD STE 115 Beverly Hills, CA 90211
20	
21	I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with U.S. Postal Service on that same day
22	with postage thereon fully prepaid at San Diego, California in the ordinary course of business. I am aware that on motion of party served, service is presumed invalid if postal cancellation date or
23	postage meter date is more than one day after date of deposit for mailing affidavit.
24	I declare under penalty of perjury under the laws of the State of California that the above is
25	true and correct.
26	Executed on October 11, 2019, at San Diego, CA.
27	Ali
28	Angelo Limpin
	- 
	ATB000062

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LEGAL DOCS	PROOF OF SERVICE	C:\fakepath\Williams POS_001.pdf	Delete	

Done

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

Batch ID: 31928008 Date: 10/11/2019 01:46:10 PM

OK

## STATE OF CALIFORNIA DWC DISTRICT OFFICE E-COVER SHEET

Companion Cases Ex			ocation*: CTL
More than 15 Compa	nion Cases	Walk Thru	Yes 🔿 No 💿
Date: ( MM/DD/YYYY)	10/11/2019		
Case Number*:	ADJ12524635	SSN(Numbers Only)	
O Specific Injury	(If Specific Injury, use the start da	te as the specific date of injury)	
OCumulative 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 :			
Please check unit to be	e filed on ( check only one bo	)*	
ADJ O DEL		EF SAU ()	INT () RSU
Companion Cases			
Case 1:		1	
OSpecific Injury	(If Specific Injury, use the start da	te as the specific date of injury)	
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Body Part 1 :		Body Part 2	
Body Part 3 :		Body Part 4	
Other Body Parts :	· [	, Anatani,≝, tatan tahan tahin ta 	
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Case 2:			
Case 2:	(If Specific Injury, use the start da	te as the specific date of injury)	
	(If Specific Injury, use the start da	te as the specific date of injury)	
OSpecific Injury			
O Specific Injury		(END DATE: MM/DD/YYYY)	 
OSpecific Injury OCumulative Injury Body Part 1 :		(END DATE: MM/DD/YYYY) Body Part 2 :	

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

<u> </u>		
Case Number:	ADJ12524635	
(Choose only one)		
a specific injury on		
na filo and	(MM/DD/YY)	YY)
⊠a cumulative trauma	a injury which began	
		(START DATE: MM/DD/YYYY)
	and ended	ON 03/15/2019 (END DATE: MM/DD/YYYY)
Name(s) of Answering	Party(ies) WALMA	RT ASSOCIATES INC
	· · · · · · · · · · · · · · · · · · ·	e leave blank spaces between names, numbers or words)
Injured Worker		
First Name*		
MI		
Last Name*	ľ	WILLIAMS
Employer Information		
Insured	Self-Insured	OLegally Uninsured
Employer Name WA		_
Employer Street Addre	ess/PO Box	6750 KIMBALL AVE
City	(	CHINO
State		CA
Zip Code (Numbers O	nly)!	91708
	mation (if applicable -	include even if carrier is adjusted by claims administrator)
Insurance Carrier Name	AMERICAN INSUR	
Insurance Carrier Stre	et Addr/PO Box	PO BOX 14731
City		LEXINGTON
State		KY
Zip Code (Numbers O	nly)	40512

Claims Administrator Information	(if applicable)
Claims Admin Name YORK EL	DORADO HILLS
Claims Admin Str Addr/PO Box	PO BOX 14731
City	LEXINGTON
State	KY
Zip Code (Numbers Only)	40512
	ny the allegations of the application as indicated below with such h and admit all other material allegations.
☐ Occupation	Field size limited to 129 characters
⊠Injury	Field size limited to 85 characters (IF DENIAL IS BASED ON DATE OR PART OF BODY INJURED, EXPLAIN FULLY)
⊠Insurance Coverage	Field size limited to 84 characters (STATE IF EMPLOYER HAS BEEN NOTIFIED TO APPEAR AND DEFEND)

Liability for self-procured	
[™] treatment	
	Field size limited to 129 characters
Liability for future medical	
Lutreatment	
	Field size limited to 129 characters
Medical Legal Costs	
	1
	Field size limited to 129 characters
P	
Earnings	ACCORDING TO PROOF
	Field size limited to 129 characters
Periods of Disability	MARCH 15, 2019
	Field size limited to 84 characters
	(GIVE LAST DAY WORKED AND CORRECT DATE OF RETURN TO WORK).
Rehabilitation	
•	
	Field size limited to 129 characters
Supplemental Job	
displacement / return to	
work	
	Field size limited to 129 characters
	APPORTIONMENT
Kali anna ian ana ann	
	Field size limited to 126 characters
	(IF APPORTIONMENT IS CLAIMED, SO STATE)

IT IS FURTHER ALLEGED
1. Defendants have paid disability indemnity in the total amount of \$ 0         at the rate of \$ 466.67
a week beginning through MM/DD/YYYY
plus
2. Affirmative defenses and other matters : (Field size limited to 448 characters)
ALL DEFENSES UNDER THE LABOR CODE, INSURANCE CODE, CIVIL CODE AND CODE OF CIVIL PROCEDURE'S, POST-TERMINATION NOTICE OF INJURY.
The Answer to this Application is being filed on behalf of ( Please check one only ) OEmployer OInsurance Carrier OBoth Defendant(s) do(es) not waive the right to raise additional issues in accordance with the provisions
OEmployer OInsurance Carrier OBoth
<ul> <li>Employer Insurance Carrier</li> <li>Defendant(s) do(es) not waive the right to raise additional issues in accordance with the provisions</li> </ul>
<ul> <li>Employer Insurance Carrier OBoth</li> <li>Defendant(s) do(es) not waive the right to raise additional issues in accordance with the provisions of law and the Rules of Practice and Procedure if other issues develop.</li> </ul>
Employer       Insurance Carrier       Both         Defendant(s) do(es) not waive the right to raise additional issues in accordance with the provisions of law and the Rules of Practice and Procedure if other issues develop.         Dated:       10/11/2019
OEmployer       Insurance Carrier       OBoth         Defendant(s) do(es) not waive the right to raise additional issues in accordance with the provisions of law and the Rules of Practice and Procedure if other issues develop.         Dated:       10/11/2019         Date (MM/DD/YYYY)
OEmployer       Insurance Carrier       OBoth         Defendant(s) do(es) not waive the right to raise additional issues in accordance with the provisions of law and the Rules of Practice and Procedure if other issues develop.         Dated:       10/11/2019 Date (MM/DD/YYYY)         S DANIEL HAWKES       Phone Number       6195439960
○ Employer       ○ Insurance Carrier       ○ Both         Defendant(s) do(es) not waive the right to raise additional issues in accordance with the provisions of law and the Rules of Practice and Procedure if other issues develop.         Dated:       10/11/2019         Date (MM/DD/YYYY)         S DANIEL HAWKES       Phone Number         6195439960
OEmployer       Insurance Carrier       OBoth         Defendant(s) do(es) not waive the right to raise additional issues in accordance with the provisions of law and the Rules of Practice and Procedure if other issues develop.         Dated:       10/11/2019         Date (MM/DD/YYYY)       Date (MM/DD/YYYY)         S DANIEL HAWKES       Phone Number         Signature       Figure
OEmployer       Insurance Carrier       OBoth         Defendant(s) do(es) not waive the right to raise additional issues in accordance with the provisions of law and the Rules of Practice and Procedure if other issues develop.         Dated:       10/11/2019         Date (MM/DD/YYYY)       Date (MM/DD/YYYY)         S DANIEL HAWKES       Phone Number         6195439960       Signature         irm Name       TESTAN LAW SAN DIEGO         ddress/PO Box       7676 HAZARD CENTER DRIVE SUITE 500

RE: Williams, Kevin v. Walmart Inc. WCAB CASE NO.: ADJ12524635; ADJ12524618

## VERIFICATION

State of California, County of San Diego -- ss.

I, the undersigned say:

I am one of the attorneys for the Petitioner in the above entitled action. I have read the Answer to Application for Adjudication of Claim and know the contents thereof; and I certify that the same is true of my knowledge, except as to those matters which are therein stated upon my information and belief, and as to those matters I believe to be true.

I declare under penalty of perjury under the law of the State of California that the foregoing is true and correct. Executed on October 11, 2019 at San Diego, California.

i millen

Daniel Hawkes Attorney for Defendants

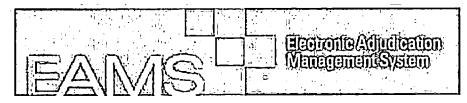
Ï		
1	TESTAN LAW SAN DIEGO	
2	4970955 6195439960	
3	angelolimpin@atblaw.net	
4	PROOF OF SERVICE	
5	STATE OF CALIFORNIA, COUNTY OF SAN DIEGO	
	I am employed in the County of San Diego, State of California. I am over the age of 18, and	
6	not a party to the within action. My business address: Testan Law, 7676 Hazard Center DR STE 500, San Diego, CA 92108.	
7		
.8	On October 11, 2019, I served the foregoing document(s) on the case of Williams, Kevin v. Walmart Inc./WCAB Case No. ADJ12524635; ADJ12524618/Claim No. 8949558; 8949567	
9	described as:	
10	Answer to Application for Adjudication of Claim	
11	on the interested parties in this action by placing the original or a true copy thereof enclosed in a	
12	sealed envelope addressed as follows:	
13	[X] BY ELECTRONIC TRANSMISSION I transmitted a PDF version of this document by electronic mail to the WCAB through EAMS.	
	Workers' Compensation Appeals Board	
14	1065 N Pacificenter DR STE 170 & 200 Anaheim, CA 92806	
15		
16	Christine Leonard York Risk Services Group, Inc.	
17	PO Box 14731 Lexington, KY 40512	
18	Law Offices of Natalia Foley	
19	8306 Wilshire BLVD STE 115 Beverly Hills, CA 90211	
20		
21	I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with U.S. Postal Service on that same day	
22	with postage thereon fully prepaid at San Diego, California in the ordinary course of business. I	
	am aware that on motion of party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing affidavit.	
23		'
24	I declare under penalty of perjury under the laws of the State of California that the above is true and correct.	
25		
26	Executed on October 11, 2019, at San Diego, CA.	
27	10th	
28	AngeloLimpin	
	-1	
	ATB000071	Į

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Document Type*:	select V		
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<b>Document Type</b>	Document Title	File Name	·
LEGAL DOCS	10770.6 VERIFICATION	C:\fakepath\Williams VERI_001.pdf	Delete
LEGAL DOCS	PROOF OF SERVICE	C:\fakepath\Williams POS_001.pdf	Delete

Done



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

Batch ID: 31927957 Date: 10/11/2019 01:42:45 PM

OK

# STATE OF CALIFORNIA Division of Workers' Compensation Workers' Compensation Appeals Board

## **KEVIN WILLIAMS**,

Applicant,

vs.

## WAL-MART ASSOCIATES INC; YORK EL DORADO HILLS;

Defendants.

