# RECORDS

| | | | |
|---|---|---|---|
| Applicant/Plaintiff | **Kevin Williams** | | |
| Case No. | SIF12524618 | | |
| Defendant | Wal-Mart Distribution | | |
| Date of Injury | 09/09/2018 to 03/20/2019 | | |
| File/Claim Num | | Date Published | 3/24/2021 |
| Records of | **Adelson, Testan and Brundo** | | |
| Location Copied | 31330 Oak Crest Drive<br>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

These records were produced under U.S. Patent No. 8,301,611

# 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 A Deposition Officer – Med-Legal, LLC

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

on the 03/29/21 day of ____________________, at 10:00 o'clock AM., to testify in the above-entitled 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 not appear! Simply call (800) 244-3495 and somebody will copy the records for you at your office.**

# 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.

| Signature | 955 Overland Court, Suite 200, San Dimas, CA 91773 | (626) 653-5160 |
|---|---|---|
| Signature | Address | Telephone |

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.

| Name of Person Served | Date | Place |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

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

Executed on____________, at____________, California.

Signature

Control #: **22-5414-3**

DWC WCAB 32 (Side 2) (REV. 06/18)

# Attachment

**Re:**

Patient/Applicant: Kevin Williams Social Security #: 000-00-0000
AKA: 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 not 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**

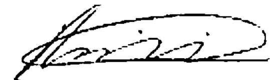
I declare that I am employed in the County of Los Angeles, over the age of 18 years and not a party to this action. My business address is: 955 Overland Court, Ste. 200 San Dimas, California 91773.

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<br>DEFENDANT/RESPONDENT: Wal-Mart Distribution | CASE NUMBER:<br>SIF12524618 |
|---|---|

## PROOF OF SERVICE

1. I served this Subpoena Duces Tecum by delivering a copy to the person served as follows:

   [✔] Personal Delivery [ ] Certified Mail [ ] Regular Mail [ ] Via Facsimile

   a. Person served (name): Stacy Carr

   b. Address where served: 31330 Oak Crest Drive, Westlake 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) [✔] Witness fees were paid.
   Amount: ________ $ 15 Check Number: 3313279

   (2) [ ] Copying fees were paid.
   Amount: ________ $______

   f. Fee for service: _________ $______

2. I received this subpoena for service on (date): 03/09/2021
3. 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 California process server.
   e. [ ] Exempt from registration under Business and Professions Code Section 22350(b).
   f. [ ] Registered professional photocopier.
   g. [ ] Exempt from registration under Business and Professions Code section 22451.
4. Name, address, telephone number, and, if applicable, county of registration and number:

   Richard Woodard , LA – 7235

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

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

Date: 03/09/2021

/S/ Richard Woodard

► ______________________

(SIGNATURE)

(**For California sheriff or marshal use only**)
I **certify** that the foregoing is true and correct.

Date: ______________________

► ______________________

(SIGNATURE)



Control Number: 22-5414-3

# Records Order Form

03/08/21

**Notice of Copying to:**

OD LEGAL LOS ANGELES
355 S Grand Ave Ste 1800
LOS ANGELES, CA 90071

**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
**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 ____

**Send records:**

☐ Same as above

**E-mail addresses required for the electronic sets:**
________________________@________________
________________________@________________

☐ **Bill to My Office** (*Invoice will be sent to the address on this notice.*)

☐ **Bill to the Insurance Carrier**

__________________________________________ (Print your name)

__________________________________________ (Sign your name) **Control #: 22-5414-3**
(Signature required)

**Med-Legal, LLC**
**Photocopy Reg #/County x-423/Los Angeles**
**Tax ID # 45-4424177**
955 Overland Court, Suite 200, San Dimas, CA 91773, (800) 244-3495 FAX (800) 962-4896

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

# Records Order Form

03/08/21

**Notice of Copying to:**

SIBTF SACRAMENTO
1750 Howe Avenue Ste 370
Sacramento, CA 95825

**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
**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 ____

**Send records:**

☐ Same as above

**E-mail addresses required for the electronic sets:**
______________________@________________
______________________@________________

☐ **Bill to My Office** (*Invoice will be sent to the address on this notice.*)

☐ **Bill to the Insurance Carrier**

________________________________________ (Print your name)

________________________________________ (Sign your name) **Control #: 22-5414-3**

(Signature required)

**Med-Legal, LLC**
**Photocopy Reg #/County x-423/Los Angeles**
**Tax ID # 45-4424177**
955 Overland Court, Suite 200, San Dimas, CA 91773, (800) 244-3495 FAX (800) 962-4896

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

PROOF OF SERVICE

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 not a party to the within action. My business address: Testan Law, 7676 Hazard Center DR STE 500, San Diego, CA 92108.

On 11/19/2019, I served the foregoing document(s) on the case of Williams, Kevin v. Walmart Inc./WCAB Case No. ADJ12524635; ADJ12524618/Claim No. 8949558; 8949567 described as: **WALKTHROUGH APPEARANCE SHEET; ORDER APPROVING COMPROMISE AND RELEASE AND FULLY EXECUTED COMPROMISE AND RELEASE AGREEMENT** on the interested parties in this action by placing the original or a true copy thereof enclosed in a sealed envelope addressed as follows:

**Christine Leonard**
**York Risk Services Group, Inc.**
**PO Box 14731**
**Lexington, KY 40512**

**Natalia Foley, Esq.**
**Law Offices of Natalia Foley**
**8306 Wilshire Blvd., Suite 115**
**Beverly Hills, CA 90211**

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 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.

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

Executed on 11/19/2019, at San Diego, CA.

ANGELA ROSS

**Start of Records**

TD

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

Kevin Williams
*Applicant,*

vs.

Walmart Inc
*Defendants.*

**WALK THROUGH APPEARANCE SHEET**

ADJ 12524635
ADJ 12524618 ADJ 12743430

Efiler: Yes____ No X

Case set for hearing: Yes X No___

Walk through document:

X C&R ______ STIP WITH AWARD

______ 5710 DEPOSITION ATTORNEY'S FEES

______ PETITION TO COMPEL ATTENDANCE AT MEDICAL EVALUATION/DEPO

______ PETITION FOR STAY ORDER-PJ ONLY

APPEARANCES

APPLICANT ☐ PRESENT ☐ NOT PRESENT

APPLICANT REPRESENTED BY ______ ☐ ATTORNEY ☐ HEARING REP.

DEFENDANT REPRESENTED BY Testan Law Daniel Hawkes ☒ ATTORNEY ☐ HEARING REP.

OTHERS APPEARING ______ ☐ ATTORNEY ☐ HEARING REP.

INTERPRETER ______ CERTIFICATION NO. ______

DISPOSITION: ☒ OTOC ☐ ORDER SUSPENDING ACTION ON C&R/STIPS ☒ C&R/STIPS APPROVED

ORDER(s)/COMMENT(s): Post-term denied claims settled @ depo. AA is represented. No liens per Δ. No EDD. Depo fee $900 to be pd by Δ outside C&R. There is waiver of AME!

☐ PETITION APPROVED: ☐ 5710 FEES ☐ 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:______ Location______

DATE: 11/18/19

[signature]
WORKERS' COMPENSATION JUDGE

NOTICE TO: Δ - Mr Hawkes Pursuant to Rule 10500, you are designated to serve this/ these document(s) on all interested parties including all lien claimants.

[ ] Served on parties and lien claimants present

Date 11/18/19 By [signature]

FOR WCAB USE ONLY:

JUDGE ASSIGNED: PETTY

RECEIVED
NOV 1 8 2019
DWC
SAN BERNARDINO

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

Kevin Williams

*Applicant,*

vs.

Walmart Inc; Ace American Insurance Co

*Defendant(s).*

Case No(s). ADJ12524635
ADJ12524618
ADJ12743430

San Bernardino District Office

**ORDER APPROVING COMPROMISE AND RELEASE**

The parties to the above-entitled action have filed a Compromise and Release on 11-18-2019 in the amount of $ 15,000.00. 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.

☒ Injury AOE/COE is seriously in issue as to ☒ all body parts alleged ☐ the following body parts: ______ based on ☒ dispute of law and fact ☐ statute of limitations ☐ medical opinions of ______ ☐ witness(es) ______.

☒ The parties have considered and included the release of any ☒ 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:

☐ paid in the amount of $ 2250.00 to Law Offices of Natalia Foley.

☐ paid $______ to ______ and $______ to ______ per fee agreement.

☐ The amount of $______ is ordered withheld from the settlement by defendant until resolution 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 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(c).

☒ There are no liens of record in the Board's system as of this date. ☐ The lien of the EDD has been resolved.

☒ Depo fee of $900.00 to be paid by Δ to AA outside of settlement.

Dated at San Bernardino, California: 11/18/19

☐ Filed and served by mail on all parties on the Official Address Record.

☒ Notice to: Δ - Mr Hawkes

You are designated and ordered per Rule 10500 to serve this/these 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: [signature]

[signature]
MYRLE R. PETTY
Workers' Compensation
Administrative Law Judge

# STATE OF CALIFORNIA
# DWC DISTRICT OFFICE

## DOCUMENT COVER SHEET

Is this a new case? Yes ☐ No ☑ Companion Cases Exist ☐ Walkthrough Yes ☑ No ☐

More than 15 Companion Cases ☐

11/18/2019
Date:(MM/DD/YYYY)

SSN: ____________

☐ Specific Injury

ADJ12524618
Case Number 1

☑ Cumulative Injury 09/09/2018 (Start Date: MM/DD/YYYY) 03/20/2019 (End Date: MM/DD/YYYY)

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

Body Part 1: ____________ Body Part 3: ____________

Body Part 2: ____________ Body Part 4: ____________

Other Body Parts: ____________

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

☐ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ SAU ☐ INT ☐ RSU

**Companion Cases**

☐ Specific Injury

ADJ12524635
Case Number 2

☑ Cumulative Injury 10/01/2018 (Start Date: MM/DD/YYYY) 03/15/2019 (End Date: MM/DD/YYYY)

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

Body Part 1: ____________ Body Part 3: ____________

Body Part 2: ____________ Body Part 4: ____________

Other Body Parts: ____________

A0J12743430

~~UNASSIGNED~~

Case Number 3

[x] Specific Injury

[ ] Cumulative Injury

01/22/2019

(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

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

Body Part 1: 420 Body Part 3: ____

Body Part 2: ____ Body Part 4: ____

Other Body Parts: ____

Case Number 4

[ ] Specific Injury

[ ] Cumulative Injury

(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

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

Body Part 1: ____ Body Part 3: ____

Body Part 2: ____ Body Part 4: ____

Other Body Parts: ____

Case Number 5

[ ] Specific Injury

[ ] Cumulative Injury

(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

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

Body Part 1: ____ Body Part 3: ____

Body Part 2: ____ Body Part 4: ____

Other Body Parts: ____

# DOCUMENT SEPARATOR SHEET

Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title COMPROMISE AND RELEASE

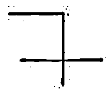
Document Date 11/13/2019
MM/DD/YYYY

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

ADJ12524618
Case Number 2

Case Number 5

Unassigned ADJ 12743430
Case Number 3

551-47-5680
SSN (Numbers Only)

