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

Batch ID: 27568929 Date: 07/06/2017 12:16:56 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) 07/06/2017

Case Number:*

SSN(Numbers Only) 623681468

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

( ) Cumulative Injury 06/26/2017 (START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

Body Part 1 : 410 ABDOMEN - INCLUD

Body Part 2 : 500 LOWER EXTREMITI

Body Part 3 : 141 JAW - INCLUDING C

Body Part 4 : 420 BACK - INCLUDING

Other Body Parts : 145 TEETH

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

(•) ADJ ( ) DEU ( ) SIF ( ) UEF ( ) VOC ( ) 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	
SSN	623681468

Amended Application ☐

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: 90211 MDR

Injured Worker

First Name*	SEMEN
MI	
Last Name*	LEV
Street Address 1 /PO Box*	17547 WILLARD ST
Street Address 2 /PO Box	
International Address	
City*	
State*	CA
Zip Code* (Numbers Only)	91325

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*	HVACONTROL INC
Employer Street Address/PO Box*	17735 SAN FERNANDO MISSION BLVD
City*	GRANADA HILLS
State*	CA
Zip Code* (Numbers Only)	91344

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

Insurance Carrier Name	SECURITY NATIONAL INSURANCE COMPANY
Street Address/PO Box	2710 GATEWAY OAKS DRIVE SUITE 150N
City	SACRAMENTO
State	CA
Zip Code (Numbers Only)	95833

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* 09/11/1960 (Date of birth : MM/DD/YYYY)

, while employed as a(n) AIR-CONDITIONER TECHNICIAN
(Occupation at the time of injury)

suffered a: (Choose only one)

(•) specific injury on **06/26/2017** (DATE OF INJURY: MM/DD/YYYY)

( ) cumulative trauma injury which began on

(START DATE: MM/DD/YYYY) and ended on (END DATE: MM/DD/YYYY)

The injury occured at* 7831 TEXHOMA AVE
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

NORTHRIDGE (City)* , CA (State)* 91325 (Zip Code)*

(State which parts of the body were injured)

Body Part 1 : **410 ABDOMEN - INCLUDING IN** Body Part 2 : **500 LOWER EXTREMITIES - NOT S**

Body Part 3 : **141 JAW - INCLUDING CHIN AN** Body Part 4 : **420 BACK - INCLUDING BACK MUS**

Other Body Parts : **145 TEETH**

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

APPLICANT SLEPT WHILE TRANSFERRING AIR-CONDITIONING UNIT TO THE CO-WORKER, FELT THROUGH A HOLE IN THE CEILING, INJURING THE ENTIRE AREA BETWEEN THE LEGS, INCLUDING CROTCH, REPRODUCTIVE ORGANS, THE WHOLE FRONT PART OF THE BODY , STOMACH, CHEST, RIBS, JAW, HEAD, KNOCKING OUT MOST OF THE FRONT TEETH

3. Actual earnings at the time of injury

Rate of Pay $ 10.00 ( ) Monthly ( ) Weekly (•) Hourly

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

Number of hours worked per week. 50

4. The injury caused disability as follows

Last day off work due to injury : 06/26/2017 (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. Field size limited to 80 characters	
Name of Doctor/Hospital/Clinic 2. Field size limited to 80 characters	

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

Case Number 1	
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)	1194930
Attorney/Rep First Name	NATALIA
Attorney/Rep MI	
Attorney/Rep Last Name	FOLEY
Street Address/PO Box	8306 WILSHIRE BLVD STE 11
City	CA
State	90211
Zip Code (Numbers Only)	

Applicant Attorney / Representative Signature	S NATALIA FOLEY
Applicant Signature	S SEMEN LEV

Dated at _____ , California Date _____

City (MM/DD/YYYY)

VENUE AUTHORIZATION

I HEREBY AUTHORIZE MY WORKERS' COMPENSATION CASE(S) FOR INJURY(IES) DATED June 26, 2017 TO BE FILED AT THE MDR WORKERS' COMPENSATION APPEALS BOARD.

