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	TYPED OR WRITTEN LETTER	C:\fakepath\01 - application verification.pdf	Delete
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STATE OF CALIFORNIA DWC DISTRICT OFFICE E-COVER SHEET

Companion Cases E More than 15 Compa		Walk Thru	Location: CTL Yes ()	No (•)
Date: (MM/DD/YYYY)	06/21/2021			
Case Number*:	ADJ13487196	SSN(Numbers Only)		
○ Specific Injury	(If Specific Injury, use the start d)	
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 b	ох)∗		
• ADJ 🔿 DEU		IEF O SAU C) INT ()	RSU
Companion Cases				
Case 1:				
1				
⊖ Specific Injury	(If Specific Injury, use the start d	」 ate as the specific date of injury)	
)	
Cumulative Injury	(If Specific Injury, use the start d	(END DATE: MM/DD/YYYY))	
Cumulative Injury Body Part 1 :		(END DATE: MM/DD/YYYY) Body Part 2 :)	
Cumulative Injury Body Part 1 : Body Part 3 :		(END DATE: MM/DD/YYYY))	
Cumulative Injury Body Part 1 :		(END DATE: MM/DD/YYYY) Body Part 2 :)	
Cumulative Injury Body Part 1 : Body Part 3 :		(END DATE: MM/DD/YYYY) Body Part 2 :)	
Cumulative Injury Body Part 1 : Body Part 3 : Other Body Parts : Case 2:		(END DATE: MM/DD/YYYY) Body Part 2 : Body Part 4 :		
 Cumulative Injury Body Part 1 : Body Part 3 : Other Body Parts : Case 2: Specific Injury 	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YYYY) Body Part 2 : Body Part 4 :		
 Cumulative Injury Body Part 1 : Body Part 3 : Other Body Parts : Case 2: Specific Injury Cumulative Injury 	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YYYY) Body Part 2 : Body Part 4 :		
 Cumulative Injury Body Part 1 : Body Part 3 : Other Body Parts : Case 2: Specific Injury 	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YYYY) Body Part 2 : Body Part 4 :		
 Cumulative Injury Body Part 1 : Body Part 3 : Other Body Parts : Case 2: Specific Injury Cumulative Injury 	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YYYY) Body Part 2 : Body Part 4 :		

0 0			
Case 3:			
○Specific Injury	(If Specific Injury, use the start da	te as the specific date	e of injury)
OCumulative Injury	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YY	(Y)
Body Part 1 :		Body Part 2 :	
Body Part 3 :		Body Part 4 :	
Other Body Parts :			

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

Case 5:			
○ Specific Injury	(If Specific Injury, use the start da	te as the specific date	e of injury)
Cumulative Injury	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YY)	YY)
Body Part 1 :		Body Part 2 :	
Body Part 3 :		Body Part 4 :	
Other Body Parts :			

Case 6:			
⊖ Specific Injury	(If Specific Injury, use the start da	ate as the specific date	e of injury)
Cumulative Injury	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YY	YY)
Body Part 1 :		Body Part 2 :	
Body Part 3 :		Body Part 4 :	
Other Body Parts :			

Case 7:			
⊖ Specific Injury	(If Specific Injury, use the start da	te as the specific date	e of injury)
⊖Cumulative Injury	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YY	YY)
Body Part 1 :		Body Part 2 :	
Body Part 3 :		Body Part 4 :	
Other Body Parts :			

Case 8:			
⊖ Specific Injury	(If Specific Injury, use the start da	ate as the specific date	e of injury)
⊖Cumulative Injury	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YY	YY)
Body Part 1 :		Body Part 2 :	
Body Part 3 :		Body Part 4 :	
Other Body Parts :			

Case 9:			
⊖ Specific Injury	(If Specific Injury, use the start da	ate as the specific date	e of injury)
Cumulative Injury	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YY	YY)
Body Part 1 :		Body Part 2 :	
Body Part 3 :		Body Part 4 :	
Other Body Parts :			