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

☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

☒ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

☐ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

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

**Employee(Completion of this section is required)**

KEVIN
First Name

MI

RECEIVED
NOV 18 2019
DWC
SAN BERNARDINO

WILLIAMS
Last Name

2070 AVENIDA HACIENDA
Address/PO Box (Please leave blank spaces between numbers, names or words)

CHINO HILLS | CA | 91709
City | State | Zip Code

**Employer Information (Completion of this section is required)**

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

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

6750 KIMBALL AVE
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

CHINO | CA | 91708
City | State | Zip Code

**Applicant's Attorney or Authorized Representative:**

☐ Law Firm/Attorney ☐ Non Attorney Representative

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)

| ANAHEIM | CA | 92808 |
|---|---|---|
| City | State | Zip Code |

**Defendant's Attorney or Authorized Representative:**

☐ Law Firm/Attorney ☐ Non Attorney Representative

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 DIEGO | CA | 92108 |
|---|---|---|
| City | State | Zip Code |

**Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims 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, names or words)

| Lexington | Ky | 40512 |
|---|---|---|
| City | State | Zip Code |

**Claims Administrator Information (if known and if applicable)**

YORK RISK SERVICES GROUP, INC.
Name (Please leave blank spaces between numbers, names or words)

PO BOX 14731
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

LEXINGTON — KY — 40512
City — State — Zip Code

**IT IS CLAIMED THAT:**

1. The injured employee, born 02/17/1964 (DATE OF BIRTH: MM/DD/YYYY), alleges that while employed as a(n)

_____________________________ , sustained injury
(OCCUPATION AT THE TIME OF INJURY)

arising out of and in the course of employment at the locations 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

ADJ12524635 — Case Number 1

☒ Cumulative Injury

10/01/2018 (Start Date: MM/DD/YYYY) — 03/15/2019 (End Date: MM/DD/YYYY)

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

Body Part 1: 841 Body Part 2: ______ Body Part 3: ______

Body Part 4: ______ Other Body Parts: ______

The injury occurred at 702 SW 8th St
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

Bentonville, AR 72716
City, State, Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

ADJ12524618
Case Number 2

☐ Specific Injury
☒ Cumulative Injury

09/09/2018 (Start Date: MM/DD/YYYY)
03/20/2019 (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: 450  Other Body Parts: 500

The injury occurred at 702 SW 8th St
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

Bentonville, AR 72716
City, State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

ADJ12743430
Unassigned
Case Number 3

☒ Specific Injury
☐ Cumulative Injury

01/22/2019 (Start Date: MM/DD/YYYY)
(End Date: MM/DD/YYYY)
*(If Specific Injury, use the start date as the specific date of injury)*

Body Part 1: 420  Body Part 2:  Body Part 3:

Body Part 4:  Other Body Parts:

The injury occurred at 702 SW 8th St
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

Bentonville, AR 72716
City, State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

Case Number 4

☐ Specific Injury
☐ Cumulative Injury

(Start Date: MM/DD/YYYY)
(End Date: MM/DD/YYYY)
*(If Specific Injury, use the start date as the specific date of injury)*

Body Part 1:  Body Part 2:  Body Part 3:

Body Part 4:  Other Body Parts:

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

City, State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ Specific Injury

Case Number 5 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
*(If Specific Injury, use the start date as the specific date of injury)*

Body Part 1: ______ Body Part 2: ______ Body Part 3: ______

Body Part 4: ______ Other Body Parts: ______

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

______ City ______, State ______ Zip Code ______

Body parts, conditions and systems may not be incorporated by reference to medical reports.

2. Upon approval of this compromise agreement by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge and payment in accordance with the provisions hereof, the employee releases and forever discharges the above-named employer(s) and insurance carrier(s) from all claims and causes of action, whether now known or ascertained or which may hereafter arise or develop as a result of the above-referenced injury(ies), including any and all liability of the employer(s) and the insurance carrier(s) and each of them to the dependents, heirs, executors, representatives, administrators or assigns of the employee. Execution of this form has no effect on claims that are not within the scope of the workers' compensation law or claims that are not subject to the exclusivity provisions of the workers' compensation law, unless otherwise expressly stated.

3. This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury set forth in Paragraph No. 1 and further explained in Paragraph No. 9 despite any language to the contrary elsewhere in this document or any addendum.

4. Unless otherwise expressly stated, approval of this agreement RELEASES ANY AND ALL CLAIMS OF APPLICANT'S DEPENDENTS TO DEATH BENEFITS RELATING TO THE INJURY OR INJURIES COVERED BY THIS COMPROMISE AGREEMENT. The parties have considered the release of these benefits in arriving at the sum in Paragraph 7. Any addendum duplicating this language pursuant to Sumner v WCAB (1983) 48 CCC 369 is unnecessary and shall not be attached.

5. Unless otherwise expressly ordered by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge, approval of this agreement does not release any claim applicant may have for vocational rehabilitation benefits or supplemental job displacement benefits.

6. The parties represent that the following facts are true: (If facts are disputed, state what each party contends under Paragraph No. 9.)

EARNINGS AT TIME OF INJURY $ 700

TEMPORARY DISABILITY INDEMNITY PAID Ø Weekly Rate $ 466.67

Period(s) Paid ______ (Start Date: MM/DD/YYYY) ______ (End Date: MM/DD/YYYY)

PERMANENT DISABILITY INDEMNITY PAID Ø Weekly Rate $ 290.00

Period(s) Paid ______ (Start Date: MM/DD/YYYY) End date ______ (End Date: MM/DD/YYYY)

TOTAL MEDICAL BILLS PAID $ 1843.42 Total Unpaid Medical Expense to be Paid By: Defendant

Unless otherwise specified herein, the employer will pay no medical expenses incurred after approval of this agreement.

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
Settlement 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 ________

$ 2,250.00 requested as applicant's attorney's fee.

LEAVING A BALANCE OF $ 12,750.00 ✓, 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 forth 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, litigate or otherwise resolve all valid liens of record with the exception of any child support or spousal support liens, such liens remain the sole responsibility of the applicant.

Defendant will pay applicant attorneys LC 5710 depo fee for the 11-13-19 depo in the amount of $800.

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 | |
|---|---|---|
| KEW | DH | earnings |
| KEW | DH | temporary disability |
| KEW | DH | jurisdiction |
| KEW | DH | apportionment |
| KEW | DH | employment |
| KEW | DH | injury AOE/COE |
| KEW | DH | serious and willful misconduct |
| KEW | DH | discrimination (Labor Code §132a) |
| KEW | DH | statute of limitations |
| KEW | DH | future medical treatment |
| KEW | DH | other: medical mileage/out of pocket expenses |
| KEW | DH | permanent disability |
| KEW | DH | self-procured medical treatment, except as provided in Paragraph 7 |
| KEW | DH | vocational rehabilitation benefits/supplemental job displacement benefits |

COMMENTS:

Either party may appear ex parte for the purpose of obtaining approval of this settlement. Penalties and interest waived if payment is made within 30 days of OACR. Case is denied, post termination notice of injury.

See addendums 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 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.

Witness the signature hereof this 13 day of November, 2019 at Redlands, CA

| | | | |
|---|---|---|---|
| Alicia Torres 11/13/2019 | | [signature] 11/13/19 | |
| Witness 1 | (Date) | Applicant (Employee) KEVIN WILLIAMS | (Date) |
| [signature] | | [signature] 11/13/19 | |
| Witness 2 | (Date) | Attorney for Applicant NATALIA FOLEY, ESQ. | (Date) |
| | | [signature] 11-18-19 | |
| Interpreter | (Date) | Attorney for Defendant | (Date) |
| | | Attorney for Defendant | (Date) |
| | | Attorney for Defendant | (Date) |
| | | Attorney for Defendant | (Date) |

## ACKNOWLEDGMENT

State of California
County of ______________________________)

On ____________________ before me, ________________________________
(insert name and title of the officer)

personally appeared ________________________________________________________,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature ______________________________ **(Seal)**

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

ADDENDUM TO COMPROMISE AND RELEASE A

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.

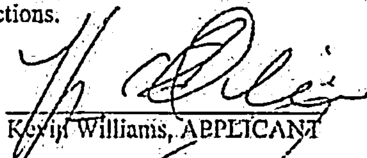
All permanent disability advances, including any not listed in paragraph 7, are to be deducted from the settlement amount.

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 all 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: 11/13/19 Kevin Williams, APPLICANT

DATED: 11/13/19 Natalia Foley, Esq.
ATTORNEY FOR APPLICANT

RECEIVED
NOV 18 2019
DWC
SAN BERNARDINO

Addendum B

| RE: | Employee: | Kevin Williams |
|---|---|---|
| | Employer: | Walmart Inc. |
| | Claim Number: | 8949558; 8949567 |
| | Date of Injury: | 10/01/2018 - 03/15/2019; 09/09/2018 - 03/20/2019 |

## AFFIDAVIT OF WAIVER OF QME 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 ~~based upon the findings of and~~ not exercise my right to a qualified medical evaluation, from a physician selected from a panel.

Employee Signature

11/18/19

Date

RECEIVED

NOV 18 2019

DWC
SAN BERNARDINO

STATE OF CALIFORNIA
# WORKERS' COMPENSATION APPEALS BOARD

Kevin Williams

*Applicant,*

v.

Walmart Inc; Ace American Insurance Co.

*Defendants.*

Case No.

**AFFIDAVIT OF DEFENDANT RE: RESOLUTION OF LIENS**

I, Daniel Hawkes, am the attorney or representative for defendant Ace American Insurance Co, in the above-entitled matter.

I have made the following good faith efforts to resolve each of the liens in this case. List ALL lien claims below, use supplemental pages as necessary.

| LIEN CLAIMANT | NATURE & DATE OF LIEN RESOLUTION EFFORTS | RESULT |
|---|---|---|
| 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 / 15 / 2019.

RECEIVED
NOV 1 8 2019
DWC

[signature]

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

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

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

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

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

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

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

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

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

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

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

1. Name. *Nombre.* KEVIN G. WILLIAMS Today's Date. *Fecha de Hoy.* 09/03/2019
2. Home Address. *Dirección Residencial.* 2010 AVENIDA HACIENDA
3. City. *Ciudad.* CHINO CA State. *Estado.* CA Zip. *Código Postal* 91709
4. Date of Injury. *Fecha de la lesión (accidente).* JAN/2019 LOWER BACK NOV. 2018 – EST. TO 08/19/2019 Time of injury. *Hora en que ocurrió.* a.m. p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* 6050 Kimball AVE CHINO CA 91708
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* Stress and strain due to repetitive movement over period of time LOWER BACK / NECK / SHOULDER / HAND
7. Social Security Number. *Número de Seguro Social del Empleado.* 551 47 - 5680
8. Signature of employee. *Firma del empleado.* X [signature]

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

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

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

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

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

*EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD*

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

7/1/04 Rev.