DATED: 7/5/2017

APPLICANT

APPLICANT'S ATTORNEY:

NATALIA FOLEY BEVERLY HILLS
8306 WILSHIRE BLVD STE 115
BEVERLY HILLS CA 90211
TEL 310 707 8098
FAX 310 626 9632
NFOLEYLAW@GMAIL.COM

WC-105

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:

Marina del Rey - MDR

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 _____ Date 07/05/2017

Employee's Name SEMEN LEV

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.

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 07/05/2017

Attorney's name NATALIA FOLEY BEVERLY HILLS

Address 8306 WILSHIRE BLVD STE 115
BEVERLY HILLS CA 90211

Phone No. ( ) TEL 310 707 8098
FAX 310 626 9632
NFOLEYLAW@GMAIL.COM

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 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.

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.* SEMEN LEV Today's Date. *Fecha de Hoy.* 07/05/2017
2. Home Address. *Dirección Residencial.* 17547 WILLARD ST
3. City. *Ciudad.* NORTHRIDGE State. *Estado.* CA Zip. *Código Postal.* 91325
4. Date of Injury. *Fecha de la lesión (accidente).* 06/26/2017 Time of Injury. *Hora en que ocurrió.* ____ a.m. 5 p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* house of the company' client 7831 Texhoma Ave, Northridge, CA 91325
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* I slept while transferring air- conditioning unit to the co-worker, felt through a hole in the ceiling, injuring the entire area between the legs, including crotch, reproductive organs, the whole front part of the body , stomach, chest, ribs, jaw, head, knocking out most of the front teeth
7. Social Security Number. *Número de Seguro Social del Empleado.* 623 68 1468
8. Signature of employee. *Firma del empleado.* ____

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 **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.

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: 07/14/2017

Applicant: _____
Signature

Dated: 07/14/2017

Applicant' Attorney _____
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."

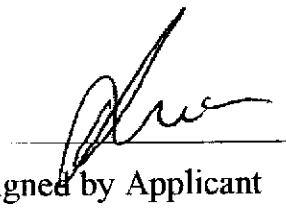
APPLICATION VERIFICATION

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: 7/14/2017



Signed by Applicant

Applicant Attorney: NATALIA FOLEY BEVERLY HILLS/ UAN **1194930**
LAW OFFICES OF NATALIA FOLEY,
8306 WILSHIRE BLVD STE 115 BEVERLY HILLS CA 90211
TEL 310 707 8098/FAX 310 626 9632/ NFOLEYLAW@GMAIL.COM

Case Title: **SEMEN LEV vs. HVACONTROL INC**
WCAB #: UNASSIGNED

PROOF OF SERVICE BY MAIL
(CCP §1013(a) and 2015.5)
STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am employed in the county aforesaid; I am over the age of eighteen years and not a party to the within entitled action; my business address is 8306 WILSHIRE BLVD STE 115 BEVERLY HILLS CA 90211.

I am readily familiar with the business' practice for collection and processing of correspondence for mailing with the United States Postal Service, and the fact that the correspondence would be deposited with the United States Postal Service that same day in the ordinary course of business.

On 7/14/2017 I served the foregoing document(s) described as:

APPLICATION OF ADJUDICATION OF CLAIM,
4906(G), FEE DISCLOSURE STATEMENT AND VENUE AUTHORIZATION

On all interested party(ies) in this action, by placing the true and correct copy(ies) thereof enclosed in a sealed envelope(s) with postage thereon fully prepaid, in the United States mail at Santa Ana, California, addressed as follows:

Board:
WCAB MDR
4720 LINCOLN BOULEVARD,
2ND FLOOR
MARINA DEL REY,
CA 90292-6902

Applicant
SEMEN LEV
17547 WILLARD ST
NORTHRIDGE CA 91325

Employer
HVACONTROL INC
17735 SAN FERNANDO
MISSION BLV GRANADA
HILLS, CA 91344

Insurance

Adjuster

Defense Attorney

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

Executed on 7/14/2017 in the City of Newport Beach, County of Orange, State of California.