WCAB Case No. ADJ12524618; ADJ12524635

ANAHEIM DISTRICT OFFICE

JOINT ORDER GRANTING CHANGE OF VENUE – Labor Code section 5501.5

## **VENUE TRANSFER:**

Pursuant to Defendant's Petition for Change of Venue and objection to venue in Anaheim was filed within 30 days of service of the Notice of Applications pursuant to Labor Code section 5501.5 (c),

## **GOOD CAUSE APPEARING:**

IT IS HEREBY ORDERED that the above-entitled cases be transferred to the Worker's Compensation Appeals Board Office in San Bernardino.

June of

Jamie Spitzer PRESIDING WORKERS' COMPENSATION JUDGE

SERVICE:

DATE: 11/06/2019

KEVIN WILLIAMS- 2070 AVENIDA HACIENDA, CHINO, CA 91709, US Mail NATALIA FOLEY BEVERLY HILLS- nfoleylaw@gmail.com, Email TESTAN LAW SAN DIEGO- SANDIEGO@BTNLAW.NET, Email

ON: 11/06/2019 BY: L. NGO

## STATE OF CALIFORNIA DIVISION OF WORKERS' COMPENSATION WORKERS' COMPENSATION APPEALS BOARD

WALK THROUGH APPEARANCE SHEET Keun Williams ADJ 12 52 4635 A0512524618 Efiler: Yes No Case set for hearing: Yes + No Applicant, Walk through document: C&R _____STIP_WITH AWARD 5710 DEPOSITION ATTORNEY'S FEES Walmart Inc PETITION TO COMPEL ATTENDANCE AT MEDICAL EVALUATION/DEPO + PETITION FOR STAY ORDER-PJ ONLY Defendants. **APPEARANCES** NOT PRESENT APPLICANT PRESENT HEARING REP. APPLICANT REPRESENTED BY ATTORNEY DEFENDANT REPRESENTED BY Testan Can Daniel HEARING REP. DATTORNEY ATTORNEY HEARING REP. OTHERS APPEARING INTERPRETER **CERTIFICATION NO** DISPOSITION: DOTOC ORDER SUSPENDING ACTION ON CARISTIPS DECAR) STIPS APPRI HOMICA ORDER(s)/COMMENT(s); (YME PETITION APPROVED: 5710 PETITION TO COMPEL ATTENDANCE AT MEDICAL EVALUATION/DEPO PETITION FOR STAY ORDER 30 DAYS TO SUBMIT REQUESTED DOC. PETITION DISAPPROVED. SET FOR STATUS CONF. Date: Time: Judge: DATE: WORKERS' COMPENSATION JUDGE Wersuant to Rule 10500, you are designated to serve this/ these document(s) on all Interested parties including all NOTICE TO: lien claimants. [] Served on parties and lien claimants present By ( Date // FOR WCAB USE ONLY: JUDGE ASSIGNED RECEIVED NOV 1 8 2019 DWC SAN BERNARDINO

## STATE OF CALIFORNIA **DIVISION OF WORKERS' COMPENSATION** WORKERS' COMPENSATION APPEALS BOARD

Kevin Williams

Applicant,

vš.

Walmart Inc; Ace American Insumnie Co Defendant(s).

Case No(s). ADJ12524635 A 0 J 12 02 4618 A 0 J 12 7 434 30

San Bernardino District Office

## ORDER APPROVING COMPROMISE AND RELEASE

The parties to the above-entitled action have filed a Compromise and Release on  $\frac{12-18-2019}{12-18-2019}$  in the amount of 15,000 For the reasons set forth in the Compromise and Release, incorporated herein by reference, and \$ based upon review of the medical reports and other relevant documents, which are hereby received into evidence, this judge now finds that the settlement amount is adequate, is in the best interest of the parties, and should be approved.

The following provisions are applicable only if checked:

Death Benefits: The parties have considered the release of death benefits in reaching their agreement.

Carter/Rodgers Finding: The parties have considered and included the release of claims for injuries in vocational rehabilitation in their settlement.

- A Injury AOE/COE is seriously in issue as to A all body parts alleged I the following body parts:

based on A dispute of law and fact □ statute of limitations I medical opinions of □ witness(es) The parties have considered and included the release of any F-Labor Code Section 132a claim(s) - serious & willful misconduct allegations (per Labor Code Section 4551 and/or 4553).

This agreement includes settlement of any claim for a Supplemental Job Displacement Benefit voucher.

## THE COMPROMISE AND RELEASE IS ORDERED APPROVED.

AWARD IS MADE according to the terms of the Compromise and Release, with the following provisions: Attorney's fees per the Compromise & Release are ordered:

$\Box$ paid in the amount of			F N-Jalin	E.I.
□ paid in the amount of	\$	to Law Offices	J Natalia	
🗆 paid \$	to	and \$	to	per fee agreement.
The amount of \$	is ordere	d withheld from the sett	lement by defendan	t until resolution of fee dispute between

mount of is ordered withheld from the settlement by defendant until resolution of fee dispute  $\Box$  applicant's current & former attorney(s)  $\Box$  applicant & prior attorney(s)  $\Box$  and further order of the court. All liens listed on the OAR as of this date have been resolved, per defendant's affidavit, withdrawn or dismissed by the judge. There remain unresolved liens. D Any party/lien claimant may request a conf. by filing a Declaration of Readiness to Proceed. Defendant is ordered to comply with 8 CCR 10608(f) without violating LC 4903.6(d). Specifically, non-physician lien claimants are not entitled to medical information about an injured worker without prior written approval of the appeals board detailing what info is to be provided and a finding that such info is relevant to the proof of the matter for which it is sought. Lien claimants are now a parties per Rule 10205(aa)(5) & are required to appear at all future hearings per Rule 10770.1(e).

I There are no liens of record in the Board's system as of this date. I The lien of the EDD has been resolved. If Depo fee of \$900.00 to be paid by \$ 10 AA outside of settlement.

Dated at San Bernardino, California: 11/18 □ Filed and served by mail on all parties on the Official Address Record.

documents within five (5) days on all parties as shown on the Official Address Record. Proof of svc. to be filed only if requested by WCAB. Date: 11/18/19 By: MAPS

**MYRLE R, PETTY** Workers' Compensation Administrative Law Judge

ATB000076

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			/C DISTRIC		ET		
Is this a new case?	Yes	No 🗸 C	ompanion Cases	Exist	Walkthroug	h Yes	VNO
More than 15 Com	panion Cases						
11/18/2019 Date:(MM/DD/YYY	Y)	Specif	īc Injury		SSN:	e <del></del>	
ADJ12524618 Case Number 1		Cumul		09/2018 irt Date: MM/DD/YY (If Specific Injury, 1			e: MM/DD/YYY
Body Part 1:			<u></u>		Bödy Part 3:		
Body Part 2:					Body Part 4:		
Other Body Parts:		<del></del>	<u> </u>		<u></u>		
lease check unit to	be filed on ( c	heck only one	box )				
ADJ [	DEU	SIF		SAU		NT	RSU
ompanion Cases	2	Specif	ic Injury	*****			
ADJ12524635 Case Number 2	,	Cumul	ative Injury (Star	)1/2018 rt Date: MM/DD/YY If Specific Injury, us			: MM/DD/YYY
Body Part 15					Body Part 3:	<u> </u>	
Body Part 2:		<u> </u>			Body Part 4:		
Other Body Parts:							İ

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A OJ 1274 343c UNASSIGNED Case Number 3	Specific Injury	01/22/2019 (Start Date: MM/DD/YYYY) (If Specific Injury, use the start date a	(End Date: MM/DD/YYYY) s the specific date of injury)
Body Part 1: 420		Body Part 3:	·
Body Part 2:	·	Body Part 4:	<u> </u>
Other Body Parts:			
Case Number 4	Specific Injury	(Start Date: MM/DD/YYYY) (If Specific Injury, use the start da	(End Date: MM/DD/YYYY)
Body Part 1:		Body Part 3:	:
Body Part 2:		Body Part 4:	<u></u>
Other Body Parts:		<del></del>	
:	Specific Injury		
Case Number 5	Cumulative Injury	(Start Date: MM/DD/YYYY) (If Specific Injury, use the start da	(End Date: MM/DD/YYYY) te as the specific date of injury)
Body Part 1:		Body Part 3:	
Body Part 2:		Body Part 4:	
Other Body Parts:		···;	
DWC-CA form 10232.1 Rev. 11/2017-	Page 2 of 8	,	
1	ATB0	00078	

DOCUMENT SEPARATOR SHEET	

Product Delivery Unit	ADJ	
Document Type	LEGAL DOCS	
Document Title COMPROMISE AN	D RELEASE	
Document Date	11/13/2019 MM/DD/YYYY	
Author	TESTAN LAW SAN DIEGO	
· · · · · · · · · · · · · · · · · · ·	Office Use Only	;
Received Date	MM/DD/YYYY	



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

ADJ12524635 Case Number 1	Case Number 4		<u></u> ,
ADJ12524618 Case Number 2	Case Number 5		
Case Number 3	551-47-568 SSN (Numbers Only)	80	<u> </u>
Venue Choice is based upon: (Complet	on of this section is required)		
County of residence of employee (Labo	or Code section 5501.5(a)(1) or (d).)		
County where injury occ irred (Labor C	ode section 5501.5(a)(2) or (d).)		
County of principal place of business o	f employee's attorney (Labor Code section 55	501.5(a)(3) c	or (d).)
SBR			
	e of Hearing (From Document Cover Sheet)		
Employee(Completion of this section is			
KEVIN			
First Name	·	MI	RECEIVED
WILLIAMS			I Know York Gana 5 17 June Bart
Last Name			NOV 1 8 2019
2070 AVENIDA HACIENDA			DWC SAN BERNARDINO
Address/PO Box (Please leave blank spac	es between numbers, names or words)		
CHINO HILLS		CA.	91709
City		State	Zlp Code
Employer Information (Completion of the Insured Self-Insured		Unii	nsured
WALMART INC.			-
Employer Name (Please leave blank space	es between numbers, names or words)		
6750 KIMBALL AVE			
Employer Street Address/PD Box (Please	leave blank spaces between numbers, name	s or words)	
CHINO		CA	91708
City		State	Zip Code
DWC-CA form 10214 (c) (Rev. 11/2008) (Page 1 of 9)			·
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pplicant's Attorney or Authorized Representative:		
Law Firm/Attorney		
NATALIA	<u> </u>	
First Name		
FOLEY	;	
Last Name	•	
j		
Law Firm Number		
LAW OFFICES OF NATALIA FOLEY		· · · · · · · · · · · · · · · · · · ·
Law Firm Name		`
8018 E SANTA ANA CYN RD STE 100-215		
Address/PO Box (Please leave blank spaces between numbers, names or words)		
ANAHEIM	CA	92808
City	State	Zip Code
Defendant's Attorney or Authorized Representative:	·	
Law Firm/Attorney		
DANIEL		
First Name	:	
HAWKES		
Last Name 4970955	_ ^	
Law Firm Number		
TESTAN LAW		;
Law Firm Name	-	
7676 HAZARD CENTER DR STE 500		
Address/PO Box (Please leave blank spaces between numbers, names or words)	·	
SAN DEGO	CA	92108
City	<u>State</u>	Zip Code
nsurance Carrier Information (if known and if applicable - include even if carr	ier is adjusted by	ciaims administrator)
ACE AMERICAN INSURANCE CO.		
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)		_
PO Box 14731		
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, na	imes or words)	
1 mars 1	14.1	Varia
City	- <u>Stata</u>	YUS12
	Sidle	
WC-CA form 10214 (c) (Rev. 11/2008) (Page 2 of 9)		