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

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

## WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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

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

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

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

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

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

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

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

1. Name. *Nombre.* KEVIN E WILLIAMS Today's Date. *Fecha de Hoy.* 09/08/19
2. Home Address. *Dirección Residencial.* 2070 AVENIDA HACIENDA
3. City. *Ciudad.* CHINO HILLS State. *Estado.* CA Zip. *Código Postal.* 91709
4. Date of Injury. *Fecha de la lesión (accidente).* October 2018 - 03/15/2019 Time of Injury. *Hora en que ocurrió.* ____ a.m. ____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* 6750 Kimball AVE CHINO CA 91708
6. Describe injury and part of body affected. *Describa la lesión y parte 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. *Firma del empleado.* X [signature]

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

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

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

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

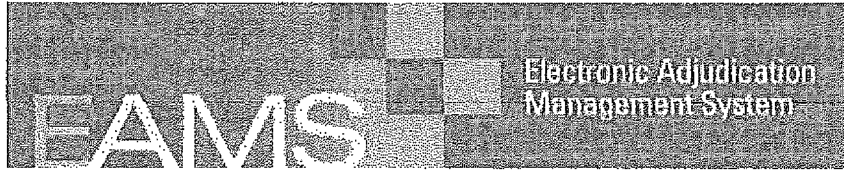
☐ Employer copy/*Copia del Empleador* ☐ Employee copy/ *Copia del Empleado*

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

*EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD*

☐ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

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

OK

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

REQUIRED FIELDS SHOWN BY "*"

Is this a new Case?* Yes (•) No ( )

Location: CTL

Companion Cases Exist ☐

More than 15 Companion Cases ☐

Walk Thru Yes ( ) No (•)

Date: ( MM/DD/YYYY) 09/09/2019

Case Number:*

SSN(Numbers Only) 551475680

( ) Specific Injury (If Specific Injury, use the start 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 EXTREMITIE

Body Part 4 : 200 NECK

Other Body Parts : 500 LOWER EXTREMITI

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

(•) ADJ ( ) DEU ( ) SIF ( ) UEF ( ) SAU ( ) INT ( ) RSU

**Companion Cases**

**Case 1:**

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

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

Body Part 1 :

Body Part 2 :

Body Part 3 :

Body Part 4 :

Other Body Parts :

**Case 2:**

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

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

Body Part 1 :

Body Part 2 :

Body Part 3 :

Body Part 4 :

Other Body Parts :

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION

# WORKERS' COMPENSATION APPEALS BOARD
# APPLICATION FOR ADJUDICATION OF CLAIM

| Case Number | | *Amended Application* ☐ |
|---|---|---|
| SSN | 551475680 | |

***Venue Choice is based upon:***

◯ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

◯ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

⦿ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

* Enter the zipcode for the venue choice designated above, and then tab to Hearing Location Field and choose the corresponding Hearing Location Code: 92807 | AHM

***Injured Worker***

| | |
|---|---|
| First Name* | KEVIN |
| MI | |
| Last Name* | WILLIAMS |
| Street Address 1 /PO Box* | 2070 AVENIDA HACIENDA |
| Street Address 2 /PO Box | |
| International Address | |
| City* | CHINO HILLS |
| State* | CA |
| Zip Code* (Numbers Only) | 91709 |

**Applicant (If other than injured employee)**

◯ Insurance Carrier ◯ Employer ◯ Lien Claimant

| Name | |
|---|---|
| Street Address 1 /PO Box | |
| Street Address 2 /PO Box | |
| City | |
| State | |
| Zip Code (Numbers Only) | |

**Employer Information**

◯ Insured ◯ Self-Insured ◯ Legally Uninsured ◉ Uninsured

| Employer Name* | WAL-MART ASSOCIATES INC |
|---|---|
| Employer Street Address/PO Box* | 702 SW 8TH STREET |
| City* | BENTONVILLE |
| State* | AR |
| Zip Code* (Numbers Only) | 72716 |

**Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)**

| Insurance Carrier Name | |
|---|---|

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

**Claims 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* 02/17/1964 (Date of birth : MM/DD/YYYY)

, while employed as a(n) RECORD PROCESSOR (Occupation at the time of injury)

suffered a: ( Choose only one )

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

◉ cumulative trauma injury which began on 09/09/2018 (START DATE: MM/DD/YYYY) and ended on 03/20/2019 (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)

CHINO (City)* , CA (State)* 91708 (Zip Code)*

(State which parts of the body were injured)

| | | | |
|---|---|---|---|
| Body Part 1 : | 420 BACK - INCLUDING BACK | Body Part 2 : | 450 SHOULDERS - SCAPULA AND |
| Body Part 3 : | 300 UPPER EXTREMITIES - NO | Body Part 4 : | 200 NECK |

Other Body Parts : 500 LOWER EXTREMITIES - NOT SPECIFIED

**2.The injury occurred as follows:**

**( Explain What The Worker Was Doing At The Time Of Injury And How The Injury Occured )**

Field size limited to 325 characters

STRESS AND STRAIN DUE TO REPETITIVE MOVEMENT OVER PERIOD OF TIME AND DUE TO LIFTING HEAVY BOXES, INJURED LOWER BACK, NECK, SHOULDERS, LOWER EXTREMITIES, REPORTED TO THE SUPERVISOR, SENT TO INDUSTRIAL CLINIC

**3. Actual earnings at the time of injury**

Rate of Pay $ ______ ○ Monthly ○ Weekly ○ Hourly

State value of tips, meals, lodging or other advantages regularly received $ ______ ○ Monthly ○ Weekly ○ Hourly

Number of hours worked per week. ______

**4. The injury caused disability as follows**

Last day off work due to injury : ______ (MM/DD/YYYY)

| | | |
|---|---|---|
| First Period of Disability: | Start date ______ (MM/DD/YYYY) | End date ______ (MM/DD/YYYY) |
| Second Period of Disability: | Start date ______ (MM/DD/YYYY) | End date ______ (MM/DD/YYYY) |

## 5. Compensation

Compensation was paid : ◯ Yes ◉ No

| Total paid: | |
|---|---|
| Weekly rate(s): | |
| Date of last payment: | |

(MM/DD/YYYY)

**6. Has the worker received any unemployment insurance benefits and/or any unemployment compensation disability benefits (state disability) since the date of injury?**

◯ Yes ◉ No

## 7. Medical treatment

Medical treatment was received : ◯ Yes ◯ No

All treatment was furnished by the Employer or Insurance Carrier : ◯ Yes ◯ No

| Date of last treatment | |
|---|---|

(MM/DD/YYYY)

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

**Did Medi-Cal pay for any health care related to this claim ? :** ◯ Yes ◯ No

**Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or examined for this injury, but that were not provided or paid for by the employer or insurance carrier:**

| Name of Doctor/Hospital/Clinic 1.<br>Field size limited to 80 characters | |
|---|---|
| Name of Doctor/Hospital/Clinic 2.<br>Field size limited to 80 characters | |

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

| Case Number 1 | |
|---|---|
| Case Number 2 | |
| Case Number 3 | |
| Case Number 4 | |

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

- [x] Temporary disability indemnity
- [x] Permanent disability indemnity
- [x] Reimbursement for medical expense
- [ ] Rehabilitation
- [x] Medical treatment
- [x] Supplemental Job Displacement/Return to Work
- [x] Compensation at proper rate
- [x] Other (Specify) ALL OTHER BEVEFITS

Is the Applicant Represented?: ○ Yes ○ No if "No", applicant is to sign and date below.

if "Yes", applicant's representative is to complete the following and is to sign and date below

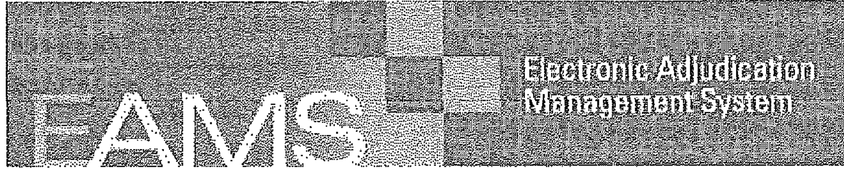
◉ Law Firm/Attorney ○ Non Attorney Representative

| Law Firm or Company Name(If Applicable) |
| --- |
| NATALIA FOLEY BEVERLY HILLS |

| Field | Value |
| --- | --- |
| 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 |

| Field | Value |
| --- | --- |
| Applicant Attorney / Representative Signature | S NATALIA FOLEY |
| Applicant Signature | |

Dated at BEVERLY HILLS (City), California Date 09/09/2019 (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

OK

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

REQUIRED FIELDS SHOWN BY "*"

Is this a new Case?* Yes (•) No ( )  Location: CTL

Companion Cases Exist [ ]  Walk Thru Yes ( ) No (•)

More than 15 Companion Cases [ ]

Date: ( MM/DD/YYYY) 09/09/2019

Case Number:*  SSN(Numbers Only) 551475680

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

(•) Cumulative Injury 10/01/2018 (START DATE: MM/DD/YYYY) 03/15/2018 (END DATE: MM/DD/YYYY)

Body Part 1 : 841 NERVOUS SYSTEM  Body Part 2 :

Body Part 3 :  Body Part 4 :

Other Body Parts :

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

(•) ADJ ( ) DEU ( ) SIF ( ) UEF ( ) SAU ( ) INT ( ) RSU

**Companion Cases**

**Case 1:**

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

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

Body Part 1 :  Body Part 2 :

Body Part 3 :  Body Part 4 :

Other Body Parts :

**Case 2:**

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

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

Body Part 1 :  Body Part 2 :

Body Part 3 :  Body Part 4 :

Other Body Parts :

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION

# WORKERS' COMPENSATION APPEALS BOARD
# APPLICATION FOR ADJUDICATION OF CLAIM

| Case Number | | *Amended Application* | ☐ |
|---|---|---|---|
| SSN | 551475680 | | |

***Venue Choice is based upon:***

◯ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

◯ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

◉ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

* Enter the zipcode for the venue choice designated above, and then tab to Hearing Location Field and choose the corresponding Hearing Location Code | 92807 | AHM

***Injured Worker***

| Field | Value |
|---|---|
| First Name* | KEVIN |
| MI | |
| Last Name* | WILLIAMS |
| Street Address 1 /PO Box* | 2070 AVENIDA HACIENDA |
| Street Address 2 /PO Box | |
| International Address | |
| City* | CHINO HILLS |
| State* | CA |
| Zip Code* (Numbers Only) | 91709 |

**Applicant (If other than injured employee)**

◯ Insurance Carrier ◯ Employer ◯ Lien Claimant

| Name | |
|---|---|
| Street Address 1 /PO Box | |
| Street Address 2 /PO Box | |
| City | |
| State | |
| Zip Code (Numbers Only) | |

**Employer Information**

◯ Insured ◯ Self-Insured ◯ Legally Uninsured ◉ Uninsured

| Employer Name* | WAL-MART ASSOCIATES INC |
|---|---|
| Employer Street Address/PO Box* | 702 SW 8TH STREET |
| City* | BENTONVILLE |
| State* | AR |
| Zip Code* (Numbers Only) | 72716 |

**Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)**

| Insurance Carrier Name | |
|---|---|
| Street Address/PO Box | |
| City | |
| State | |
| Zip Code (Numbers Only) | |

**Claims 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* 02/17/1964 (Date of birth : MM/DD/YYYY)

, while employed as a(n) RECORD PROCESSOR (Occupation at the time of injury)

suffered a: ( Choose only one )

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

◉ cumulative trauma injury which began on

10/01/2018 (START DATE: MM/DD/YYYY) and ended on 03/15/2018 (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)

CHINO (City)* , CA (State)* 91708 (Zip Code)*

(State which parts of the body were injured)

| Body Part 1 : | 841 NERVOUS SYSTEM - STRE | Body Part 2 : | |
|---|---|---|---|
| Body Part 3 : | | Body Part 4 : | |
| Other Body Parts : | | | |