Declared by: Tigran Tosunyan

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

Batch ID: 27569182 Date: 07/06/2017 12:35:41 PM

OK

STATE OF CALIFORNIA
DWC DISTRICT OFFICE
E-COVER SHEET

REQUIRED FIELDS SHOWN BY "*"

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

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

More than 15 Companion Cases [ ]

Date: (MM/DD/YYYY) 07/06/2017

Case Number:* SSN(Numbers Only) 623681468

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

( ) Cumulative Injury 06/17/2017 (START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

Body Part 1 : 519 LEG - NOT SPECIFI Body Part 2 :

Body Part 3 : 842 NERVOUS SYSTEM Body Part 4 :

Other Body Parts :

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

(•) ADJ ( ) DEU ( ) SIF ( ) UEF ( ) VOC ( ) 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	
SSN	623681468

Amended Application ☐

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: 90211 MDR

Injured Worker

First Name*	SEMEN
MI	
Last Name*	LEV
Street Address 1 /PO Box*	17547 WILLARD ST
Street Address 2 /PO Box	
International Address	
City*	NORTHRIDGE
State*	CA
Zip Code* (Numbers Only)	91325

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*	HVACONTROL INC
Employer Street Address/PO Box*	17735 SAN FERNANDO MISSION BLVD
City*	GRANADA HILLS
State*	CA
Zip Code* (Numbers Only)	91344

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

Insurance Carrier Name	SECURITY NATIONAL INSURANCE COMPANY
Street Address/PO Box	2710 GATEWAY OAKS DRIVE SUITE 150N
City	SACRAMENTO
State	CA
Zip Code (Numbers Only)	95833

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* 09/11/1960 (Date of birth : MM/DD/YYYY)

, while employed as a(n) AIR-CONDITIONING TECHNICIAN
(Occupation at the time of injury)

suffered a: (Choose only one)

(•) specific injury on **06/17/2017** (DATE OF INJURY: MM/DD/YYYY)

( ) cumulative trauma injury which began on

(START DATE: MM/DD/YYYY) and ended on (END DATE: MM/DD/YYYY)

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

NORTHRIDGE (City)* CA (State)* 91325 (Zip Code)*

(State which parts of the body were injured)

Body Part 1 : **519 LEG - NOT SPECIFIED** Body Part 2 :

Body Part 3 : **842 NERVOUS SYSTEM - PSYC** 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

APPLICANT WAS INSTALLING AIR-CONDITIONING UNIT AT THE PREMISES OF THE CLIENT, AND CLIENT'S DOG BIT APPLICANT'S LEFT LEG. DOG BITE AND STRESS

3. Actual earnings at the time of injury

Rate of Pay $ 10.00 ( ) 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. Field size limited to 80 characters	
Name of Doctor/Hospital/Clinic 2. Field size limited to 80 characters	

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

Case Number 1	
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)	1194930
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	S SEMEN LEV

Dated at LOS ANGELES (City), California Date 07/06/2017 (MM/DD/YYYY)

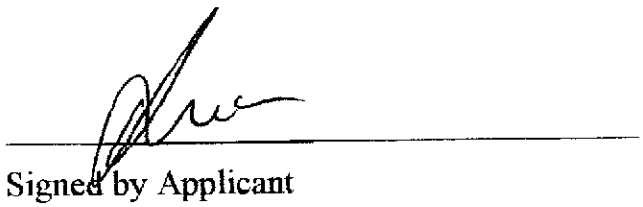
APPLICATION VERIFICATION

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: 7/6/2017



Signed by Applicant

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: 07/05/2017

Applicant: _____
Signature

Dated: 07/05/2017

Applicant' Attorney _____
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."

