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LEGAL DOCS	4906(g) DECLARATION	C:\fakepath\03 - declaration.pdf	<input type="button" value="Delete"/>
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LEGAL DOCS	PROOF OF SERVICE	C:\fakepath\04 - POS.pdf	<input type="button" value="Delete"/>
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**STATE OF CALIFORNIA
DWC DISTRICT OFFICE
E-COVER SHEET**

Companion Cases Exist <input type="checkbox"/>		Location: <input type="text" value="CTL"/>
More than 15 Companion Cases <input type="checkbox"/>		Walk Thru Yes <input type="radio"/> No <input checked="" type="radio"/>
Date: (MM/DD/YYYY)	<input type="text" value="06/21/2021"/>	
Case Number*:	<input type="text" value="ADJ13487196"/>	SSN(Numbers Only) <input type="text"/>
<input type="radio"/> Specific Injury	(If Specific Injury, use the start date as the specific date of injury)	
<input type="radio"/> Cumulative Injury	<input type="text"/>	<input type="text"/>
	(START DATE: MM/DD/YYYY) *	(END DATE: MM/DD/YYYY)
Body Part 1* :	<input type="text"/>	Body Part 2 : <input type="text"/>
Body Part 3 :	<input type="text"/>	Body Part 4 : <input type="text"/>
Other Body Parts :	<input type="text"/>	

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

ADJ DEU SIF UEF SAU INT RSU

Companion Cases

Case 1:

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

Cumulative Injury

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

Body Part 1 : Body Part 2 :

Body Part 3 : Body Part 4 :

Other Body Parts :

Case 2:

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

Cumulative Injury

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

Body Part 1 : Body Part 2 :

Body Part 3 : Body Part 4 :

Other Body Parts :

Case 3:

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 4:

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 5:

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 6:

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 7:

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 8:

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 9:

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 10:

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 11:

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 12:

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 13:

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 14:

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 15:

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 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 MECHANIC at BREA
(Occupation) (City)

California with earnings of \$ per

Applicant sustained injury arising out of and occurring in the course of his/her employment resulting in permanent and partial disability affecting the following parts of the body:

NECK UPPER EXTREMITIES BACK SHOULDERS

The permanent disability, when considered alone and without 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

TBI PTSD ARTHRITIS EYES LUMBAR NECK

The pre-existing disabilities occurred as a result of: Field size limited to 80 characters

PRIOR BODILY INJURIES GENETIC DISEASES AND PSYCHOPATHOLOGY

3. Applicant has previously filed a workers' compensation claim with the Workers' Compensation Appeals Board

Case Number ADJ13487196

4. Applicant filed for Social Security Disability benefits on

and 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

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 *Gerron Ternecka* 06/21/2023
(signature) (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
(signature) (date)

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

WORKERS DEFENDERS LAW GROUP

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: **X** *Suzanne Ferrella* 06/21/2023
(signature) (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:

X

Symona Yeranck
(signature)

06/21/2023

(date)