**2.The injury occurred as follows:**

**( Explain What The Worker Was Doing At The Time Of Injury And How The Injury Occured )**

Field size limited to 325 characters

STRESS DUE TO HOSTILE WORK ENVIRONMENT RACIAL AND SEXUAL HARASSMENT

**3. Actual earnings at the time of injury**

Rate of Pay $ ______ ○ Monthly ○ Weekly ○ Hourly

State value of tips, meals, lodging or other advantages regularly received $ ______ ○ Monthly ○ Weekly ○ Hourly

Number of hours worked per week. ______

**4. The injury caused disability as follows**

Last day off work due to injury : ______ (MM/DD/YYYY)

| | Start date | | End date | |
|---|---|---|---|---|
| First Period of Disability: | Start date | (MM/DD/YYYY) | End date | (MM/DD/YYYY) |
| Second Period of Disability: | Start date | (MM/DD/YYYY) | End date | (MM/DD/YYYY) |

## 5. Compensation

Compensation was paid : ◯ Yes ⦿ No

| Total paid: | |
|---|---|
| Weekly rate(s): | |
| Date of last payment: | |

(MM/DD/YYYY)

**6. Has the worker received any unemployment insurance benefits and/or any unemployment compensation disability benefits (state disability) since the date of injury?**

◯ Yes ⦿ No

## 7. Medical treatment

Medical treatment was received : ◯ Yes ◯ No

All treatment was furnished by the Employer or Insurance Carrier : ◯ Yes ◯ No

| Date of last treatment | |
|---|---|

(MM/DD/YYYY)

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

**Did Medi-Cal pay for any health care related to this claim ? :** ◯ Yes ◯ No

**Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or examined for this injury, but that were not provided or paid for by the employer or insurance carrier:**

| Name of Doctor/Hospital/Clinic 1. Field size limited to 80 characters | |
|---|---|
| Name of Doctor/Hospital/Clinic 2. Field size limited to 80 characters | |

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| Case Number 1 | |
|---|---|
| Case Number 2 | |
| Case Number 3 | |
| Case Number 4 | |

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

- [x] Temporary disability indemnity
- [x] Permanent disability indemnity
- [x] Reimbursement for medical expense
- [ ] Rehabilitation
- [x] Medical treatment
- [x] Supplemental Job Displacement/Return to Work
- [x] Compensation at proper rate
- [x] Other (Specify) ALL OTHER BENEFITS

Is the Applicant Represented?: (•) Yes ( ) No if "No", applicant is to sign and date below.

if "Yes", applicant's representative is to complete the following and is to sign and date below

(•) Law Firm/Attorney ( ) Non Attorney Representative

| Law Firm or Company Name(If Applicable) |
|---|
| NATALIA FOLEY BEVERLY HILLS |

| | |
|---|---|
| Law Firm Number (If Applicable) | 11964930 |
| 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 Signature | S NATALIA FOLEY |
| Applicant Signature | |

Dated at BEVERLY HILLS (City), California Date 09/09/2019 (MM/DD/YYYY)

State of California
Department of Industrial Relations
Division of Workers' Compensation

**FEE DISCLOSURE STATEMENT**

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

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

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

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

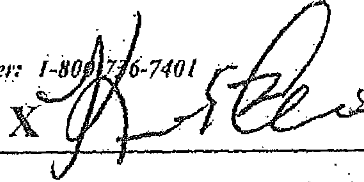
Your case is being filed at the Division of Workers' Compensation at the following location:

Anaheim - AHM

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

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

***Call this toll-free number: 1-800-736-7401***

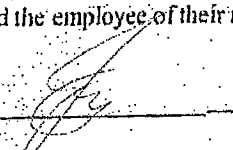


Employee's Signature X ________________ Date 9/8/2019

Employee's Name ________________

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

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



Attorney's Signature ________________ Date 9/8/2019

Attorney's name ________________

Address ________________

Phone No. (    ) ________________



9/24/2019

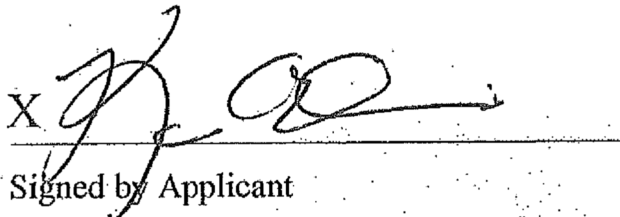
# APPLICATION VERIFICATION

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

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

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

Date: 9/8/2019

X 

Signed by Applicant

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

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

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

***PETICIÓN 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 **"Employer's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

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

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

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

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

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

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

1. Name. *Nombre.* KEVIN E WILLIAMS Today's Date. *Fecha de Hoy.* 09/08/19
2. Home Address. *Dirección Residencial.* 2070 AVENIDA HACIENDA
3. City. *Ciudad.* CHINO Hills State. *Estado.* CA Zip. *Código Postal.* 91709
4. Date of Injury. *Fecha de la lesión (accidente).* October 2018 - 03/15/2019 Time of Injury. *Hora en que ocurrió.* ____ a.m. ____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* 6750 Kimball AVE CHINO CA 91708
6. Describe injury and part of body affected. *Describa la lesión y parte 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. *Firma del empleado.* X [signature]

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

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

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

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/ *Copia del Empleado*

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

*EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD*

☐ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

7/1/04 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 1)**

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

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

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

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

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

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

1. Name. *Nombre.* KEVIN G. Williams Today's Date. *Fecha de Hoy.* 09/03/2019
2. Home Address. *Dirección Residencial.* 2010 AVENida Haceuida
3. City. *Ciudad.* CHINO CA State. *Estado.* CA Zip. *Código Postal.* 91709
4. Date of Injury. *Fecha de la lesión (accidente).* JAN/2019 LOWERBACK NOV. 2018 - ESTIDO 03/19/2019 Time of Injury. *Hora en que ocurrió.* ____ a.m. ____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* 6150 Kimball AVE CHINO CA 91708
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* Stress and strain due to repetitive movement over period of time LOWER BACK/NECK/SHOULDER/HANDS
7. Social Security Number. *Número de Seguro Social del Empleado.* 551-47-5680
8. Signature of employee. *Firma del empleado.* X [signature]

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

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17. Title. *Título.* ____ 18. Telephone. *Teléfono.* ____

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

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

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

*EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD*

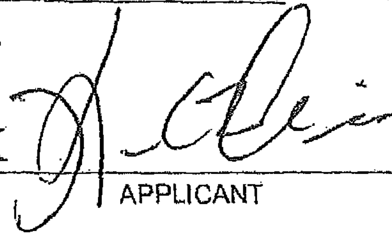
☐ Employer copy/*Copia del Empleador* ☐ Employee copy/ *Copia del Empleado* ☐ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

7/1/04 Rev.

# VENUE AUTHORIZATION

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

DATED: 9/8/2019

X 
APPLICANT

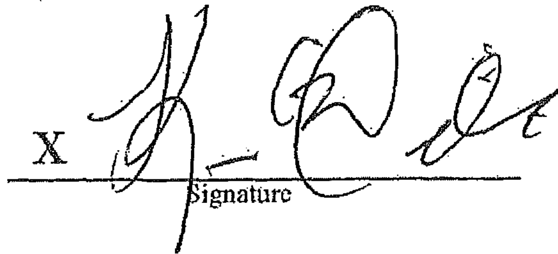
APPLICANT'S ATTORNEY:

WC-105

## DECLARATION PURSUANT TO LABOR CODE SECTION 4906(g)

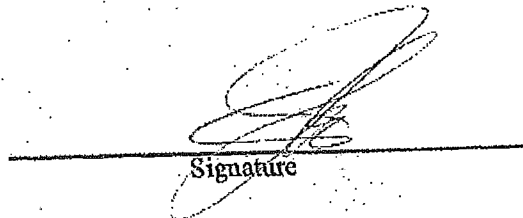
Pursuant to Labor Code Section 4906(g), I declare under penalty of perjury that I have not violated Section 139.3 and I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or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

Dated: 9/8/2019



X ____________________
Signature

Dated: 9/8/2019



____________________
Signature

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

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

**PROOF OF SERVICE**

*State Of California*
*County of Los Angeles*

I am employed in the county of Los Angeles, State of California.
I am over the age of 18 years and not a party to the within action; my business address is:
8306 WILSHIRE BLVD STE 115
BEVERLY HILLS CA 90211

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

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

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

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

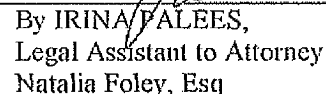
WCAB (AHM)
1065 N PACIFIC CENTER DR
STE 170
ANAHEIM CA 92806

KEVIN WILLIAMS
2070 AVENIDA HACIENDA
CHINO HILLS CA 91709

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

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

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
Executed on: 9/9/2019 at Los Angeles, CA



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

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

# 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 ☐

Location*: CTL
Walk Thru Yes ○ No ⦿

Date: ( MM/DD/YYYY) 10/11/2019

Case Number*: ADJ12524618

SSN(Numbers Only)

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

○ Cumulative Injury (START DATE: MM/DD/YYYY) * (END DATE: MM/DD/YYYY)

Body Part 1 :

Body Part 2 :

Body Part 3 :

Body Part 4 :

Other Body Parts :

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

⦿ ADJ ○ DEU ○ SIF ○ UEF ○ SAU ○ INT ○ RSU

**Companion Cases**

**Case 1:**

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

○ Cumulative Injury (START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

Body Part 1 :

Body Part 2 :

Body Part 3 :

Body Part 4 :

Other Body Parts :

**Case 2:**

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

○ Cumulative Injury (START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

Body Part 1 :

Body Part 2 :

Body Part 3 :

Body Part 4 :

Other Body Parts :

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

**Case Number:** ADJ12524618

**(Choose only one)**

☐ a specific injury on ______ **(MM/DD/YYYY)**

☑ a cumulative trauma injury which began on 09/09/2018 (START DATE: MM/DD/YYYY)

and ended on 03/20/2019 (END DATE: MM/DD/YYYY)

Name(s) of Answering Party(ies): WALMART ASSOCIATES INC

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

**Injured Worker**

| | |
|---|---|
| First Name* | KEVIN |
| MI | |
| Last Name* | WILLIAMS |

**Employer Information**

◉ Insured ◯ Self-Insured ◯ Legally Uninsured ◯ Uninsured

| | |
|---|---|
| Employer Name | WALMART INC |
| Employer Street Address/PO Box | 6750 KIMBALL AVE |
| City | CHINO |
| State | CA |
| Zip Code (Numbers Only) | 91708 |

**Insurance Carrier Information** (if applicable - include even if carrier is adjusted by claims administrator)

| | |
|---|---|
| Insurance Carrier Name | ACE AMERICAN INSURANCE CO |
| Insurance Carrier Street Addr/PO Box | PO BOX 14731 |
| City | LEXINGTON |
| State | KY |
| Zip Code (Numbers Only) | 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 |

ANSWERING DEFENDANTS deny the allegations of the application as indicated below with such explanations as expressly set forth and admit all other material allegations.