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 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.

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.* SEMEN LEV Today's Date. *Fecha de Hoy.* 07/05/2017
2. Home Address. *Dirección Residencial.* 17547 WILLARD ST
3. City. *Ciudad.* NORTHRIDGE State. *Estado.* CA Zip. *Código Postal.* 91325
4. Date of Injury. *Fecha de la lesión (accidente).* June 17, 2017 Time of Injury. *Hora en que ocurrió.* ____ a.m. 2.30 p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* HOUSE OF COMPANY' CLIENT, NORTHRIDGE CA
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* Dog bite and stress when installing air-conditioning at the property of company's client
7. Social Security Number. *Número de Seguro Social del Empleado.* 623 68 1468
8. Signature of employee. *Firma del empleado.*

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 **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

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:

Marina del Rey - MDR

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 _____ Date 07/05/2017

Employee's Name SEMEN LEV

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.

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(c) and (g)(1).

Attorney's Signature _____ Date 07/05/2017

Attorney's name NATALIA FOLEY BEVERLY HILLS

Address 8306 WILSHIRE BLVD STE 115
BEVERLY HILLS CA 90211

Phone No. ( ) TEL 310 707 8098
FAX 310 626 9632
NFOLEYLAW@GMAIL.COM

VENUE AUTHORIZATION

I HEREBY AUTHORIZE MY WORKERS' COMPENSATION CASE(S) FOR INJURY(IES) DATED June 17, 2017 TO BE FILED AT THE MDR WORKERS' COMPENSATION APPEALS BOARD.

DATED: 7/5/2017

APPLICANT

APPLICANT'S ATTORNEY:

NATALIA FOLEY BEVERLY HILLS
8306 WILSHIRE BLVD STE 115
BEVERLY HILLS CA 90211
TEL 310 707 8098
FAX 310 626 9632
NFOLEYLAW@GMAIL.COM

Applicant Attorney: NATALIA FOLEY BEVERLY HILLS/ UAN **1194930**
LAW OFFICES OF NATALIA FOLEY,
8306 WILSHIRE BLVD STE 115 BEVERLY HILLS CA 90211
TEL 310 707 8098/FAX 310 626 9632/ NFOLEYLAW@GMAIL.COM

Case Title: **SEMEN LEV vs. HVACONTROL INC**
WCAB #: UNASSIGNED

PROOF OF SERVICE BY MAIL
(CCP §1013(a) and 2015.5)
STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am employed in the county aforesaid; I am over the age of eighteen years and not a party to the within entitled action; my business address is 8306 WILSHIRE BLVD STE 115 BEVERLY HILLS CA 90211.

I am readily familiar with the business' practice for collection and processing of correspondence for mailing with the United States Postal Service, and the fact that the correspondence would be deposited with the United States Postal Service that same day in the ordinary course of business.

On 7/14/2017 I served the foregoing document(s) described as:

APPLICATION OF ADJUDICATION OF CLAIM,
4906(G), FEE DISCLOSURE STATEMENT AND VENUE AUTHORIZATION

On all interested party(ies) in this action, by placing the true and correct copy(ies) thereof enclosed in a sealed envelope(s) with postage thereon fully prepaid, in the United States mail at Santa Ana, California, addressed as follows:

Board:
WCAB MDR
4720 LINCOLN BOULEVARD,
2ND FLOOR
MARINA DEL REY,
CA 90292-6902

Applicant
SEMEN LEV
17547 WILLARD ST
NORTHRIDGE CA 91325

Employer
HVACONTROL INC
17735 SAN FERNANDO
MISSION BLV GRANADA
HILLS, CA 91344

Insurance

Adjuster

Defense Attorney

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

Executed on 7/14/2017 in the City of Newport Beach, County of Orange, State of California.

Declared by: Tigran Tosunyan