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Claims Administrator Information (if known and if applicabl	le) .
YORK RISK SERVICES GROUP, INC.	
Name (Please leave blank spaces between numbers, names or words	s)
PO BOX 14731	
Street Address/PO Box (Please leave blank spaces between numbers	s, names or words)
LEXINGTON	KY 40512 State Zip Code
IT IS CLAIMED THAT:	- f
1. The injured employee, born 02/17/1964	, alleges that while employed as a(n)
	, sustained injury
OCCUPATION AT THE TIME	
arising out of and in the course of employment at the locations a	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	and the second second second second second second second second second second second second second second second
	10/01/2018         63/15/2019           (Start Date: MM/DD/YYYY)         (End Date: MM/DD/YYYY)
	(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY) Specific Injury, use the start date as the specific date of injury)
. (0.	Specific lightly, ase the start date as the specific date of lightly)
Body Part 1: 841 Body Part 2:	Body Part 3:
та на македи и село с <u>о со /u>	
Body Part 4: Other Body Parts:	
The injury occurred at 702 SW St St (Street Address/PO Box - Please leave	blank spaces between numbers names or words
- 1	
Bentonville, <u>AR</u> City State	
City State Body parts, conditions and systems may not be_inco	

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	Specific Injury	·
ADJ12524618		09/09/2018 03720/2019
Case Number 2	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: 200	Body Part 2:	300 Body Part 3: 420
Body Part 4: Y50		ts:500
The injury occurred at	02 SW 8th	SH- leave blank spaces between numbers, names or words)
	(Street Address/FO Box - Flease	reave blank spaces between numbers, names of words)
Dentonuille	, <u>A</u>	<u>K</u> 72778
Body parts, conditio	ns and systems may not be	e incorporated by reference to medical reports.
	Specific Injury	
AUJ 12743430		0//22/2019
Case Number 3	Cumulative Injury	(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
	4	(If Specific Injury, use the start date as the specific date of injury)
Body Part 1: 7 20	Body Part 2:	Body Part 3:
30dy Part 4:	Other Body Part	s:
The injury occurred at	2 5w 8th 8	57 leave blank spaces between numbers, names or words)
Bentonville	<u>A</u>	$\frac{1}{7276}$
City		
Body parts, con litic		e incorporated by reference to medical reports.
,	Specific Injury	
Case Number 4	Cumulative Injury	(Start 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 Part	s;
	• · · ·	
The injury occurred at		leave blank spaces between numbers, names or words)
	(Street Address/PO Box - Please	leave blank spaces between numbers, names or words)
•		
City	, Sta	ate Zip.Code

•

	Specific Injury			
Case Number 5	Cumulative In	ury (Start L (If Specifi	Date: MM/DD/YYYY) c Injury, use the start date as the sp	(End Date: MM/DD/YYYY) ecific date of injury)
Body Part 1:	Body Part	2:	Body Part 3:	
Body Part 4:	Other Boo	y Parts:	<del></del>	
The injury occurred at	(Street Address/PO Box -	Please leave blank s	spaces between numbers, names or wo	ords)
	ity - ditions and systems may n		Zip Code ed by reference to medical repo	rts.
administrative law judge a discharges the above-nar or ascertained or which m liability of the employer(s) representatives, administr the scope of the workers'	and payment in accordance ned employer(s) and insur- ay hereafter arise or devel- and the insurance carrier(s ators or assigns of the emp	with the provisio ince carrier(s) fro op as a result of t s) and each of the ployee. Execution s that are not sub	npensation Appeals Board or a ns hereof, the employee releas of all claims and causes of action the above-referenced injury(ies em to the dependents, heirs, ex n of this form has no effect on co oject to the exclusivity provision	es and forever on, whether now known ), including any and all ecutors, laims that are not within
Paragraph No. 1 and furth any addendum. 4. Unless otherwise expre DEPENDENTS TO DEAT AGREEMENT. The partie	ner explained in Paragraph essiy stated, approval of this H BENEFITS RELATING 7 s have considered the relea	No. 9 despite an s agreement REL TO THE INJURY ase of these ben	s, or systems and for the dates y language to the contrary else EASES ANY AND ALL CLAIM OR INJURIES COVERED BY efits in arriving at the sum in Pa C 369 is unnecessary and shall	where in this document or S OF APPLICANT'S THIS COMPROMISE ragraph 7. Any addendum
5. Unless otherwise expre administrative law judge,	essiv ordered by the Worke	rs' Compensatior does not release	Appeals Board or a workers' c any claim applicant may have	ompensation
6. The parties represent the Paragraph No. 9.)			lisputed, state what each party	contends under
EARNINGS AT TIME OF	INJURY\$ 700	כ		
TEMPORARY DISABILIT		Ø	Weekly Rate \$	466.67
Period(s) Paid(Star	t Date: MM/DD/YYYY)	(End Date: I	MM/DD/YYYY)	
PERMANENT DISABILI		&	Weekly Rate \$	290.00
Period(s) Paid(s	Stari Date: MM/DD/YYYY)	End date	(End Date: MM/DD/YYYY)	
TOTAL MEDICAL BILLS PA	ND\$ 1843.42	Total Unpaid I	Medical Expense to be Paid By	Defendant
Unless otherwise specifie	d herein, the employer will	oay no medical e	xpenses incurred after approva	l of this agreement,
DWC-CA form 10214 (c) (Rev. 1	1/2008) (Page 5 of 9)	·		·

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7. The parties agree to settle the above claim(s) on account of the injury(ies) by the payment of the SUM OF 15,000,00. \$ tilement 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 requested as applicant's attorney's fee. LEAVING A BALANCE OF \$  $\frac{12,750}{24}$ , 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 for h 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): Defendant will pay, adjust, linguts or other wise resolve all valid liens of neard with the exception of any child support or Spoussal support liens, such liens remain the sole responsibility of the applicant. Defendant will pay appliant attorneys LC 5710 deputre for the 11-13-19 deputent attorneys LC 5710 deputre for the . }

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

A	pplicant	Detendant	
	KEN	017	earnings
-	KEW	017	temporary disability
ł	ÉW	DH	jurisdiction
]	KEW	PH	apportionment
k	EW	DH	employment
K	ÉN	DH	injury AOE/COE
K	EN	DH	sericus and willful misconduct
	AN	DH	disc imination (Labor Code §132a)
k	ÉW	OU	statute of limitations
	KEN	D	future medical treatment
Ł	EW	DH	other Macked Mileorge/out of nucket exprass
Ì	(EW	DH	pern anent disability
Ł	EN	DH	self-procured medical treatment, except as provided in Paragraph 7
}	(EIV)	014	vocational rehabilitation benefits/supplemental job displacement benefits
	OMMEN	TS:	
	E, the	r party	may appear ex parte for the purpose of obtaining approved of
			neul Penalhes and interest warred if payment is made
	With	NIL 30	days of OACR, Case is denied, post termination notice of
	Injur	Υ.	
	Se	e adden	dumi A gr B.

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.

V	Vitness the signature hereof this	13 day of NOVELUE	Lel, 2019 an Kell	laudes Ch
	Alicia Torce	11/13/2019	1 Adde	= 11/13/19
<u>نينې</u>	Witness 1 Witness 2	(Date)	Applicant (Employee) KEVIN WILLIAMS Attorney for Applicant NATALEX FOLEY-ESO	(Date) <u>11/13/19</u> (Date) 11-19-11
-	Interpreter	(Date)	Attorney for Defendant	(Date)
			Attorney for Defendant	(Date)
			Attorney for Defendant	(Date)

Attorney for Defendant

(Date)

	AC	KNOWLE	DGMENT
State of California County of		)	
On	dّď	efore me,	(insert name and title of the officer)
subscribed to the wi his/her/their authoriz	n the basis of sat thin instrument a zed capacity(ies),	nd acknowled and that by h	ence to be the person(s) whose name(s) is/are ged to me that he/she/they executed the same in is/her/their signature(s) on the instrument the
person(s), or the en	tity upon behalf o	f which the pe	erson(s) acted, executed the instrument.
	LTY OF PERJU	· · · · · · · · · · ·	
I certify under PENA	LTY OF PERJUR d correct.	· · · · · · · · · · ·	erson(s) acted, executed the instrument.

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## ADDENDUM TO COMPROMISE AND RELEASE

#### 12. ADDITIONAL SETTLEMENT PROVISIONS

Applicant warrants and represents, and the parties stipulate, that Applicant did not sustain any compensable injury as a result of Applicant's employment by defendant other than the alleged injuries listed in this Compromise and Release, and that as a result of said alleged injuries Applicant did not sustain injury to any body part, system, or condition not listed in this Compromise and Release.

Defendant shall be responsible for only unpaid medical expense incurred through the date of Applicant's execution of this Compromise and Release and only as specified in paragraph 8. Applicant shall be responsible for all medical expense incurred after the date of Applicant's execution of this Compromise and Release.

Applicant warrants and represents that Applicant is not eligible for Social Security or Medicare benefits, has not applied for Social Security benefits, and does not intend to apply for Social Security benefits at any time within the next 30 months.

It is not the intention of Defendant to shift liability for future medical treatment to the Federal Government. The parties have considered the interests of Medicare; Applicant accepts full and sole liability for dealing with and satisfying any future claims by Medicare out of the proceeds of this settlement. Neither Applicant's Attorney nor Defendant will have any obligation to respond to or reimburse Medicare for any benefit deemed received by Applicant.

All permanent disability advances, including any not listed in paragraph 7, are to be deducted from the settlement amount.

Any and all claims and petitions alleging violation of Labor Code section 132a and/or 4553 by defendant employer are herewith dismissed with prejudice. The parties stipulate that defendant employer has not violated Labor Code sections 132a or 4553.

This settlement includes all claims for interest pursuant to Labor Code section 5800, penalties pursuant to Labor Code sections 4650 and 5814, Attorney's fees pursuant to Labor Code sections 4607 and 5814.5, and costs, attorney's fees and sanctions pursuant to Labor Code section 5813, from the date(s) of injury herein through the 30th day after service of the Order Approving Compromise and Release.

Provided that the defendant employer maintains a medical provide network, the following is hereby stipulated to by the applicant: The defendant has complied with all statutes and regulations regarding the medical provider network; the defendant has had at all times since the date(s) of injury the right to medical provider network control; the defendant provided all required medical provider network notices to the applicant on a timely basis; and, the applicant received ail required medical provider network notices on a timely basis.

The defendant disputes all medical bills and lien claims relating to treatment provided by any person or entity not within the medical provider network. The defendant reserves the right to litigate the issue of reasonableness and necessity of all costs, treatment, and services procured outside the medical provider network, and the defendant expressly reserves to itself all statutory and regulatory defenses, whether expressly or implicitly set forth in the Labor Code and all applicable regulatory sections.