**DENIALS**
**(Mark X if allegation is denied)** **EXPLAIN BELOW**

☐ Employment

Field size limited to 129 characters

☐ Occupation

Field size limited to 129 characters

☒ Injury

NATURE AND EXTENT

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 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

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

☒ Permanent disability

APPORTIONMENT

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 ______ (MM/DD/YYYY) 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 )

○ 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
Signature

Phone Number 6195439960

| Field | Value |
|---|---|
| Firm Name | TESTAN LAW SAN DIEGO |
| Address/PO Box | 7676 HAZARD CENTER DRIVE SUITE 500 |
| City | SAN DIEGO |
| State | CA |
| Zip Code (Numbers Only) | 92108 |

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

2

3 # VERIFICATION

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

5 I, the undersigned say:

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

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

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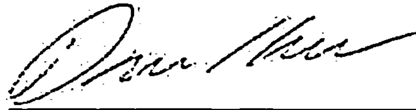
13 

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15 Daniel Hawkes
Attorney for Defendants

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TESTAN LAW SAN DIEGO
4970955
6195439960
angelolimpin@atblaw.net

PROOF OF SERVICE

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 not a party to the within action. My business address: Testan Law, 7676 Hazard Center DR STE 500, San Diego, CA 92108.

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 described as:

Answer to Application for Adjudication of Claim

on the interested parties in this action by placing the original or a true copy thereof enclosed in a sealed envelope addressed as follows:

[X] BY ELECTRONIC TRANSMISSION I transmitted a PDF version of this document by electronic mail to the WCAB through EAMS.

**Workers' Compensation Appeals Board**
**1065 N Pacificenter DR STE 170 & 200**
**Anaheim, CA 92806**

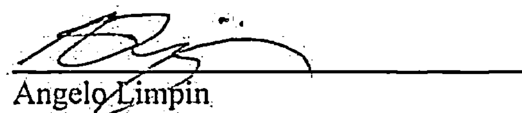
**Christine Leonard**
**York Risk Services Group, Inc.**
**PO Box 14731**
**Lexington, KY 40512**

**Law Offices of Natalia Foley**
**8306 Wilshire BLVD STE 115**
**Beverly Hills, CA 90211**

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 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.

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

Executed on October 11, 2019, at San Diego, CA.



Angelo Limpin

Document Type*: ---select---

Document Title*: ---select---

Document Date: (MM/DD/YYYY)

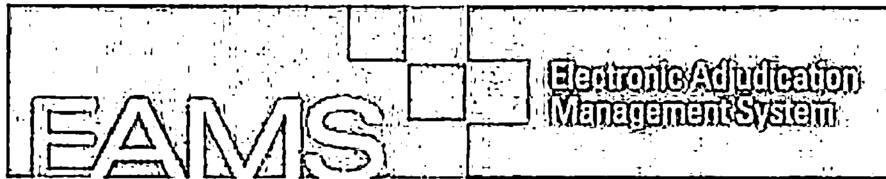
Author:

File Upload*: Browse...

Attachment

Uploaded Documents

| Document Type | 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: 31928008 Date: 10/11/2019 01:46:10 PM

OK

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

Companion Cases Exist ☐
More than 15 Companion Cases ☐
Location*: CTL
Walk Thru Yes ○ No ◉
Date: ( MM/DD/YYYY) 10/11/2019
Case Number*: ADJ12524635
SSN(Numbers Only)
○ Specific Injury (If Specific Injury, use the start date as the specific date of injury)
○ Cumulative Injury (START DATE: MM/DD/YYYY) * (END DATE: MM/DD/YYYY)
Body Part 1 :
Body Part 2 :
Body Part 3 :
Body Part 4 :
Other Body Parts :

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

◉ ADJ ○ DEU ○ SIF ○ UEF ○ SAU ○ INT ○ RSU

**Companion Cases**

**Case 1:**
○ Specific Injury (If Specific Injury, use the start date as the specific date of injury)
○ Cumulative Injury (START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)
Body Part 1 :
Body Part 2 :
Body Part 3 :
Body Part 4 :
Other Body Parts :

**Case 2:**
○ Specific Injury (If Specific Injury, use the start date as the specific date of injury)
○ Cumulative Injury (START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)
Body Part 1 :
Body Part 2 :
Body Part 3 :
Body Part 4 :
Other Body Parts :

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

**Case Number:** ADJ12524635

**(Choose only one)**

☐ a specific injury on ______ **(MM/DD/YYYY)**

☑ a cumulative trauma injury which began on 10/01/2018 (START DATE: MM/DD/YYYY)

and ended on 03/15/2019 (END DATE: MM/DD/YYYY)

Name(s) of Answering Party(ies): WALMART ASSOCIATES INC

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

**Injured Worker**

| | |
|---|---|
| First Name* | KEVIN |
| MI | |
| Last Name* | WILLIAMS |

**Employer Information**

◉ Insured ○ Self-Insured ○ Legally Uninsured ○ Uninsured

| | |
|---|---|
| Employer Name | WALMART INC |
| Employer Street Address/PO Box | 6750 KIMBALL AVE |
| City | CHINO |
| State | CA |
| Zip Code (Numbers Only) | 91708 |

**Insurance Carrier Information** (if applicable - include even if carrier is adjusted by claims administrator)

| | |
|---|---|
| Insurance Carrier Name | ACE AMERICAN INSURANCE CO |
| Insurance Carrier Street Addr/PO Box | PO BOX 14731 |
| City | LEXINGTON |
| State | KY |
| Zip Code (Numbers Only) | 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 |

ANSWERING DEFENDANTS deny the allegations of the application as indicated below with such explanations as expressly set forth and admit all other material allegations.

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**(Mark X if allegation is denied)** **EXPLAIN BELOW**

☐ Employment

Field size limited to 129 characters

☐ Occupation

Field size limited to 129 characters

☒ Injury

NATURE AND EXTENT

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(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

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☐ Liability for future medical treatment

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APPORTIONMENT

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(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 ____________ (MM/DD/YYYY) through ____________ (MM/DD/YYYY)

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○ 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
Signature

Phone Number 6195439960

| Firm Name | TESTAN LAW SAN DIEGO |
|---|---|
| Address/PO Box | 7676 HAZARD CENTER DRIVE SUITE 500 |
| City | SAN DIEGO |
| State | CA |
| Zip Code (Numbers Only) | 92108 |

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

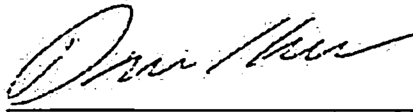
# VERIFICATION

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.



Daniel Hawkes
Attorney for Defendants

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TESTAN LAW SAN DIEGO
4970955
6195439960
angelolimpin@atblaw.net

PROOF OF SERVICE

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 not a party to the within action. My business address: Testan Law, 7676 Hazard Center DR STE 500, San Diego, CA 92108.

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Answer to Application for Adjudication of Claim

on the interested parties in this action by placing the original or a true copy thereof enclosed in a sealed envelope addressed as follows:

[X] BY ELECTRONIC TRANSMISSION I transmitted a PDF version of this document by electronic mail to the WCAB through EAMS.

**Workers' Compensation Appeals Board**
**1065 N Pacificenter DR STE 170 & 200**
**Anaheim, CA 92806**

**Christine Leonard**
**York Risk Services Group, Inc.**
**PO Box 14731**
**Lexington, KY 40512**

**Law Offices of Natalia Foley**
**8306 Wilshire BLVD STE 115**
**Beverly Hills, CA 90211**

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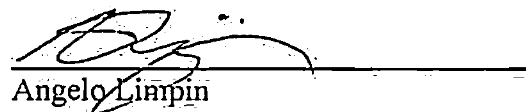


Angelo Limpin

Document Type*: ---select---

Document Title*: ---select---

Document Date: (MM/DD/YYYY)

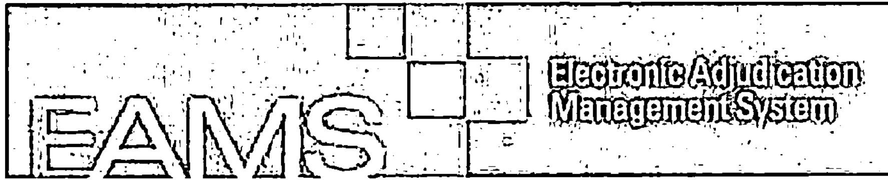
Author:

File Upload*: Browse...

Attachment

Uploaded Documents

| Document Type | 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*

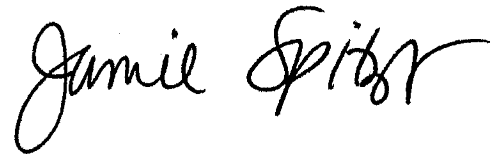
**JOINT ORDER GRANTING CHANGE OF VENUE – Labor Code section 5501.5**

**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.**



DATE: 11/06/2019

**Jamie Spitzer**
PRESIDING WORKERS' COMPENSATION JUDGE

**SERVICE:**
**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

Kevin Williams

*Applicant,*

vs.

Walmart Inc

*Defendants.*

## WALK THROUGH APPEARANCE SHEET

ADJ 12524635
ADJ 12524618 ADJ 12743430

Efiler: Yes ____ No X

Case set for hearing: Yes X No ___

Walk through document:

X C&R ______ STIP WITH AWARD
______ 5710 DEPOSITION ATTORNEY'S FEES
______ PETITION TO COMPEL ATTENDANCE AT MEDICAL EVALUATION/DEPO
______ PETITION FOR STAY ORDER-PJ ONLY

APPEARANCES

APPLICANT ☐ PRESENT ☐ NOT PRESENT

APPLICANT REPRESENTED BY ______ ☐ ATTORNEY ☐ HEARING REP.

DEFENDANT REPRESENTED BY Testan Law Daniel Hawkes ☒ ATTORNEY ☐ HEARING REP.

OTHERS APPEARING ______ ☐ ATTORNEY ☐ HEARING REP.

INTERPRETER ______ CERTIFICATION NO. ______

DISPOSITION: ☒ OTOC. ☐ ORDER SUSPENDING ACTION ON C&R/STIPS ☒ C&R/STIPS APPROVED

ORDER(s)/COMMENT(s): Post-term denied claims settled @ depo. AA is represented. No liens per Δ. No EDD. Depo fee $900 to be pd by Δ outside C&R. There is waiver of QME.

☐ PETITION APPROVED : ☐ 5710 FEES ☐ 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: ______ Location ______

DATE: 11/18/19 [signature: Myrle R Petty]

WORKERS' COMPENSATION JUDGE

NOTICE TO: Δ - Mr Hawkes Pursuant to Rule 10500, you are designated to serve this/these document(s) on all interested parties including all lien claimants.

[ ] Served on parties and lien claimants present

Date 11/18/19 By [signature: M Petty]

FOR WCAB USE ONLY:

JUDGE ASSIGNED: Petty

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

Kevin Williams

*Applicant,*

vs.

Walmart Inc; Ace American Insurance Co

*Defendant(s).*

Case No(s). ADJ12524635
ADJ12524618
ADJ12743430

San Bernardino District Office

**ORDER APPROVING COMPROMISE AND RELEASE**

The parties to the above-entitled action have filed a Compromise and Release on 11-18-2019 in the amount of $ 15,000.00. 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.

☒ **Injury AOE/COE** is seriously in issue as to ☒ all body parts alleged ☐ the following body parts: ______ based on ☒ dispute of law and fact ☐ statute of limitations ☐ medical opinions of ______ ☐ witness(es) ______.

☒ The parties have considered and included the release of any ☒ 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:

☐ paid in the amount of $ 2250.00 to Law Offices of Natalia Foley.

☐ paid $______ to ______ and $______ to ______ per fee agreement.

☐ The amount of $______ is ordered withheld from the settlement by defendant until resolution 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 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).