Case 10:			
◯ Specific Injury	(If Specific Injury, use the start da	te as the specific date	of injury)
⊖Cumulative Injury	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YYY	Y)
Body Part 1 :		Body Part 2 :	
Body Part 3 :		Body Part 4 :	
Other Body Parts :			

Case 11:			
⊖ Specific Injury	(If Specific Injury, use the start da	te as the specific date	e of injury)
⊖Cumulative Injury	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YY	YY)
Body Part 1 :		Body Part 2 :	
Body Part 3 :		Body Part 4 :	
Other Body Parts :			

Case 12:			
⊖ Specific Injury	(If Specific Injury, use the start da	te as the specific date	e of injury)
⊖Cumulative Injury	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YY	YY)
Body Part 1 :		Body Part 2 :	
Body Part 3 :		Body Part 4 :	
Other Body Parts :			

Case 13:			
⊖Specific Injury	(If Specific Injury, use the start da	te as the specific date	e of injury)
⊖Cumulative Injury	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/Y)	(YYY)
Body Part 1 :		Body Part 2 :	
Body Part 3 :		Body Part 4 :	
Other Body Parts :			
		1	

Case 14:			
○ Specific Injury	(If Specific Injury, use the start da	te as the specific date	e of injury)
⊖Cumulative Injury	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YY	YY)
Body Part 1 :		Body Part 2 :	
Body Part 3 :		Body Part 4 :	
Other Body Parts :			

Case 15:			
⊖ Specific Injury	(If Specific Injury, use the start da	ate as the specific dat	e of injury)
⊖Cumulative Injury	(START DATE: MM/DD/YYYY)	(END DATE: MM/DD/YY	YY)
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 SUBSEQUENT INJURIES FUND BENEFITS

Case No1.	ADJ13487196
Case No2.	
Case No3.	
Case No4.	
Case No5.	

Injured Worker

First Name*	SZYMON
MI	
Last Name*	JERMAKOW

Vs

Employer Name*	PACIFIC PLASTICS
Insurance Carrier Name	PACIFIC COMP CLAIM THOU OAKS
Third Party Administrator	PACIFIC COMP CLAIM THOU OAKS

APPLICATION FOR SUBSEQUENT INJURIES FUND BENEFITS

1. Applicant SZYMON JERMAKOW

, born	on	05/04/1940	was injured on	03/	15/2020
		(MM/DD/YYYY)*			(MM/DD/YYYY)
, as a	MEC	CHANIC			at BREA
		(Occupation)			(City)
Califo	ornia v	with earnings of \$		per	
Applica	ant su	stained injury arising	out of and occurrir	ng in	the course of his/her employment
resultir	ng in p	permanent and partia	I disability affecting	the f	ollowing parts of the body:
NECK	UPPI	ER EXTREMITIES B	ACK SHOULDERS	;	
The pe	erman	ent disability, when c	onsidered alone ar	nd wit	hout regard to or adjustment for the

applicant's occupation or age is equal to 35 percent or more of total disability.

2.	Immediately prior to the injury, applicant was permanently disabled in the following respects: Field size limited to 80 characters

	BI PTSD ARTHRITIS EYES LUMBAR NECK	
	ne pre-existing disabilities occurred as a result of: Field size limited to 80 characters	
	RIOR BODILY INJURIES GENETIC DISEASES AND PSYCHOPATHOLOGY	
3.	pplicant has previously filed a workers' compensation claim with the Workers' Compensation ppeals Board	
	ase Number ADJ13487196	
4.	pplicant filed for Social Security Disability benefits on	
	nd is receiving \$ per month. (MM/DD/YYYY)	
	Applicant's Social Security Number is (Numbers Only)	

WHEREFORE, applicant requests benefits as provided by law

Attorney for Applicant Signature	S NATALIA FOLEY
	· · · · · · · · · · · · · · · · · · ·