DATED: DATED: 1

Williams, APPLICAN

Natalia Foley, Est ATTORNEY FOR APPLICANT

RECEIVED

NUY 1 8 2019 DWC SAN BERNARDINO

Addendon B

. Employee: Employer: Claim Number: Date of Injury:

RE:

Kevin Williams Walmart Inc. 8949558; 8949567 10/01/2018 - 03/15/2019; 09/09/2018 - 03/20/2019

## AFFIDAVIT OF WAIVER OF OME PROCESS

I, Kevin Williams, was advised in writing on that I have the right to disagree with my primary treating physician's findings and conclusions, and be afforded the opportunity to request a comprehensive medical evaluation from a physician selected from a panel of Qualified Medical Evaluator's assigned by the Division of Worker's Compensation Medical Unit

I have-read-the-report-by-my-treating-physician, -dated -, and agree with the doctor's history, examination and description of my-condition. I choose to settle my case basedupon the findings of and not exercise my right to a qualified medical evaluation, from a physician selected from a panel.

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mployee Signature

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NOV 1 8 2019

DWC SAN BERNARDINO

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# STATE OF CALIFORNIA WORKERS' COMPENSATION APPEALS BOARD

Kevin Williams	Case No.
Applicant, v.	AFFIDAVIT OF DEFENDANT RE: RESOLUTION OF LIENS
Walmart Inc; Ace American	
Msurance Co.	
Defendants.	
I. Daniel Hawkes	, an the attorney or representativ
for defendant Ace American Insuran	a Co
	fforts to resolve each of the liens in this case.
List ALL lien claims below, use supplemental	pages as necessary.
	TURE & DATE RESULT
LIEN CLAIMANT NAT OF LIEN	
LIEN CLAIMANT NAT	TURE & DATE RESULT
LIEN CLAIMANT NAT OF LIEN	TURE & DATE RESULT
<u>LIEN CLAIMANT</u> <u>OF LIEN</u> <u>OF LIEN</u> <u>No Know Lien</u> Claimant	TURE & DATE RESULT
<u>LIEN CLAIMANT</u> <u>NAT</u> OF LIEN No Know Lien Claimants	TURE & DATE RESULT
<u>LIEN CLAIMANT</u> <u>NAT</u> OF LIEN No Know Lien Claimants	TURE & DATE RESULT
<u>LIEN CLAIMANT</u> <u>NAT</u> OF LIEN No Know Lien Claimants	TURE & DATE RESULT

was executed at San Diego California on <u>11 1 5 1 2019</u>

# RECEIVED

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SHAREHU []n-: J@ FJ

## STATE OF CALIFORNIA DIVISION OF WORKER'S COMPENSATION WORKER'S COMPENSATION APPEALS BOARD NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

Received by MAY 1 8 2020

Date of Original Lien:	05/11/2020				
ADJ Case Number:	ADJ12524635				
A specific injury on	(date):	<u> </u>			
A cumulative trauma injury beginning on (date):		(date): 10/01/2018	ending (date):	03/15/2019	
Social Security Number	•				
Date of Birth:					

Injured Worker	
First Name:	KEVIN
Middle Initial:	
Last Name:	WILLIAMS
Address / PO Box:	PROTECTED PER DWC POLICY
City:	CHINO
State:	CA
Zip Code:	91709
Address / PO Box: City: State:	PROTECTED PER DWC POLICY CHINO CA

## **Injured Worker's Attorney or Representative**

Name:	NATALIA FOLEY ANAHEIM
Address / PO Box:	5753 E SANTA ANA CANYON RD STE G 616
City:	ANAHEIM
State:	CA
Zip Code:	92807

## Lien Claimant

Organization Name:	PSYCHOLOGICAL ASSESSMENT LAGUNA NIGUEL
First Name:	
Last Name:	
Address / PO Box:	PO BOX 6299
City:	LAGUNA NIGUEL
State:	CA
Zip Code:	92607
Phone Number:	7149720040

EDEX INFORMATION SYSTEMS JACKSON EAMS UDQ JULIA BURNS USE 1-209-223-3461 ext. 100 ONLY SUPPORT@EDEXIS.COM

Filed On Behalf of: PSYCHOLOGICAL ASSESSMENT LAGUNA NIGUEL **Contact Person:** Nina Lofton 7149720040

# EDEXIS Proof of Service and Delivery Declaration

Employee: Williams, Kevin

Case Number(s): ADJ12524635

#### List of Documents Served, as Provided:

1/4: Original Bill ( Psychological Assessment Laguna Niguel, 05/11/2020, Id#:7516453 ) 2/4: Notice And Request For Allowance Of Lien ( Id#:7516454 ) 3/4: 10770.5 Verification ( Id#:7516455 )

4/4: 4903.8 (d) Declaration ( Id#:7516456 )

I hereby certify, I am at least 18 years of age and not a party to this action. I am a resident of, or employed in the county where the mailing took place. On the signature date below, a true copy of the document(s) listed above was served either by enclosing them in a sealed envelope addressed to each party named at the address(es) shown below, each envelope was placed for collection and mailing at the business address below with postage fully prepaid following established business practices; or served by other previously agreed upon method of electronic delivery, and there was no report of delay in the electronic transmission or physical mailing of the documents.

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

Business address for collection & mailing: 255 NEW YORK RANCH RD, JACKSON CA 95642

S CHARLES BOWEN 05/13/2020 Signature and Date:

TESTAN LAW SAN DIEGO % TESTAN LAW 31330 Oak Crest Dr Westlake Village CA 91361-4632 YORK EL DORADO HILLS % YORK RISK SERVICES PO Box 14731 Lexington KY 40512-4731

USPS 1 of 2 3569694471-0000077560 USPS 2 of 2 0971819207-000000840

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Testan Law San Diego Testan Law 31330 Oak Crest Dr Westlake Village Ca 91361-4632

For questions in regards to this mailing, please contact the sender at the top of this page.

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 Edexis Order ID
 1365154

 DWC Case #
 ADJ12524635

Pages 10 Packet Type LIEN form and attachments

## Lien Claimant's Attorney or Representative

Law Firm or Attorney	Non-Attorney Representative  Not Represented
Organization Name:	
First Name:	
Last Name:	
Address / PO Box:	
City:	
State:	
Zip Code:	
Phone Number:	
Employer	
Name:	WALMART INC
Address / PO Box:	6750 KIMBALL AVE
City:	CHINO
State:	CA
Zip Code:	91708
Insurance Carrier or Cl Name:	YORK EL DORADO HILLS
Address / PO Box:	PO BOX 14731
City:	LEXINGTON
State:	KY
Zip Code:	40512
A Martin Contragony Martin, C. C. S. C. Contragony and C. C. C. C. C. C. C. C. C. C. C. C. C.	
and the first of the second second second second second second second second second second second second second	carrier or Claims Administrator's Attorney or Representative
Name:	TESTAN LAW SAN DIEGO
Address / PO Box:	31330 OAK CREST DR
City:	WESTLAKE VILLAGE
State:	СА
Zip Code:	91361
Constrained and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second se Second second seco	91361

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of 1087.41 (Total Lien Amount) against any amount now due or which may hereafter become payable as compensation to the above-named employee on account of the above-claimed injury.

## This request and claim for lien is for:

- A reasonable attorney's fee for legal services pertaining to any claim for compensation either before the appeals board or before any of the appellate courts, and the reasonable disbursements in connection therewith. (Labor Code § 4903 (a).)
- The reasonable expense incurred by or on behalf of the injured employee, as provided by Labor Code § 4600. (Labor Code § 4903 (b).) (Provider Information section and Declaration pursuant to Labor Code § 4903.05(c) must be completed.)
- Claims of costs. (Labor Code § 4903.05) Specify nature and statutory basis in the box below.
- The reasonable value of the living expenses of an injured employee or of his or her dependents, subsequent to the injury. (Labor Code § 4903 (c).)
- The reasonable burial expenses of the deceased employee. (Labor Code § 4903 (d).)
- The reasonable living expenses of the spouse or minor children of the injured employee, or both, subsequent to the date of the injury, where the employee has deserted or is neglecting his or her family. (Labor Code § 4903 (e).)
- The amount of indemnification granted by the California Victims of Crime Program. (Labor Code § 4903 (i).)
- Other Lien(s): Specify nature and statutory basis.

## If a filing fee is not required, indicate the reason below:

- O This is not a lien filed under Labor Code section 4903 (b) and is not a claim of costs filed as a lien.
- O This lien is exempt from the filing fee under Labor Code section 4903.05 (d) (7).

## NOTE: ORIGINAL BILL AND ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

## Provider Information (Completion is required if filing a lien under Labor Code section 4903 (b).)

Rendering	Туре:	DWCPDT0013 PHYSICIAN	- MEDICAL TREATMEN	T			
Provider 1	Other Type:						
	Name:	PSYCHOLOGICAL ASSES	SYCHOLOGICAL ASSESSMENT LAGUNA NIGUEL				
	NPI:	1982895421	License or Cert Number	PSY12317			
Billing	Name:	PSYCHOLOGICAL ASSES	SSESSMENT LAGUNA NIGUEL				
Provider 1	NPI:	1982895421	Initial Date of Service:	11/11/2019			

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## Declaration pursuant to Labor Code section 4903.05(c).

(Completion is required if filing a lien under Labor Code section 4903 (b).)

I declare under penalty of perjury under the laws of the State of California that the Lien Claimant is a provider or proper assignee of the provider and the following is true and correct:

The dispute that is the subject of this lien is not subject to independent medical review and independent bill review; and

the	HAS DOCUMENTATION THAT MEDICAL TREATMENT HAS BEEN NEGLECTED OR UNREASONABLY REFUSED TO THE EMPLOYEE AS PROVIDED IN LC 4600.
Provider:	
L	

S ELIZABETH FLORES

05/11/2020

(Signature of Lien Claimant)

(Date of Signature)

A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

(Signature of Attorney/Representative for Lien Claimant)

S LESLEE IBARRA

(Signature of Lien Claimant)

05/11/2020

(Date of Signature)

05/11/2020 16:26:45

## CONTACT PERSON: CASE INFORMATION:

10770_5_A

EAMS

## ADJ12524635 / KEVIN WILLIAMS NINA LOFTON / 7149720040

EDEX INFORMATION SYSTEMS JACKSON FORM ID:

20200511162344 001365154

UDQ JULIA BURNS USE 1-209-223-3461 EXT 100 SUPPORT@EDEXIS.COM The party filing this form automatically generated these documents using the EDEXIS online EAMS service. EDEXIS is a DWC-approved Third-Party EAMS Filer. Learn more at EDEXIS.COM or call 1-209-223-3461

# **10770.5 LIEN FILING VERIFICATION**

I declare under penalty of perjury:

Under the laws of the State of California that one of the time periods set forth in Rule 10770.5(a) has elapsed, that the section 4903(b) lien, the lien for medical-legal costs, or the application is not being filed solely because of a dispute subject to the independent medical review and/or independent bill review process; and

If an application for adjudication is being filed:

That venue is proper as set forth in Rule 10770.5(b) and that I have made a diligent search and have determined that no adjudication case number exists for the same injured worker and the same date of injury. In determining that no adjudication case number exists for the same injured worker and the same date of injury, I have made a diligent search consisting of the following efforts listed below:

The following statement provided by the lien claimant or its representative specifies in
detail the facts establishing that one of the events in 10770.5(a) has occurred:

CARRIER BILLED AND NO PAYMENT RECEIVED

OFFICIAL SIGNATURE

S LESLEE IBARRA

LESLEE IBARRA

05/11/2020

#### **CONTACT PERSON:** NINA LOFTON / 7149720040 **CASE INFORMATION:** ADJ12524635 / KEVIN WILLIAMS

EDEX INFORMATION SYSTEMS JACKSON FORM ID: 20200511162344 001365154 EAMS The party filing this form automatically generated UDQ JULIA BURNS these documents using the EDEXIS online EAMS service. USE 1-209-223-3461 EXT 100 EDEXIS is a DWC-approved Third-Party EAMS Filer. ONLY SUPPORT@EDEXIS.COM Learn more at EDEXIS.COM or call 1-209-223-3461

## 4903.8(d) DECLARATION

I declare under penalty of perjury pursuant to the laws of the State of California the foregoing is true and correct:

(1) The services or products described in the bill for services or products were actually provided to the (1) The betters of products decenteed in the only for services of products were detainly provided to the injured employee.(2) The billing statement attached to the lien truly and accurately describes the services or products that

were provided to the injured employee.