☒ There are no liens of record in the Board's system as of this date. ☐ The lien of the EDD has been resolved.

☒ Depo fee of $900.00 to be paid by Δ to AA outside of settlement.

Dated at San Bernardino, California: 11/18/19

☐ Filed and served by mail on all parties on the Official Address Record.

☒ Notice to: Δ - Mr Hawkes

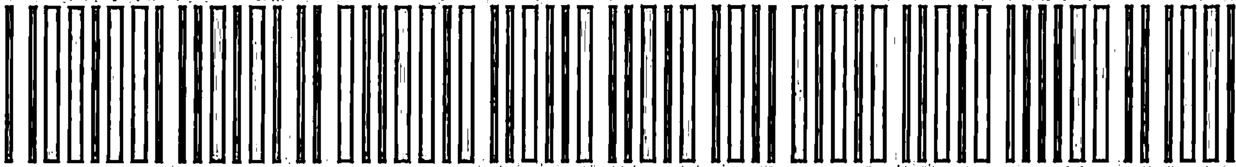
You are designated and ordered per Rule 10500 to serve this/these documents within five (5) days on all parties as shown on the Official Address Record. Proof of svc. to be filed only if requested by WCAB.

Date: 11/18/19 By: [signature]

[signature]
MYRLE R. PETTY
Workers' Compensation
Administrative Law Judge

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

## DOCUMENT COVER SHEET



Is this a new case? Yes ☐ No ☑ Companion Cases Exist ☐ Walkthrough Yes ☑ No ☐

More than 15 Companion Cases ☐

11/18/2019
Date:(MM/DD/YYYY)

SSN: ____________

☐ Specific Injury

ADJ12524618
Case Number 1

☑ Cumulative Injury 09/09/2018 (Start Date: MM/DD/YYYY) 03/20/2019 (End Date: MM/DD/YYYY)

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

Body Part 1: ____________ Body Part 3: ____________

Body Part 2: ____________ Body Part 4: ____________

Other Body Parts: ____________

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

☐ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ SAU ☐ INT ☐ RSU

**Companion Cases**

☐ Specific Injury

ADJ12524635
Case Number 2

☑ Cumulative Injury 10/01/2018 (Start Date: MM/DD/YYYY) 03/15/2019 (End Date: MM/DD/YYYY)

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

Body Part 1: ____________ Body Part 3: ____________

Body Part 2: ____________ Body Part 4: ____________

Other Body Parts: ____________

AOJ 12743430

~~UNASSIGNED~~

Case Number 3

[x] Specific Injury

[ ] Cumulative Injury

01/22/2019
(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

Body Part 1: 420

Body Part 3: ______

Body Part 2: ______

Body Part 4: ______

Other Body Parts: ______

Case Number 4

[ ] Specific Injury

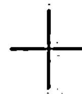
[ ] Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

Body Part 1: ______



Body Part 3: ______

Body Part 2: ______

Body Part 4: ______

Other Body Parts: ______

Case Number 5

[ ] Specific Injury

[ ] Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

Body Part 1: ______

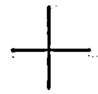
Body Part 3: ______

Body Part 2: ______

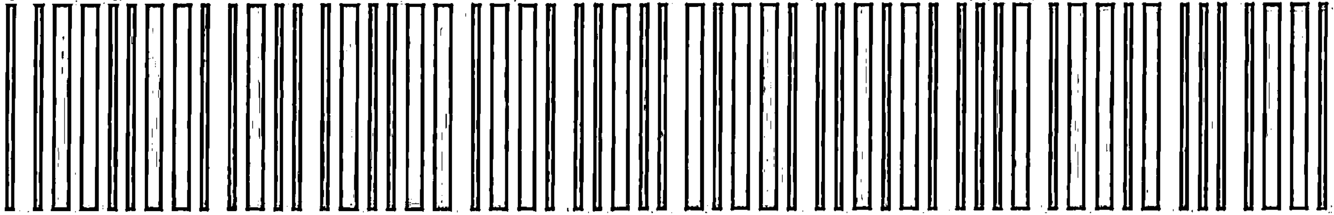
Body Part 4: ______

Other Body Parts: ______





# DOCUMENT SEPARATOR SHEET



Product Delivery Unit ADJ

Document Type LEGAL DOCS

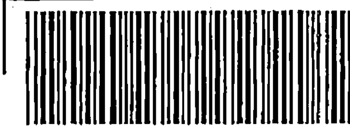
Document Title COMPROMISE AND RELEASE

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

ADJ12524618
Case Number 2

Case Number 5

~~Unassigned~~ ADJ12743430
Case Number 3

551-47-5680
SSN (Numbers Only)

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

☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

☒ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

☐ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

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

**Employee(Completion of this section is required)**

KEVIN
First Name

MI

RECEIVED
NOV 1 8 2019
DWC
SAN BERNARDINO

WILLIAMS
Last Name

2070 AVENIDA HACIENDA
Address/PO Box (Please leave blank spaces between numbers, names or words)

CHINO HILLS | CA | 91709
City | State | Zip Code

**Employer Information (Completion of this section is required)**

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

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

6750 KIMBALL AVE
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

CHINO | CA | 91708
City | State | Zip Code

**Applicant's Attorney or Authorized Representative:**

☐ Law Firm/Attorney ☐ Non Attorney Representative

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)

| ANAHEIM | CA | 92808 |
|---|---|---|
| City | State | Zip Code |

**Defendant's Attorney or Authorized Representative:**

☐ Law Firm/Attorney ☐ Non Attorney Representative

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 DIEGO | CA | 92108 |
|---|---|---|
| City | State | Zip Code |

**Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims 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, names or words)

| Lexington | Ky | 40512 |
|---|---|---|
| City | State | Zip Code |

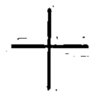
**Claims Administrator Information (if known and if applicable)**

YORK RISK SERVICES GROUP, INC.
Name (Please leave blank spaces between numbers, names or words)

PO BOX 14731
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

LEXINGTON — KY — 40512
City — State — Zip Code

**IT IS CLAIMED THAT:**



1. The injured employee, born 02/17/1964 (DATE OF BIRTH: MM/DD/YYYY), alleges that while employed as a(n)

____________________ , sustained injury
(OCCUPATION AT THE TIME OF INJURY)

arising out of and in the course of employment at the locations 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

ADJ12524635
Case Number 1

☒ Cumulative Injury

10/01/2018 (Start Date: MM/DD/YYYY) — 03/15/2019 (End Date: MM/DD/YYYY)

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

Body Part 1: 841 Body Part 2: ____ Body Part 3: ____

Body Part 4: ____ Other Body Parts: ____

The injury occurred at 702 SW 8th St
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

Bentonville, AR 72716
City, State, Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ Specific Injury

ADJ12524618
Case Number 2

☒ Cumulative Injury

09/09/2018 (Start Date: MM/DD/YYYY)

03/20/2019 (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: 450 Other Body Parts: 500

The injury occurred at 702 SW 8th St
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

Bentonville, AR 72716
City, State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

ADJ12743430
Unassigned
Case Number 3

☒ Specific Injury

☐ Cumulative Injury

01/22/2019 (Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

Body Part 1: 420 Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

The injury occurred at 702 SW 8th St
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

Bentonville, AR 72716
City, State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ Specific Injury

Case Number 4

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

Body Part 1: Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

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

City, State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ Specific Injury

Case Number 5 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
*(If Specific Injury, use the start date as the specific date of injury)*

Body Part 1: ________ Body Part 2: ________ Body Part 3: ________

Body Part 4: ________ Other Body Parts: ________

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

________ City, State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

2. Upon approval of this compromise agreement by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge and payment in accordance with the provisions hereof, the employee releases and forever discharges the above-named employer(s) and insurance carrier(s) from all claims and causes of action, whether now known or ascertained or which may hereafter arise or develop as a result of the above-referenced injury(ies), including any and all liability of the employer(s) and the insurance carrier(s) and each of them to the dependents, heirs, executors, representatives, administrators or assigns of the employee. Execution of this form has no effect on claims that are not within the scope of the workers' compensation law or claims that are not subject to the exclusivity provisions of the workers' compensation law, unless otherwise expressly stated.

3. This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury set forth in Paragraph No. 1 and further explained in Paragraph No. 9 despite any language to the contrary elsewhere in this document or any addendum.

4. Unless otherwise expressly stated, approval of this agreement RELEASES ANY AND ALL CLAIMS OF APPLICANT'S DEPENDENTS TO DEATH BENEFITS RELATING TO THE INJURY OR INJURIES COVERED BY THIS COMPROMISE AGREEMENT. The parties have considered the release of these benefits in arriving at the sum in Paragraph 7. Any addendum duplicating this language pursuant to Sumner v WCAB (1983) 48 CCC 369 is unnecessary and shall not be attached.

5. Unless otherwise expressly ordered by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge, approval of this agreement does not release any claim applicant may have for vocational rehabilitation benefits or supplemental job displacement benefits.

6. The parties represent that the following facts are true: (If facts are disputed, state what each party contends under Paragraph No. 9.)

EARNINGS AT TIME OF INJURY $ 700

TEMPORARY DISABILITY INDEMNITY PAID Ø Weekly Rate $ 466.67

Period(s) Paid ________ (Start Date: MM/DD/YYYY) ________ (End Date: MM/DD/YYYY)

PERMANENT DISABILITY INDEMNITY PAID Ø Weekly Rate $ 290.00

Period(s) Paid ________ (Start Date: MM/DD/YYYY) End date ________ (End Date: MM/DD/YYYY)

TOTAL MEDICAL BILLS PAID $ 1843.42 Total Unpaid Medical Expense to be Paid By: Defendant

Unless otherwise specified herein, the employer will pay no medical expenses incurred after approval of this agreement.

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
Settlement 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 ______

$ 2,250.00 requested as applicant's attorney's fee.

LEAVING A BALANCE OF $ 12,750.00 ✓, 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 forth 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, litigate or otherwise resolve all valid liens of record with the exception of any child support or spousal support liens, such liens remain the sole responsibility of the applicant.

Defendant will pay applicant attorneys LC 5710 depo fee for the 11-13-19 depo in the amount of $800.

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 | |
|---|---|---|
| KEW | DH | earnings |
| KEW | DH | temporary disability |
| KEW | DH | jurisdiction |
| KEW | DH | apportionment |
| KEW | DH | employment |
| KEW | DH | injury AOE/COE |
| KEW | DH | serious and willful misconduct |
| KEW | DH | discrimination (Labor Code §132a) |
| KEW | DH | statute of limitations |
| KEW | DH | future medical treatment |
| KEW | DH | other: medical mileage/out of pocket expenses |
| KEW | DH | permanent disability |
| KEW | DH | self-procured medical treatment, except as provided in Paragraph 7 |
| KEW | DH | vocational rehabilitation benefits/supplemental job displacement benefits |

COMMENTS:

Either party may appear ex parte for the purpose of obtaining approval of this settlement. Penalties and interest waived if payment is made within 30 days of OACR. Case is denied, post termination notice of injury.

See addendum: 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 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.