Applicant Signature	SZYMON JERMAKOW
Street Address/PO Box	751 S WEIR CANYON RD STE 157-455
City	ANAHEIM
State	CA
Zip Code (Numbers Only)	92808

1 2 3	E-Filer: UAN: EAMS #: Address:	NATALIA FOLEY, ESQ WORKERS DEFENDERS A 13792552 WORKERS DEFENDERS I 751 S Weir Canyon Rd Ste Tel: 714 948 5054/ Cell: 310	LAW GROUP	
4			PROOF OF SERVICE	
5	1. I am over the age of 18 and not a party of this cause. I am a resident of or employed in the			
6	county where the mailing occurred. My residence or business address is 751 S Weir Canyon Rd Ste 157-455			
7	Anaheim CA 92808 2. I served the following documents:			
8	APPLICATION FOR SIBTF			
9	by enclosing a true copy in a sealed envelope addressed to each person whose name and address is shown			
10	below and depositing the envelope in the US mail with the postage fully prepaid.			
11	• Date of Mailing: 6/21/2023			
12	Place of Mailing: Anaheim, Orange County, CA			
13	3. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.			
14	Date: 6/21/2023		A	
15	By Irina Palees, Legal Assistant			
16			to Attorney Natalia Foley	
17	Name and Address of each Person to whom Notice was Mailed			
18	List of the perso	ns served:		
19	OD LEGAL 355 S. GRAND AVE STE) AVE STE 1400	SIBTF 1750 HOWE AVENUE, SUITE 370	
20	LOS ANGELE		SACRAMENTO, CA 95825-3367	
21	WCAB 1065 LINK #170 ANAHEIM CA 92806		PACIFIC COMP CLAIM THOU OAKS	
22			PO BOX 5042 THOUSAND OAKS CA 91359	
23	SZYMON JERMAKOW 3744 LAKE CREST DR UNIT 62 YORBA LINDA CA 92886		GILSON DAUB	
24			3005 S EL CAMINO REAL SAN CLEMENTE, CA 92672	
25				
26				
27				
28				
	PROOF OF S	SERVICE		

WORKERS DEFENDERS LAW GROUP

8018 E Santa Ana Cyn Ste 100-215, Anaheim Hills CA 92808 Tel: 714 948 5054 / Fax: 310 626 9632 / workerlegalinfo@gmail.com

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 ad I have no offered, delivered, received, or accepted any rebate, refund, commission, preferences, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examinations ort evaluations.

APPLICANT:	X <u>Gyman Gernarder</u> (signature)	06/21/2023 (date)
APPLICANT' ATTORNEY	(signature)	06/21/2023 (date)

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".

WORKERS DEFENDERS LAW GROUP

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 Garmon Formerka

06/21/2023 (date)

Employee's Printed 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

06/21/2023 (date)

Attorney's Printed Name: LAW FIRM ADDRESS: (signature) (date) Natalia Foley, Esq Workers Defenders Law Group, 8018 E Santa Ana Cyn Ste 100-215, Anaheim Hills CA 92808 Tel: 714 948 5054 / Fax: 310 626 9632 / workerlegalinfo@gmail.com

ADDENDUM TO DISCLOSURE

According to the Workers' Compensation Appeal Board Rules of Procedure, Section 10775 and the Policy and Procedure Manual 6.8.4, Attorney fee could range up to 15% or more, based n the complexity of the case, amount of work performed and time involved, and results obtained as well as other variables.

The Judge will determine the attorney fees. Under section 10778 of these Rules, you are hereby informed that this is an adverse interest and that you have right to independent counsel.

APPLICANT: <u>Sysnen Formulla</u> (signature)

06/21/2023

(date)

WORKERS DEFENDERS LAW GROUP

8018 E Santa Ana Cyn Ste 100-215, Anaheim Hills CA 92808 Tel: 714 948 5054 $\,/$ Fax: 310 626 9632 / workerlegalinfo@gmail.com

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.

APPLICANT:

Х mos Gerancika

(signature)

06/21/2023

(date)