**OFFICIAL SIGNATURE** 

S ELIZABETH FLORES

ELIZABETH FLORES

05/11/2020

AT	B0	00	101
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NUCC Instruction	i Manua	avaliable at www	.nucc.org	• ••••		
PENALTIES	AND	INTEREST	APPLY	AFTER	60	DAYS

	this hill is true and correct to	YORKWALMARTSAMS
that that	this bill is true and correct to the best of my knowledge.	PO BOX 14731
	C 5703 (a)(1)	LEXINGTON KY ADDE
HEALTH INSURANCE CLAIM FOR	M	LEXINGTON KY 1055 FILL - 1
RAPPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE INC	elson J. Flores, Ph.D., Q.M.E.	. (800) 339-1109 PIO
	CHAMPVA GROUP FECA OTHER HEALTH PLAN BLK LUNG (1000)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#) (Medicald#) (ID#/DoD#)	(Member ID#) HEALTH PLAN BLK LUNG (ID#) (ID#)	551-47-5680
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
WILLIAMS KEVIN	02 17 1964 My F	WALMART 7. INSURED'S ADDRESS (No., Street)
5. PATIENT'S ADDRESS (No., SIreet) 2070 AVENIDA HACIENDA	Self Spouse Child Other	702 S W 8TH STREET
	STATE 8. RESERVED FOR NUCC USE	CITY STATE
CHINO HILLS	CA	BENTOVILLE AR
ZIP CODE TELEPHONE (Include Area C	ode)	ZIP CODE     TELEPHONE (Include Area Code)       72716     ()
91709 <b>(9</b> 09 <b>)</b> 8428277	itial) 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
9. OTHER INSURED'S NAME (Last Name, First Name, Middle In WILLIAMS, KEVIN		ADJ1252463512524618
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
CL#:8949558		02 17 1964
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC) WALMART
02 17 1964		C. INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO	YORKWALMARTSAMS
WALMART d. INSURANCE PLAN NAME OF PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
SEDGWICK		YES NO If yes, complete items 9, 9a, and 9d. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
READ BACK OF FORM BEFORE CO		payment of medical benefits to the undersigned physician or supplier for services described below.
<ol> <li>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 au to process this claim. I also request payment of government ber below.</li> </ol>	refits either to myself of to the party who accepts assignment	38171253 025011060 00000.
SIGNED SIGNATURE ON FILE	DATE	SIGNED SIGNATURE ON FILE
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (L	MP) 15. OTHER DATE MM   DD   YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
I DO 15 JOID QUAL. TNUTURY	<u> </u>	FROM TO 1 18. HOSPITALIZATION DATES RELATED 10 CUMHENT SERVICES MM, DD, YY MM, DD, YY
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a, NP4 931 237 981	FROM TO YY
NELSON J FLORES PHDQME 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES
		YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate	A-L to service line below (24E) ICD Ind.	22. RESUBMISSION CODE ORIGINAL REF. NO.
а. <u>8.69</u> в. <u>L</u>	c. L D. L	23. PRIOR AUTHORIZATION NUMBER
E. L F. L	G. L H. L K. L L. L	
	D. PROCEDURES, SERVICES, OR SUPPLIES E.	F. G. H. I. J. DAYS EPSUT ID. RENDERING CR Family OUAL PROVIDER ID. #
From To PLACE OF MM DD YY MM DD YY SERVICE EMG	(Explain Unusual Circumstances) DIAGNOSIS CPT/HCPCS   MODIFIER POINTER	\$CHARGES UNITS Part QUAL PROVIDER ID. # 018 PSY12317
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		0B PSY12317
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3 11 11 19 11 11 19 11	96136 59 1	0B PSY12317
4 11 11 19 11 11 19 111	96137   59      1	126.34 2 NPI 183123798
5		NPI
6		
	ATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Us
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31. SIGNATURE OF PHYSICIAN OF SUPPLIER 32, S	ERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (714)972 0040
INCLUDING DEGREES OR CREDENTIALS PSY	CHOLOGICAL ASSESSMENT SERV	PSYCHOLOGICAL ASSESSMENT SERV
apply to this bill and are made a part thereof.) 434	4 LATHAM ST STE 120	PO BOX 6299
NELSON J. FLORES PH.D. RIV	VERSIDE CA 92501	LAGUNA NIGUEL, CA 92607-6299
SIGNED DATE a.	PLEASE PRINT OR TYPE	APPROVED OMB-0938-1197 FORM 1500 (02-1



Received By:

JUL 27 2020

Testan Law San Diego Testan Law 31330 Oak Crest Dr Westlake Village, Ca 91361-4632

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For questions in regards to this mailing, please contact the sender at the top of this page.

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 DWC Case #
 ADJ12524635

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Page 1 of 1

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EDEX INFORMATION SYSTEMS JACKSON JULIA BURNS 1-209-223-3461 ext. 100 SUPPORT@EDEXIS.COM

Filed On Behalf of: PSYCHOLOGICAL ASSESSMENT LAGUNA NIGUEL Contact Person: Claribel Valadez 7149720040

# **EDEXIS Proof of Service and Delivery Declaration**

Employee: Williams, Kevin

Case Number(s): ADJ12524635

#### List of Documents Served, as Provided:

1/2: Declaration Of Readiness To Proceed ( Id#:7564412 ) 2/2: 10770.6 Verification ( Id#:7564414 )

I hereby certify, I am at least 18 years of age and not a party to this action. I am a resident of, or employed in the county where the mailing took place. On the signature date below, a true copy of the document(s) listed above was served either by enclosing them in a sealed envelope addressed to each party named at the address(es) shown below, each envelope was placed for collection and mailing at the business address below with postage fully prepaid following established business practices; or served by other previously agreed upon method of electronic delivery, and there was no report of delay in the electronic transmission or physical mailing of the documents.

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

Business address for collection & mailing: 255 NEW YORK RANCH RD, JACKSON CA 95642

Signature and Date: S CHARLES BOWEN 07/24/2020

TESTAN LAW SAN DIEGO % TESTAN LAW 31330 Oak Crest Dr Westlake Village CA 91361-4632 YORK EL DORADO HILLS % YORK RISK SERVICES PO Box 14731 Lexington KY 40512-4731

USPS 1 of 2 3569694471-0000077560 USPS 2 of 2 0971819207-0000000840

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## STATE OF CALIFORNIA DIVISION OF WORKERS' COMPENSATION WORKERS' COMPENSATION APPEALS BOARD DECLARATION OF READINESS TO PROCEED

**NOTICE:** Any objection to the proceedings requested by a Declaration of Readiness to proceed shall be filed and served within ten (10) days after service of the Declaration.

Case No	ADJ12524635
Applicant First Name	KEVIN
MI	
Last Name	WILLIAMS
Employer Information	VS
Employer Name	WALMART INC
Employer Street Address / PO Box	6750 KIMBALL AVE
City	CHINO
State	CA
Zip Code (Numbers Only)	91708
Declarants: Please designate yo	ur role (Please Select Only One)*

- O Employee
- O Applicant
- O Defendant
- Lien Claimant

## Declarant requests: (Please Select Only One)*

- O Mandatory Settlement Conference
- O Rating MSC*
- Lien Conference

## At the present time the principal issues are:

- Compensation Rate
- Temporary Disability
- Permanent Disability
- AOE/COE
- Employment
- Other OUTSTANDING LIEN

- O Status Conference
- O Priority Conference

## (Check all that apply)

- Rehabilitation / SJDB
- Self-procured Medical Treatment
- Future Medical Treatment
- Discovery

Declarant relies on the report(s) of:

Doctor(s)

Dated

(MM/DD/YYYY

Declarant states under penalty of perjury that (1) he or she is presently ready to proceed to hearing on the issues below and has made the following specific, genuine, good faith efforts to resolve the dispute(s) listed below,

ATTEMPTS HAVE BEEN MADE TO SETTLE LIEN TO NO AVAIL. LIEN CLAIMANT SEEKS WCAB ASSISTANCE IN RESOLUTION OF LIEN INCLUDING PENALTIES AND INTEREST, DISCOVERY PENDING. LIEN CLAIMANT HAS A PERSON WITH FULL SETTLEMENT AUTHORITY IMMEDIATELY AVAILABLE BY TELEPHONE, 714-972-0040, MONDAY - FRIDAY 8:00 AM - 5:00 PM.

And (2) unless a status or priority conference is requested, I have completed discovery on the issues listed above, and that all medical reports in my possession or control have been filed and served as required by applicable rules.

If you are a lien claimant filing for a lien conference, you must complete this section:

The lien filing fee or activation fee has been paid.

Confirmation No: D8Q9YHL6XXXXX

A filing fee or activation fee is not required because the lien is exempt or because either the lien [ was not filed under Labor Code section 4903(b) or the lien is not a claim of costs.

A filing fee was previously paid under the law in effect from 2004 to 2006 and proof of that payment is attached.

Copies of this Declaration have been served this date as shown on the attached proof of service.

Declarant's Signature	S LESLEE IBARRA		
Name and Law Firm	PSYCHOLOGICAL ASSESSMENT LAGUNA NIGUEL		
Address	PO BOX 6299 LAGUNA NIGUEL CA 92607		
Phone Number	7149720040		
Date (MM/DD/YYYY)	07/22/2020		

*For a Rating MSC, all ratable medical reports, including treating physician, QME and AME reports, must be filed with this Declaration of Readiness, unless they have been previously filed. A Rating MSC will be set only where the issues are limited to permanent disability and the need for future medical treatment.