Witness the signature hereof this 13 day of November, 2019 at Redlands, CA

| | | | |
|---|---|---|---|
| Alicia Torres | 11/13/2019 | [signature] | 11/13/19 |
| Witness 1 | (Date) | Applicant (Employee) KEVIN WILLIAMS | (Date) |
| [signature] | | [signature] | 11/13/19 |
| Witness 2 | (Date) | Attorney for Applicant NATALIA FOLEY, ESQ. | (Date) |
| | | [signature] | 11-18-19 |
| Interpreter | (Date) | Attorney for Defendant | (Date) |
| | | | |
| | | Attorney for Defendant | (Date) |
| | | | |
| | | Attorney for Defendant | (Date) |
| | | | |
| | | Attorney for Defendant | (Date) |

## ACKNOWLEDGMENT

State of California
County of ______________________________)

On ______________________ before me, ________________________________________
(insert name and title of the officer)

personally appeared ______________________________________________________________,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature ______________________________ **(Seal)**

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

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.

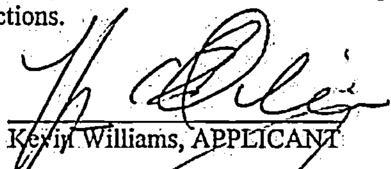
Any and all claims and petitions alleging violation of Labor Code section 132a and/or 4553 by defendant employer are herewith dismissed with prejudice. The parties stipulate that defendant employer has not violated Labor Code sections 132a or 4553.

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 all required medical provider network notices on a timely basis.

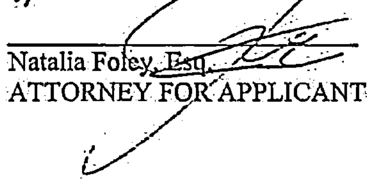
The defendant disputes all medical bills and lien claims relating to treatment provided by any person or entity not within the medical provider network. The defendant reserves the right to litigate the issue of reasonableness and necessity of all costs, treatment, and services procured outside the medical 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: 11/13/19



Kevin Williams, APPLICANT

DATED: 11/13/19



Natalia Foley, Esq.
ATTORNEY FOR APPLICANT

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NOV 18 2019
DWC
SAN BERNARDINO

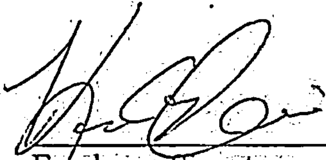
Addendum B

| RE: | Employee: | Kevin Williams |
|---|---|---|
| | Employer: | Walmart Inc. |
| | Claim Number: | 8949558; 8949567 |
| | Date of Injury: | 10/01/2018 - 03/15/2019; 09/09/2018 - 03/20/2019 |

## AFFIDAVIT OF WAIVER OF QME 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 ~~based upon the findings of and~~ not exercise my right to a qualified medical evaluation, from a physician selected from a panel.



Employee Signature

11/18/19
Date

RECEIVED
NOV 1 8 2019
DWC
SAN BERNARDINO

STATE OF CALIFORNIA

# WORKERS' COMPENSATION APPEALS BOARD

Kevin Williams

*Applicant,*

v.

Walmart Inc; Ace American Insurance Co.

*Defendants.*

Case No.

**AFFIDAVIT OF DEFENDANT RE: RESOLUTION OF LIENS**

I, Daniel Hawkes, am the attorney or representative for defendant Ace American Insurance Co, in the above-entitled matter.

I have made the following good faith efforts to resolve each of the liens in this case. List ALL lien claims below, use supplemental pages as necessary.

| LIEN CLAIMANT | NATURE & DATE OF LIEN RESOLUTION EFFORTS | RESULT |
|---|---|---|
| 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 / 15 / 2019.

RECEIVED

NOV 1 8 2019

DWC

S[illegible]

ATB000091

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

Received by
MAY 18 2020

Date of Original Lien: 05/11/2020

ADJ Case Number: ADJ12524635

☐ A specific injury on (date):

☑ A cumulative trauma injury beginning on (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

**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

20200511162344_001365154 ~ 2020-05-11T16:28:44

| EAMS UDQ USE ONLY | EDEX INFORMATION SYSTEMS JACKSON<br>JULIA BURNS<br>1-209-223-3461 ext. 100<br>SUPPORT@EDEXIS.COM | **Filed On Behalf of:**<br>PSYCHOLOGICAL ASSESSMENT LAGUNA NIGUEL<br>**Contact Person:**<br>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 California 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 05/13/2020

| | |
|---|---|
| **TESTAN LAW SAN DIEGO % TESTAN LAW** | **USPS 1 of 2** |
| 31330 Oak Crest Dr Westlake Village CA 91361-4632 | 3569694471-0000077560 |
| **YORK EL DORADO HILLS % YORK RISK SERVICES** | **USPS 2 of 2** |
| PO Box 14731 Lexington KY 40512-4731 | 0971819207-0000000840 |

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PSYCHOLOGICAL ASSESSMENT LAGUNA NIGUEL
PO BOX 6299 LAGUNA NIGUEL CA 92607
NINA LOFTON (714) 972-0040

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

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Did you receive extra documents? Missing pages? Unreadable forms? Call Edexis at (866) 438-3339 to receive a fresh copy.

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| Mailing ID | 919205-1817726 |
| Edexis Order ID | 1365154 |
| DWC Case # | ADJ12524635 |
| | |
| Pages | 10 |
| Packet Type | LIEN form and attachments |

pmcover.frx

## 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 Claims Administrator

| | |
|---|---|
| Name: | YORK EL DORADO HILLS |
| Address / PO Box: | PO BOX 14731 |
| City: | LEXINGTON |
| State: | KY |
| Zip Code: | 40512 |

## Employer, Insurance Carrier or Claims Administrator's Attorney or Representative

| | |
|---|---|
| Name: | TESTAN LAW SAN DIEGO |
| Address / PO Box: | 31330 OAK CREST DR |
| City: | WESTLAKE VILLAGE |
| State: | CA |
| Zip Code: | 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).)
- [x] 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:**

- ○ This is not a lien filed under Labor Code section 4903 (b) and is not a claim of costs filed as a lien.
- ○ 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 Provider 1 | Type: | DWCPDT0013 PHYSICIAN - MEDICAL TREATMENT | | |
| | Other Type: | | | |
| | Name: | PSYCHOLOGICAL ASSESSMENT LAGUNA NIGUEL | | |
| | NPI: | 1982895421 | License or Cert Number: | PSY12317 |
| Billing Provider 1 | Name: | PSYCHOLOGICAL ASSESSMENT LAGUNA NIGUEL | | |
| | NPI: | 1982895421 | Initial Date of Service: | 11/11/2019 |

| Rendering Provider 2 | | | | |
|---|---|---|---|---|
| | Type: | | | |
| | Other Type: | | | |
| | Name: | | | |
| | NPI: | | License or Cert Number: | |

| Billing Provider 2 | | | | |
|---|---|---|---|---|
| | Name: | | | |
| | NPI: | | Initial Date of Service: | |

| Rendering Provider 3 | | | | |
|---|---|---|---|---|
| | Type: | | | |
| | Other Type: | | | |
| | Name: | | | |
| | NPI: | | License or Cert Number: | |

| Billing Provider 3 | | | | |
|---|---|---|---|---|
| | Name: | | | |
| | NPI: | | Initial Date of Service: | |

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

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* — 05/11/2020

*( Signature of Lien Claimant )* *( Date of Signature )*

**CONTACT PERSON:**

**CASE INFORMATION:** **ADJ12524635 / KEVIN WILLIAMS**
**NINA LOFTON / 7149720040**

| EAMS UDQ USE ONLY | EDEX INFORMATION SYSTEMS JACKSON<br>JULIA BURNS<br>1-209-223-3461 EXT 100<br>SUPPORT@EDEXIS.COM | **FORM ID:** 20200511162344_001365154<br>The party filing this form automatically generated these documents using the EDEXIS online EAMS service. EDEXIS is a DWC-approved Third-Party EAMS Filer.<br>**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

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**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 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 |

I declare under penalty of perjury that this bill is true and correct to the best of my knowledge. LC 5703 (a)(1)

Nelson J. Flores, Ph.D., Q.M.E.

YORKWALMARTSAMS
PO BOX 14731
LEXINGTON KY 40512
(800)339-1109

# HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 551-47-5680

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): WILLIAMS KEVIN

3. PATIENT'S BIRTH DATE: 02 17 1964 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): WALMART

5. PATIENT'S ADDRESS (No., Street): 2070 AVENIDA HACIENDA
CITY: CHINO HILLS STATE: CA
ZIP CODE: 91709 TELEPHONE (Include Area Code): (909 )3428277

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]

7. INSURED'S ADDRESS (No., Street): 702 S W 8TH STREET
CITY: BENTOVILLE STATE: AR
ZIP CODE: 72716 TELEPHONE (Include Area Code): ( )

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): WILLIAMS, KEVIN
a. OTHER INSURED'S POLICY OR GROUP NUMBER: CL#:8949558
b. RESERVED FOR NUCC USE: 02 17 1964 X
c. RESERVED FOR NUCC USE: WALMART
d. INSURANCE PLAN NAME OR PROGRAM NAME: SEDGWICK

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) [X] YES [ ] NO
b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)
c. OTHER ACCIDENT? [ ] YES [X] NO
10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER: ADJ1252463512524618
a. INSURED'S DATE OF BIRTH: 02 17 1964 SEX: M [X] F [ ]
b. OTHER CLAIM ID (Designated by NUCC): WALMART
c. INSURANCE PLAN NAME OR PROGRAM NAME: YORKWALMARTSAMS
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO *If yes,* complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 03 15 2019 QUAL. INJURY

15. OTHER DATE QUAL. 10 01 18

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: NELSON J FLORES PHDQME
17a. DN
17b. NPI 1831237981

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. R69 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| | 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 11 11 19 | 11 11 19 | 11 | | 96130 | 59 | 1 | 160.49 | 1 | | 0B / NPI | PSY12317 / 183123798 |
| 2 | 11 11 19 | 11 11 19 | 11 | | 96131 | 59 | 1 | 732.78 | 6 | | 0B / NPI | PSY12317 / 183123798 |
| 3 | 11 11 19 | 11 11 19 | 11 | | 96136 | 59 | 1 | 67.80 | 1 | | 0B / NPI | PSY12317 / 183123798 |
| 4 | 11 11 19 | 11 11 19 | 11 | | 96137 | 59 | 1 | 126.34 | 2 | | 0B / NPI | PSY12317 / 183123798 |
| 5 | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER: 330889238 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: WILKE001 226537

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [X] NO

28. TOTAL CHARGE: $ 1087.41

29. AMOUNT PAID: $

30. Rsvd for NUCC Use: 1087.41

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
NELSON J. FLORES PH.D.
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
PSYCHOLOGICAL ASSESSMENT SERV
4344 LATHAM ST STE 120
RIVERSIDE CA 92501
a. b.