07/22/2020 09:15:39

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## CONTACT PERSON:CLARIBEL VALADEZ / 7149720040CASE INFORMATION:ADJ12524635 / KEVIN WILLIAMS

	FAMB	EDEX INFORMATION SYSTEMS JACKSON	FORM ID:	20200722091358_001374950
	<b>WDO</b>	JULIA BURNS	The party filing this form automatically generated	
	USE ONLY	1-209-223-3461 EXT 100	these documents using the EDEXIS online EAMS service. EDEXIS is a DWC-approved Third-Party EAMS Filer.	
		SUPPORT@EDEXIS.COM	Learn more at EDEXIS.	COM or call 1-209-223-3461

#### **10770.6 VERIFICATION**

I declare under penalty of perjury under the laws of the State of California that:

[X] The Declaration of Readiness is not being filed because of a dispute subject to the Independent Medical Review and/or Independent Bill Review process.

[ ] A timely petition appealing the Administrative Director's determination regarding Independent Medical Review and/or Independent Bill Review has been filed.

AND

**[X]** The underlying case has been resolved.

[ ] At least six months has elapsed from the date of injury and the injured worker has chosen not to proceed with his or her case. In determining that the injured worker has chosen not to proceed with his or her case, I have made a diligent search consisting of the following efforts:

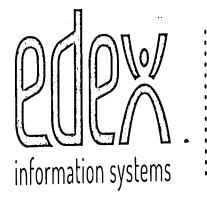
OFFICIAL SIGNATURE

#### S LESLEE IBARRA

LESLEE IBARRA

07/22/2020

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## LEGAL DOCUMENT DELIVERY

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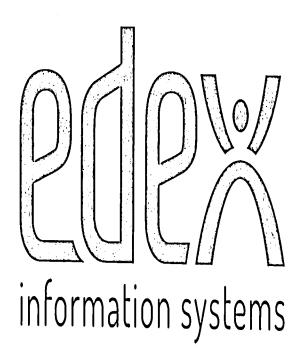
Post Office Box 579 Jackson CA 95642

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FIRST-CLASS MAIL U.S. POSTAGE PAID JACKSON, CA 95642 PERMIT NO. 18

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# LEGAL DOCUMENTS ENCLOSED



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## WE MAIL ANY DOCUMENT

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Proof of Service & Proof of Mailing included.

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#### **DIVISION OF WORKERS' COMPENSATION** WORKERS' COMPENSATION APPEALS BOARD

### **NOTICE OF HEARING**

**DATE OF SERVICE:**07/23/2020

WCAB CASE NBR(s): ADJ12524635, ADJ12743430, ADJ12524618

**EMPLOYEE:** KEVIN WILLIAMS

**EMPLOYER:***WALMART INC* 

**INSURER:** YORK EL DORADO HILLS

**TYPE OF HEARING:**Lien Conference

DATE OF HEARING:09/21/2020 MONDAY

TIME OF HEARING:01:30 P.M.

**LENGTH OF HEARING:** 

LOCATION:SBR-ADJ 464 W 4TH ST STE 239 SAN BERNARDINO/CA/92401

Map available at: <a href="http://www.dir.ca.gov/dwc/dir2.htm">http://www.dir.ca.gov/dwc/dir2.htm</a>

JUDGE: Jody Eaton 909 3834522

You are hereby notified that the above entitled case is set for hearing before the Division of Workers' Compensation of the State of California. Continuances are not favored and will be granted only upon clear showing of good cause. Please arrive before scheduled appearance time.

NOTICE TO PARTIES: Disability Accommodation is available upon request. Any person with a disability requiring accommodation at the Hearing should contact the Disability Accommodation Coordinator at the District Office of the WCAB, or the state-wide Disability Accommodation Coordinator at 1-866-681-1459 (toll free) as soon as possible.

Deaf/hard of Hearing/Speech Impaired: Any person who requires an assistive listening system or computer aided transcription system, should contact the Disability Accommodation Coordinator at the District Office or the WCAB, or the state-wide Disability Accommodation Coordinator, through the California Relay Service, by dialing 711 or 1-800-735-2929 (TTY) or 1-800-855-3000 (TYY-Spanish), as soon as possible, or no later than five (5) days before the hearing. The Division will provide a sign language interpreter upon request.

Vision Impairment (Alternate Formats): This notice can be made available in Braille, large print, computer disk, and tape cassette as a reasonable accommodation for an individual with a disability. Please contact the Disability Accommodation Coordinator.

NOTICE TO INSURER : The employer will not receive Notice of Hearing.

#### **SPECIAL COMMENTS/INSTRUCTIONS:**

APPLICANT NEED NOT APPEAR; ALL LIEN CLAIMS OF RECORD STILL IN DISPUTE SHALL APPEAR; EL TRABAJADOR LESIONADO NO TIENE QUE PRESENTARSE EN ESTA AUDIENCIA

WC01

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1	DANIEL HAWKES, ESQ. SBN: 251577	
2	TESTAN LAW 7676 Hazard Center DR STE 500	
3	San Diego, CA 92108 Telephone: 619-543-9960	
4	Facsimile: 619-543-9760	
5	Attorneys for Defendant	
6		
7		
8		ISATION APPEALS BOARD
9	FOR THE STA	TE OF CALIFORNIA
10		CASE NO: ADJ12524618; ADJ12524635
11	KEVIN WILLIAMS,	
12	Applicant,	OBJECTION TO AND PETITION FOR CHANGE OF VENUE
13	vs. WALMART INC./ACE AMERICAN	Cal. Lab. Code §5501.5 (c)
14 15	INSURANCE CO. as administered by YORK RISK SERVICES GROUP, INC.,	Cal. Code of Regs., Title 8 §10410
16	Defendant.	
17		
18	COMES NOW, defendant(s) ACE AN	MERICAN INSURANCE as administered by YORK
19	RISK SERVICES GROUP, INC., by and three	ough their attorney's of record Testan Law with their
20	Objection to Venue and Petition For Change of	Venue.
21	INTRODUCTIO	N AND CONTENTONS
22	Pursuant to the provisions of Labor Cod	le Section 5501.5(c) and Title 8, Code of Regulations,
23	Section 10410, defendant ACE American Insur	ance Company as administered by York Risk Services
24	Group Inc. (VORK) hereby exercises its right	to object to the designated venue site. The designated
	Oroup, me. (TORR) hereby exercises its right	
25		any of the options found under Labor Code section
25 26	venue site does not appear to be based on	any of the options found under Labor Code section district office which is in the California County where
	venue site does not appear to be based on $5501.5(a)(3)$ . Defendant requests transfer to a	

In this case, there appears to be no basis to file the application at an Orange County district office. Defendant objects to any county other than San Bernardino County, as there is no basis for venue at all in Orange County and defendant does hereby object to the designation of Anaheim, an Orange County district office, as the venue for this claim.

This Objection to and Petition for Change of Venue is timely made pursuant to Labor Code Section 5501.5 and WCAB rule 10410 within 30 days of Notice of the Designation of Venue and Notice of Adjudication case number. (See Statement Under Penalty of Perjury, *infra*.) Upon this timely objection to venue, the Legislature requires that venue be transferred either (1) to the California County where the injured employee resides on the date of the filing of the application or (2) to the county where the injury allegedly occurred. This is not discretionary and no showing of good cause is required. No evidentiary proceeding or hearing is needed. (Labor Code section 5501.5(c) and Code of Regulations, Title 8, Section 10410.)

In this case, the employee resides in San Bernardino County (Chino Hills, Zip code 91709) and alleges injury arising out of and during the course of his employment at the Walmart Fulfillment Center in Chino (San Bernardino County, Zip Code 91708). The only possible logical choice for proper venue site is therefore in the California County where both the alleged injury occurred and applicant's residence, San Bernardino.

#### **LEGAL DISCUSSION**

#### A.

#### There Is No Legal Basis For Venue Based Upon The Location Of The Employee's Attorney

California Labor Code Section 5501.5 subdivision (a) provides that an Application for Adjudication of Claim "shall" be filed either:

- In the county where the injured employee or dependent of the deceased employee resides on the date of filing.
- (2) In the county where the injury allegedly occurred, or, in cumulative trauma and industrial disease claims, where the last alleged injurious exposure occurred.
- (3) In the county where the employee's attorney maintains his or her principal place of business, if the employee is represented by an attorney.

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Labor Code section 5501.5, subdivision (c) further provides:

If the venue site where the application is to be filed is the county where the employees attorney maintains his or her principal place of business, the attorney for the employee shall indicate the venue site when forwarding the information request form required by section 5401.5. The employer shall have 30 days from receipt of the information request form to object to the selected venue site. Where there is an employee or objection to a venue site under paragraph (3) of subdivision (a), then the application shall be filed pursuant to either paragraph (1) or (2) of subdivision (a). [Emphasis added.]

#### <u>B.</u>

#### Venue Must Be Transferred To The County Of Alleged Injury

Upon defendant's timely and proper venue objection, the Appeals Board does not have discretion on where the application must be filed. (*Anaya v. McDonnell Douglas* (2011) 2001 Cal. Wrk. Cmp. P.D. LEXIS 57) ["if the defendant objects within 30 days of receipt of the adjudication case number and venue, the case venue <u>must</u> be changed to another venue site as provided in Labor Code section 5501.5"]; *Benavidis v. County of San Bernardino* (2010) 2010 Cal. Wrk. Cmp. P.D. LEXIS 337 ["if the defendant files a timely objection to the venue selection, then Labor Code section 5501.5(c) <u>requires</u> that venue be changed"]; *Aguilar v. Petaluma Valley Hospital* (2010) 2010 Cal. Wrk. Comp. P.D. LEXIS 212 ["objection is timely under section 5501.5(c) and WCAB Rule 10410... [t]herefore, venue <u>must</u> be transferred"].) Thus, section 5501.5 (c) <u>mandates</u> that in this matter venue "shall" be either in the county where the injured employee resided on the date of filing or the county where the alleged injury occurred.

The venue rules were intended first by the Appeals Board in 1981 and then by the Legislature in 1990 to establish some "rational relationship" between the place of filing and either the place of employee's residence at time of filing or the place of alleged injury. Prior to enactment of Labor Code Section 5501.5 in 1990, venue at the WCAB was first governed by former WCAB Rule 10403 effective July 1, 1981. The WCAB Rule 10403 Venue states:

The Application for Adjudication of Claim shall be filed in the county:

(a) Where the injured employee or dependent of a deceased employee resides on the date of filing. or

(b) Where injury allegedly occurred, or intuitive, and industrial disease claims, where the last alleged injurious exposure occurred.

If the county selected for filing has more than one office of the Worker's Compensation Appeals Board, the application shall be filed in the Worker's Compensation Appeals Board office serving the geographic area of (a) or (b) above. These geographic areas shall be defined in the Policy and Procedural Manual.

If there is no Workers' Compensation Appeals Board office in the County of (a) or (b) above, the Application for Adjudication may be filed at any office of the Workers' Compensation Appeals Board. This section shall apply to Applications for Adjudication filed on or after July 1, 1981.

By way of an en banc decision, the Appeals Board addressed the new venue rules in *Noble v*. *City of Oakland Police Department* (1982) 47 Cal. Comp. Cases 1 (Appeals Board en banc):

The new [Appeals Board venue] rules were promulgated to clarify the place of proper venue and, in our view, clearly call for venue in the disjunctive, either in the place of applicant's residence or the place of injury with the final alternative that if there is no Board office in either place, venue lies in any Board office. As stated by the panel in *Burton*, <u>supra</u>, the rules were intended to establish a rational relationship between the place of filing and either the place of applicant's residence or the place of injury, consistent with prior case law on the subject. *City of Anaheim v. WCAB (Beteag)* (1981) 116 Cal. App. 3d 248, 46 Cal. Comp. Cases 318. In the event that both the place of residence and place of injury qualify for venue and there is no Board office in one of them, or only one of the places qualifies, venue properly lies in the qualifying place with the Board office before the alternative to file in any Board office emerges. In other words, only where there is no Board office in either the place of applicant's residence and the place of injury, is there a resort to general statewide venue in any Board office. Any other interpretation would distort the clear meaning of the language and frustrate the intent of the new rules. *(Noble v. City of Oakland Police Department*, supra, 47 Cal. Comp. Cases 1, 3.)

The Appeals Board's requirement for a "rational relationship" remains the same today after the Legislature subsequently added Labor Code Section 5501.5 in 1990. (Stats 1990 ch 1550 § 59 (AB 2910)). The plain language of Section 5501.5 only allows for venue to be based upon the location of the principal place of business of the employee's attorney <u>unless</u> a defendant timely objects. However, once there has been a timely objection, venue can <u>only</u> be based upon some rational relationship with the employee's residence at the time of filing or the place of alleged injury.

In this case, there is no rational relationship between Orange County and either the place of applicant's residence or the place of alleged injury.

#### С.

#### This Case Was Wrongfully Filed In Orange County

There is no good faith basis for this case to have been filed in an Orange County district office other than that it might be the preference of applicant's attorney.

#### **CONCLUSION**

By reason of the foregoing, venue must be immediately transferred to the **San Bernardino district** office.

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Dated: October 7, 2019

Respectfully submitted **Testan Law** 

millan

Daniel Hawkes Attorney for Defendants

1 2 3 4	DANIEL HAWKES, ESQ. SBN: 251577 TESTAN LAW 7676 Hazard Center DR STE 500 San Diego, CA 92108 Telephone: 619-543-9960 Facsimile: 619-543-9760	
5	Attorneys for Defendant	
6	• • • • • • •	
7		
8	WORKERS' COMPEN	SATION APPEALS BOARD
9	FOR THE STA	TE OF CALIFORNIA
10		CASENO, AD112524219, AD112524225
1,1	KEVIN WILLIAMS,	CASE NO: ADJ12524618; ADJ12524635
12	Applicant,	<b>OBJECTION TO AND PETITION FOR CHANGE OF VENUE</b>
13	vs.	
		Cal Lab. Code 85501 5 (c)
14	WALMART INC./ACE AMERICAN ) INSURANCE CO. as administered by YORK	Cal. Lab. Code §5501.5 (c) Cal. Code of Regs., Title 8 §10410
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In this case, there appears to be no basis to file the application at an Orange County district office. Defendant objects to any county other than San Bernardino County, as there is no basis for venue at all in Orange County and defendant does hereby object to the designation of Anaheim, an Orange County district office, as the venue for this claim.

This Objection to and Petition for Change of Venue is timely made pursuant to Labor Code Section 5501.5 and WCAB rule 10410 within 30 days of Notice of the Designation of Venue and Notice of Adjudication case number. (See Statement Under Penalty of Perjury, *infra*.) Upon this timely objection to venue, the Legislature requires that venue be transferred either (1) to the California County where the injured employee resides on the date of the filing of the application or (2) to the county where the injury allegedly occurred. This is not discretionary and no showing of good cause is required. No evidentiary proceeding or hearing is needed. (Labor Code section 5501.5(c) and Code of Regulations, Title 8, Section 10410.)

In this case, the employee resides in San Bernardino County (Chino Hills, Zip code 91709) and alleges injury arising out of and during the course of his employment at the Walmart Fulfillment Center in Chino (San Bernardino County, Zip Code 91708). The only possible logical choice for proper venue site is therefore in the California County where both the alleged injury occurred and applicant's residence, San Bernardino.

#### LEGAL DISCUSSION

#### Α.

There Is No Legal Basis For Venue Based Upon The Location Of The Employee's Attorney California Labor Code Section 5501.5 subdivision (a) provides that an Application for Adjudication of Claim "shall" be filed either:

- (1) In the county where the injured employee or dependent of the deceased employee resides on the date of filing.
- (2) In the county where the injury allegedly occurred, or, in cumulative trauma and industrial disease claims, where the last alleged injurious exposure occurred.
- (3) In the county where the employee's attorney maintains his or her principal place of business, if the employee is represented by an attorney.

Labor Code section 5501.5, subdivision (c) further provides:

If the venue site where the application is to be filed is the county where the employees attorney maintains his or her principal place of business, the attorney for the employee shall indicate the venue site when forwarding the information request form required by section 5401.5. The employer shall have 30 days from receipt of the information request form to object to the selected venue site. Where there is an employee or objection to a venue site under paragraph (3) of subdivision (a), then the application shall be filed pursuant to either paragraph (1) or (2) of subdivision (a). [Emphasis added.]

#### <u>B.</u>

#### Venue Must Be Transferred To The County Of Alleged Injury

Upon defendant's timely and proper venue objection, the Appeals Board does not have 12 discretion on where the application must be filed. (Anaya v. McDonnell Douglas (2011) 2001 Cal. Wrk. Cmp. P.D. LEXIS 57) ["if the defendant objects within 30 days of receipt of the adjudication case number and venue, the case venue must be changed to another venue site as provided in Labor Code section 5501.5"]; Benavidis v. County of San Bernardino (2010) 2010 Cal. Wrk. Cmp. P.D. LEXIS 337 ["if the defendant files a timely objection to the venue selection, then Labor Code section 5501.5(c) requires that venue be changed"]; Aguilar v. Petaluma Valley Hospital (2010) 2010 Cal. Wrk. Comp. P.D. LEXIS 212 ["objection is timely under section 5501.5(c) and WCAB Rule 10410... [t]herefore, venue must be transferred"].) Thus, section 5501.5 (c) mandates that in this matter venue "shall" be either in the county where the injured employee resided on the date of filing or the county where the alleged injury occurred.

The venue rules were intended first by the Appeals Board in 1981 and then by the Legislature in 1990 to establish some "rational relationship" between the place of filing and either the place of employee's residence at time of filing or the place of alleged injury. Prior to enactment of Labor Code Section 5501.5 in 1990, venue at the WCAB was first governed by former WCAB Rule 10403 effective July 1, 1981. The WCAB Rule 10403 Venue states:

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The Application for Adjudication of Claim shall be filed in the county:

(a) Where the injured employee or dependent of a deceased employee resides on the date of filing, or

(b) Where injury allegedly occurred, or intuitive, and industrial disease claims, where the last alleged injurious exposure occurred.

If the county selected for filing has more than one office of the Worker's Compensation Appeals Board, the application shall be filed in the Worker's Compensation Appeals Board office serving the geographic area of (a) or (b) above. These geographic areas shall be defined in the Policy and Procedural Manual.

If there is no Workers' Compensation Appeals Board office in the County of (a) or (b) above, the Application for Adjudication may be filed at any office of the Workers' Compensation Appeals Board. This section shall apply to Applications for Adjudication filed on or after July 1, 1981.

By way of an en banc decision, the Appeals Board addressed the new venue rules in Noble v. City of Oakland Police Department (1982) 47 Cal. Comp. Cases 1 (Appeals Board en banc):

The new [Appeals Board venue] rules were promulgated to clarify the place of proper venue and, in our view, clearly call for venue in the disjunctive, either in the place of applicant's residence or the place of injury with the final alternative that if there is no Board office in either place, venue lies in any Board office. As stated by the panel in *Burton*, <u>supra</u>, the rules were intended to establish a rational relationship between the place of filing and either the place of applicant's residence or the place of injury, consistent with prior case law on the subject. *City of Anaheim v. WCAB (Beteag)* (1981) 116 Cal. App. 3d 248, 46 Cal. Comp. Cases 318. In the event that both the place of residence and place of injury qualify for venue and there is no Board office in one of them, or only one of the places qualifies, venue properly lies in the qualifying place with the Board office before the alternative to file in any Board office emerges. In other words, only where there is no Board office in either the place of applicant's residence and the place of injury, is there a resort to general statewide venue in any Board office. Any other interpretation would distort the clear meaning of the language and frustrate the intent of the new rules. (Noble v. City of Oakland Police Department, supra, 47 Cal. Comp. Cases 1, 3.)

The Appeals Board's requirement for a "rational relationship" remains the same today after the Legislature subsequently added Labor Code Section 5501.5 in 1990. (Stats 1990 ch 1550 § 59 (AB 2910)). The plain language of Section 5501.5 only allows for venue to be based upon the location of the principal place of business of the employee's attorney unless a defendant timely objects. However, once there has been a timely objection, venue can only be based upon some rational relationship with the employee's residence at the time of filing or the place of alleged injury.

In this case, there is no rational relationship between Orange County and either the place of applicant's residence or the place of alleged injury.

**C**.

#### This Case Was Wrongfully Filed In Orange County

There is no good faith basis for this case to have been filed in an Orange County district office other than that it might be the preference of applicant's attorney.

#### CONCLUSION

By reason of the foregoing, venue must be immediately transferred to the San Bernardino district office.

Dated: October 7, 2019

Respectfully submitted **Testan Law** 

In the

**Daniel Hawkes** Attorney for Defendants RE: Williams, Kevin v. Walmart Inc. WCAB CASE NO.: ADJ12524618; ADJ12524635

#### VERIFICATION

State of California, County of San Diego

I declare under penalty of perjury that the foregoing is true and correct and that the same was signed by me on this Statement under penalty of perjury pursuant to WCAB rule 

I, Daniel Hawkes, declare under penalty of perjury that I am the attorney for the defendant ACE American Insurance Company (ACE) as administered by York Risk Services Group. Inc. (YORK) and make this statement pursuant to WCAB Rule 10410. I am informed and believe that YORK has received only the Notice of Representation from applicant's counsel dated 09/10/2019 (attached as Exhibit #A) but has not yet received the Application for Adjudication of claim.

The defendant is aware that the applicant has filed two Applications at the Anaheim Workers' Compensation Appeals Board and the assignment of the ADJ case number by receipt of the Notices of Application dated each 9-10-19.

Defendant's first knowledge and possession of both the Application and Notice of Application has not yet occurred.

I am therefore informed and believe that this petition is therefore filed within 30 days of Notice of Venue Selection and the Application. I declare under penalty of perjury that the foregoing is true and correct and that the same was signed by me on this date.

Executed on October 7, 2019 at San Diego, California.