33. BILLING PROVIDER INFO & PH # (714 )972 0040
PSYCHOLOGICAL ASSESSMENT SERV
PO BOX 6299
LAGUNA NIGUEL, CA 92607-6299
a. 1831237981 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

**PENALTIES AND INTEREST APPLY AFTER 60 DAYS**

PSYCHOLOGICAL ASSESSMENT LAGUNA NIGUEL
PO BOX 6299 LAGUNA NIGUEL CA 92607
CLARIBEL VALADEZ (714) 972-0040

Received By:

JUL 27 2020

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

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| Edexis Order ID | 1374950 |
| DWC Case # | ADJ12524635 |
| | |
| Pages | 6 |
| Packet Type | DOR form and attachments |

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|---|---|---|

# 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** — **USPS 1 of 2**
31330 Oak Crest Dr Westlake Village CA 91361-4632 — 3569694471-0000077560

**YORK EL DORADO HILLS % YORK RISK SERVICES** — **USPS 2 of 2**
PO Box 14731 Lexington KY 40512-4731 — 0971819207-0000000840

**STATE OF CALIFORNIA**
**DWC DISTRICT OFFICE**

## DOCUMENT COVER SHEET

Is this a new case? Yes ☐ No ☑ Companion Cases Exist ☑ Walkthrough Yes ☐ No ☑

More than 15 Companion Cases ☐

07/22/20
Date:(MM/DD/YYYY)

SSN: ____________

ADJ12524635
Case Number 1

☐ Specific Injury

☐ Cumulative Injury ____________ (Start Date: MM/DD/YYYY) ____________ (End Date: MM/DD/YYYY)

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

Body Part 1: ____________ Body Part 3: ____________

Body Part 2: ____________ Body Part 4: ____________

Other Body Parts: ____________

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

☑ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ INT ☐ RSU

**Companion Cases**

ADJ12524618
Case Number 2

☐ Specific Injury

☐ Cumulative Injury ____________ (Start Date: MM/DD/YYYY) ____________ (End Date: MM/DD/YYYY)

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

Body Part 1: ____________ Body Part 3: ____________

Body Part 2: ____________ Body Part 4: ____________

Other Body Parts: ____________

ADJ12743430
Case Number 3

☐ Specific Injury

☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

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

Body Part 1: ____________ Body Part 3: ____________

Body Part 2: ____________ Body Part 4: ____________

Other Body Parts: ____________

☐ Specific Injury

Case Number 4

☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

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

Body Part 1: ____________ Body Part 3: ____________

Body Part 2: ____________ Body Part 4: ____________

Other Body Parts: ____________

☐ Specific Injury

Case Number 5

☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

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

Body Part 1: ____________ Body Part 3: ____________

Body Part 2: ____________ Body Part 4: ____________

Other Body Parts: ____________

# 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 |

**VS**

**Employer Information**

| Employer Name | WALMART INC |
|---|---|
| Employer Street Address / PO Box | 6750 KIMBALL AVE |
| City | CHINO |
| State | CA |
| Zip Code (Numbers Only) | 91708 |

**Declarants: Please designate your role** **(Please Select Only One)***

- ○ Employee
- ○ Applicant
- ○ Defendant
- ⦿ Lien Claimant

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

- ○ Mandatory Settlement Conference
- ○ Rating MSC*
- ⦿ Lien Conference
- ○ Status Conference
- ○ Priority Conference

**At the present time the principal issues are:** **(Check all that apply)**

- ☐ Compensation Rate
- ☐ Temporary Disability
- ☐ Permanent Disability
- ☐ AOE/COE
- ☐ Employment
- ☑ Other OUTSTANDING LIEN
- ☐ Rehabilitation / SJDB
- ☐ Self-procured Medical Treatment
- ☐ Future Medical Treatment
- ☑ Discovery

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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.

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

| EAMS UDQ USE ONLY | EDEX INFORMATION SYSTEMS JACKSON<br>JULIA BURNS<br>1-209-223-3461 EXT 100<br>SUPPORT@EDEXIS.COM | **FORM ID:** 20200722091358_001374950<br>The party filing this form automatically generated these documents using the EDEXIS online EAMS service. EDEXIS is a DWC-approved Third-Party EAMS Filer.<br>**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.

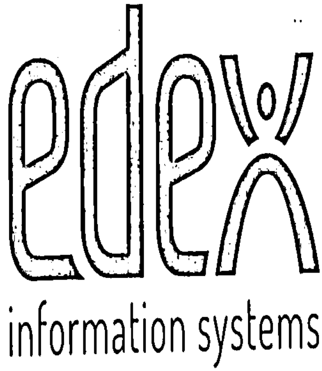
AND

[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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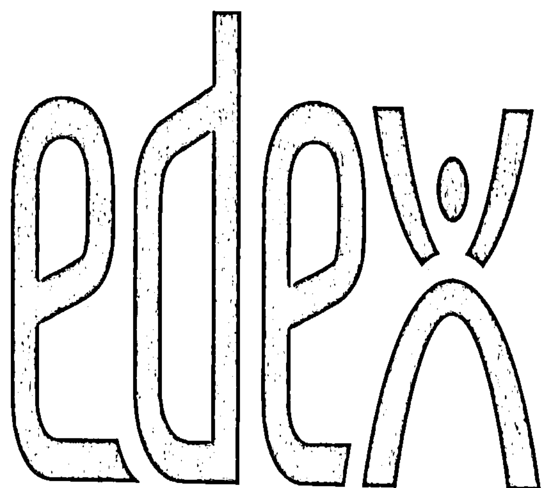


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DIVISION OF WORKERS' COMPENSATION

## 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:** http://www.dir.ca.gov/dwc/dir2.htm

**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*

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

Attorneys for Defendant

WORKERS' COMPENSATION APPEALS BOARD

FOR THE STATE OF CALIFORNIA

KEVIN WILLIAMS,

Applicant,

vs.

WALMART INC./ACE AMERICAN INSURANCE CO. as administered by YORK RISK SERVICES GROUP, INC.,

Defendant.

CASE NO: ADJ12524618; ADJ12524635

**OBJECTION TO AND PETITION FOR CHANGE OF VENUE**

**Cal. Lab. Code §5501.5 (c)**

**Cal. Code of Regs., Title 8 §10410**

COMES NOW, defendant(s) ACE AMERICAN INSURANCE as administered by YORK RISK SERVICES GROUP, INC., by and through their attorney's of record Testan Law with their Objection to Venue and Petition For Change of Venue.

## INTRODUCTION AND CONTENTONS

Pursuant to the provisions of Labor Code Section 5501.5(c) and Title 8, Code of Regulations, Section 10410, defendant ACE American Insurance Company as administered by York Risk Services Group, Inc. (YORK) hereby exercises its right to object to the designated venue site. The designated venue site does not appear to be based on any of the options found under Labor Code section 5501.5(a)(3). Defendant requests transfer to a district office which is in the California County where the alleged injury occurred within the meaning of Labor Code Section 5501.5(a)(2) and where the applicant resides per Labor Code Section 5501.5(a)(1).

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:

(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.]

**B.**

**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 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:

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

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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*, supra, 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.**

Respectfully submitted
**Testan Law**

Dated: October 7, 2019

Daniel Hawkes
Attorney for Defendants

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

Attorneys for Defendant

WORKERS' COMPENSATION APPEALS BOARD

FOR THE STATE OF CALIFORNIA

KEVIN WILLIAMS,

Applicant,

vs.

WALMART INC./ACE AMERICAN INSURANCE CO. as administered by YORK RISK SERVICES GROUP, INC.,

Defendant.

CASE NO: ADJ12524618; ADJ12524635

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**Cal. Lab. Code §5501.5 (c)**

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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.)

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### A.

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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.]

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6
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18 other than that it might be the preference of applicant's attorney.
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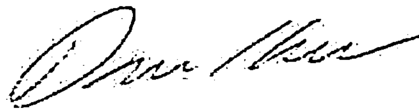
20 By reason of the foregoing, venue must be immediately transferred to the **San Bernardino district**
21 **office.**
22 Respectfully submitted
**Testan Law**
23
24 
25 Dated: October 7, 2019
Daniel Hawkes
Attorney for Defendants
26
27
28

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 110410

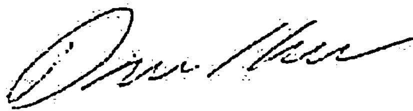
I, Daniel Hawkes, declare under penalty of perjury that I am the attorney for the defendant ACE American Insurance Company (ACE) as administered by York Risk Services Group. Inc. (YORK) and make this statement pursuant to WCAB Rule 10410. I am informed and believe that YORK has received only the Notice 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.

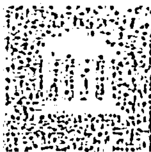
I am therefore informed and believe that this petition is therefore filed within 30 days of Notice of Venue Selection and the Application. I declare under penalty of perjury that the foregoing is true and correct and that the same was signed by me on this date.

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



Daniel Hawkes
Attorney for Defendants

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



EIN: 47-4713032
EAMS: 11964930

# LAW OFFICES OF NATALIA FOLEY

8306 Wilshire Blvd # 115 Beverly Hills, CA 90211
www.nataliafoleylaw.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:



Exhibit A

1. DWC-1 Claim Form
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.
3 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.
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



Exhibit A

orthopedic specialist as soon as possible

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)

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;

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

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

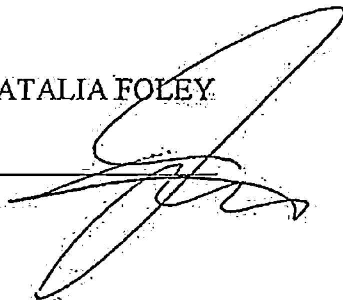
To whom it may concern

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



Exhibit A

9/24/2019

ATB000126

## 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

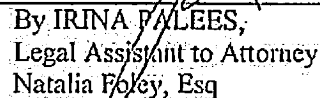
on the interested parties in this action, by placing a true copy thereof in a sealed envelope with postage thereon fully prepaid, in the United States Mail at my address stated above, addressed as follows:

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



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



Exhibit A

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TESTAN LAW SAN DIEGO
4970955
6195439960
angelolimpin@atblaw.net

PROOF OF SERVICE

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 not a party to the within action. My business address: Testan Law, 7676 Hazard Center DR STE 500, San Diego, CA 92108.

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 described as:

Objection to and Petition for Change of Venue

on the interested parties in this action by placing the original or a true copy thereof enclosed in a sealed envelope addressed as follows:

[X] BY ELECTRONIC TRANSMISSION I transmitted a PDF version of this document by electronic mail to the WCAB through EAMS.

**Workers' Compensation Appeals Board**
**1065 N Pacificenter DR STE 170 & 200**
**Anaheim, CA 92806**

**Christine Leonard**
**York Risk Services Group, Inc.**
**PO Box 14731**
**Lexington, KY 40512**

**Natalia Foley, Esq.**
**Law Offices of Natalia Foley**
**8306 Wilshire BLVD STE 115**
**Beverly Hills, CA 90211**

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 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.

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

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

Angelo Limpin

Master Case Number*:

Enter Companion Case Number: ADD

Companion Case Number: Companion Case Number DELETE

Case Type*: ---select---

Document Type*: ---select---
*(You must select Case Type before selecting Doc Type)*

Document Title*: ---select---
*(You must select Doc Type before selecting Doc Title)*

Lien Reservation Number:

Author:

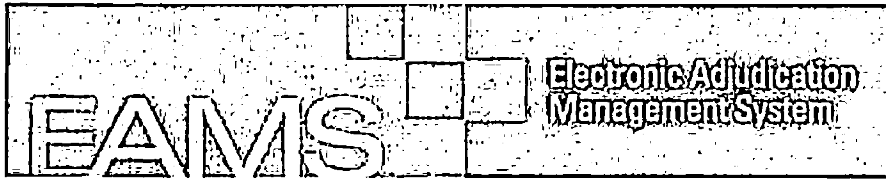
Document Date: *(mm/dd/yyyy)*

File Upload*: Browse...

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 | LEGAL DOCS | PROOF OF SERVICE | 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

OK