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Daniel Hawkes Attorney for Defendants

Natalia Foley, Esq Managing Attorney Tel (310) 707 8098; Fax (310) 626 9632 nfoleylaw@gmail.com

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LAW OFFICES OF NATALIA FOLEY

8306 Wilshire Blvd # 115 Beverly Hills, CA 90211 www.nataliafolcylaw.com

TO: WAL-MART 6150 KIMBALL AVE CHINO, CA 91708 9/10/2019

- RE: KEVIN WILLIAMS VS WAL-MART ASSOCIATES INC
- DOB: 02/17/1964
- WCAB #: ADJ12524618 (DOI: 09/09/2018 03/20/2019) ADJ12524635 (DOI: 10/01/2018 - 03/15/2019)
- CLAIM: UNASSIGNED
- NOTICE OF REPRESENTATION
- NOTICE OF WORKERS COMPENSATION CLAIM
- DEMAND FOR EMPLOYER PERSONNEL FILE (L.C. 1.198.5)
- REQUEST FOR MEDICAL TREATMENT IN THE MPN (REG. 9767.5(G)
- **REQUEST FOR COMPLETE INSURANCE FILE**
- DESIGNATION OF TREATING DOCTOR UNDER LC § 4600

#### NOTICE OF REPRESENTATION

#### To Whom It May Concern:

Please be advised that this office, The Law Offices of Natalia Foley, has been retained by the above individual to represent the above individual in regards to all workers compensation claims against the above named employer.

Please direct all communication to this office and do not contact the client directly.

Failure to abide by this demand shall result in penalties and/or sanctions ordered by the Workers Compensation Appeals Boards and/or the Superior Court of CA.

#### NOTICE OF WORKERS COMPENSATION CLAIM

Please allow this correspondence to serve as notice of the above captioned employee's workers compensation claim.

Enclosed is the following:

Page 1 of 5

#### Exhibit A

1. DWC-1 Claim Form

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- 2. Notice of Representation
- 3. Demand for Employer Personnel File
- 4. Demand for Treatment within MPN
- 5. Demand for Insurance File

Please respond via Fax or USPS with the completed DWC-1 claim form and other requested information to my attention. Our fax number is 310 626 9632.

Please also submit this claim to your workers compensation insurance carrier.

I ask that you do not contact the injured worker directly and direct all communication to your workers compensation insurance carrier.

Please note the following statutes, their requirements and the consequences of violating them:

- 1 If you fail to satisfy the requirements of Labor Code Section 5401, you may be subject to penalties;
- 2 Pursuant to Labor Code Section 132(a), it is unlawful to discriminate against an employee for claiming an industrial injury.
- Pursuant to Labor Code Section 1871.4(a)(4), makes it a felony to "make or cause to be made any knowingly false or fraudulent statements regarding entitlement to benefits with the intent to discourage an injured worker from claiming benefits or pursuing a claim; and Labor Code Section 3820 makes one engaging in such conduct subject to severe monetary penalties.

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4 If you fail to provide benefits pursuant to Labor Code Sections 4600 and 4650, we will seek penalties.

#### DEMAND FOR EMPLOYER PERSONNEL FILE (L.C. 1.198.5)

Dear Human Resources Dept:

Demand is hereby made that you, The Employer, deliver to The Law Offices of Natalia Foley the complete and not-redacted employer personnel file in regards the above named employee.

Failure to abide by this demand, pursuant to CA Labor Code 1198.5 et seq., may result, in penalties per CA Labor Code 5813.

#### REQUEST FOR MEDICAL TREATMENT IN THE MPN (REG. 9767.5(G)

#### Dear Employer and/or Workers Compensation Insurance Claims Adjuster:

Demand is hereby made that the above named injured worker treat for the industrial injuries alleged in the DWC-1 Claim Form, within your workers compensation insurance MPN. Please schedule an appointment with a treating (not just evaluating) mental health or

Page 2 of 5

#### Exhibit A

orthopedic specialist as soon as possible

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Please provide a list of medical providers to the applicant (cc. to applicant's attorney) such that applicant may find a doctor within your MPN.

Be advised that failure to authorize treatment within the MPN will result in the loss of medical control for the duration of the case. If no treatment within the MPN is authorized within 10 days of this mailing, applicant will self-procure out of the MPN according to Reg, 9767,5(g)

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If more than 30 days have passed since the date of injury, applicant is electing to exercise his/her right of free choice of treating physician in accordance with Labor Code Section 4600 and hereby designates Dr. Jonathan Nissanoff, MD as the primary treating physician or facility; or if fewer than thirty days have passed since the date of injury, applicant hereby requests a change of physician in accordance with Labor Code Section 4601 and will designate the same doctor or facility as primary treating physician or facility if there is non-compliance with said section.

Should our client be unable to return to our client's usual and customary job, this letter shall be deemed by our client to be a demand for rehabilitation services. Labor Code Section 4636 requires that the employer assign a qualified rehabilitation representative to meet with applicant when aggregate total disability continues for 90 days. In such event, we demand that such meeting be held in our office. Do not contact our client directly to set up such meeting.

If rehabilitation benefits are provided, consistent with Rocha, the enclosed Disclosure Statement and this letter shall constitute a lien for attorney's fees and our demand that 15% of all rehabilitation benefits be withheld for reasonable attorney's fees. Applicant's signature on the enclosed Disclosure Statement form constitutes consent to the above request for attorney's fees.

#### **REQUEST FOR COMPLETE INSURANCE FILE**

#### Dear Claims Adjuster,

As you have been made aware, this office has been retained by the above-named employee for the work-related injury sustained on or about the date set forth. You have been previously sent all of the documents (Application for Adjudication, Disclosure Statement, and other documents signed by the applicant and the undersigned) concurrently filed with the Workers' Compensation Appeals Board.

We hereby demand production of the following with respect to applicant which are in your possession of your insurance carrier, or your agents, or their agents:

- 1 All medical reports,
- 2 Wage Statements;
- 3 All investigation reports;
- 4 Any motion picture films, television tapes or pictures which may have been or will be taken of our client;
- 5 Any statements prepared by any Qualified Rehabilitation Representative;
- 6 Any statement made by our client with reference to our client's injury;
- 7 A history (print-out) of all benefits paid, including the dates and amounts;

Page 3 of 5

Exhibit A

- 8 Statements by co-workers; and
- 9 Employment records and personnel file.

Further, please advise if you have any sub-rosa on this matter whether you intend to use the same or not. If you have sub-rosa, send me what you have and let me know if you are going to use it. If you have no sub-rosa, confirm in writing and consider this a continuing demand through the conclusion of this file.

Pursuant to L.C. §5307.9, demand is hereby made for any and all records in your possession and further, all records transmitted should contain a declaration under penalty of perjury executed by the custodian of records. Any and all prior authorizations signed by my client are hereby fully revoked and rescinded.

I call your attention to L.C. § 5813 which allows for attorney fees to enforce the above referenced Rules of Practice and Procedure, I hope it will not become necessary to exercise this Labor Code Section but If there is not foil and complete compliance within 30 days of the date of this letter, I will request that an order issue at the next court date ordering compliance with my requests to the extent appropriate and attorney fees per L.C. § 5813,1 think you for your prompt attention to this matter

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#### DESIGNATION OF TREATING DOCTOR UNDER LC § 4600

#### To whom it may concern

Please be advised that pursuant and in accordance with Labor Code § 4600 applicant elects as his/her Primary Treating Physician and hereby wishes and appoints to have his/her medical treatment by Dr. Jonathan Nissanoff, MD as the primary treating physician or facility.

You are hereby placed on notice of this change of treating doctor. A copy of this letter to the office of the doctor will serve as notification of the responsibility to send reports and bills directly to you and as notice of the requirements of Rules and Regulations § 9785 of the Administrative Director of the Division of Industrial Accidents that the initial report must be filed within five working days after the initial examination.

Respectfully,

THE LAW OFFICES OF NATALIA FOLEY

By Natalia Foley, Esq

Page 4 of 5

Exhibit A

#### **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 9/10/2019 I served the foregoing documents described as:

NOTICE OF REPRESENTATION NOTICE OF WORKERS COMPENSATION CLAIM DEMAND FOR EMPLOYER PERSONNEL FILE (L.C. 1.198.5) REQUEST FOR MEDICAL TREATMENT IN THE MPN (REG. 9767.5(G) REQUEST FOR COMPLETE INSURANCE FILE DESIGNATION OF TREATING DOCTOR UNDER LC § 4600

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

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

Executed on: 9/10/2019 at Los Angeles, CA

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

Page 5 of 5

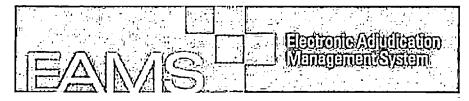
Exhibit A

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1	TESTAN LAW SAN DIEGO 4970955	1
2	6195439960	
3	angelolimpin@atblaw.net	
4	PROOF OF SERVICE	
5	STATE OF CALIFORNIA, COUNTY OF SAN DIEGO	
	I am employed in the County of San Diego, State of California. I am over the age of 18, and	
6	not a party to the within action. My business address: Testan Law, 7676 Hazard Center DR STE	
7	500, San Diego, CA 92108.	
8	On October 7, 2019, I served the foregoing document(s) on the case of Williams, Kevin v. Walmart Inc./WCAB Case No. ADJ12524618; ADJ12524635/Claim No. 8949558; 8949567	
9	described as:	
10	Objection to and Petition for Change of Venue	
11	on the interested parties in this action by placing the original or a true copy thereof enclosed in a	
12	sealed envelope addressed as follows:	
	[X] BY ELECTRONIC TRANSMISSION I transmitted a PDF version of this document by	T
13	electronic mail to the WCAB through EAMS.	
14	Workers' Compensation Appeals Board 1065 N Pacificenter DR STE 170 & 200	
15	Anaheim, CA 92806	
16	Christine Leonard	
17	York Risk Services Group, Inc. PO Box 14731	
1.14	Lexington, KY 40512	
18	Natalia Foley, Esq.	
19	Law Offices of Natalia Foley 8306 Wilshire BLVD STE 115	
20	Beverly Hills, CA 90211	
21	I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with U.S. Postal Service on that same day	
22	with postage thereon fully prepaid at San Diego, California in the ordinary course of business. I	
23	am aware that on motion of party served, service is presumed invalid if postal cancellation date or	
24	postage meter date is more than one day after date of deposit for mailing affidavit.	
25	I declare under penalty of perjury under the laws of the State of California that the above is true and correct.	
26	Executed on October 7, 2019, at San Diego, CA.	
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:20	Angelo Limpin	
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Attachment	

#### Uploaded Documents

Master Case Reference	Case ID	Case Type	Document Type	Document Title	File Name	
ADJ12524618	ADJ12524635	ADJ	LEGAL DOCS	10770.6 VERIFICATION	C:\fakepath\Williams VERI_001.pdf	Delete
ADJ12524618	ADJ12524635	ADJ			C:\fakepath\Williams POS_001.pdf	Delete
ADJ12524618	ADJ12524635	ADJ	LEGAL DOCS	OBJECTION TO VENUE	C:\fakepath\Williams Objection_001.pdf	Delete
Submit						



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

Batch ID: 31902193 Date: 10/07/2019 05:31:00 PM

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