DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD

NOTICE OF APPLICATION

DATE OF SERVICE:*04/06/2021*

WCAB CASE NBR:*ADJ14468143*

DATE OF CLAIMED INJURY:*03/23/2021*

EMPLOYEE:*MARTIN LUGO*

EMPLOYER:*WESTPAC LABS INC*

INSURER:*GALLAGHER BASSETT ALISO VIEJO*

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: 04/05/2021

WC04

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

Batch ID: 34544276 Date: 04/05/2021 05:51:00 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) 04/05/2021

Case Number:* SSN(Numbers Only) 561711451

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

( ) Cumulative Injury 03/23/2021 (START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

Body Part 1 : 440 HIPS - INCLUDING P Body Part 2 : 410 ABDOMEN - INCLUD

Body Part 3 : 420 BACK - INCLUDING 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	
SSN	561711451

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: 92808 AHM

Injured Worker

First Name*	MARTIN
MI	
Last Name*	LUGO
Street Address 1 /PO Box*	135 HORNBEAM LN
Street Address 2 /PO Box	
International Address	
City*	FOUNTAIN VALLEY
State*	CA
Zip Code* (Numbers Only)	92708

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*	WESTPAC LABS INC
Employer Street Address/PO Box*	10200 PIONEER BLVD 500
City*	SANTA FE SPRINGS
State*	CA
Zip Code* (Numbers Only)	90670

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

Insurance Carrier Name	GALLAGHER BASSETT ALISO VIEJO
Street Address/PO Box	PO BOX 2934
City	CLINTON
State	IA
Zip Code (Numbers Only)	52733

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* 07/30/1964 (Date of birth : MM/DD/YYYY)

, while employed as a(n) COURIER

(Occupation at the time of injury)

suffered a: (Choose only one)

- (•) specific injury on 03/23/2021 (DATE OF INJURY: MM/DD/YYYY)
- ( ) cumulative trauma injury which began on _____ and ended on _____

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

The injury occured at* 10200 PIONEER BLVD 500

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

SANTA FE SPRINGS , CA 90670

(City)* (State)* (Zip Code)*

(State which parts of the body were injured)

Body Part 1 : 440 HIPS - INCLUDING PELVIS, Body Part 2 : 410 ABDOMEN - INCLUDING INTER

Body Part 3 : 420 BACK - INCLUDING BACK 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

AT THE END OF MY SHIFT I FELT A STRONG SHARP PAIN IN THE PELVIC HIP AREA AND I HAD TO SIT IN THE VEHICLE FOR A WHILE UNTIL I WAS ABLE TO MOVE FORWARD. AS I ARRIVED AT LIDO TO END SHIFT IT WAS VERY DIFFICULT TO WALK AND STAND STRAIGHT WITHOUT EXPERIENCING PAIN.

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. 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)
WORKERS DEFENDERS ANAHEIM

Law Firm Number (If Applicable)	13792552
Attorney/Rep First Name	NATALIA
Attorney/Rep MI	
Attorney/Rep Last Name	FOLEY
Street Address/PO Box	8018 E SANTA ANA CANYON RD STE 100 215
City	ANAHEIM
State	CA
Zip Code (Numbers Only)	92808

Applicant Attorney / Representative Signature	S NATALIA FOLEY
Applicant Signature	

Dated at ANAHEIM , California Date 04/05/2021

City (MM/DD/YYYY)

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 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 "felonia".

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

1. Name. *Nombre.* Martin Lugo Sr Today's Date. *Fecha de Hoy.* 03/18/2021
2. Home Address. *Dirección Residencial.* 135 Hornbeam Lane
3. City. *Ciudad.* Fountain Valley State. *Estado* CA Zip. *Código Postal.* 92708
4. Date of Injury. *Fecha de la lesión (accidente).* 03/23/2021 Time of Injury. *Hora en que ocurrió.* ____ a.m. 05:00 p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* JOB SITE
   10200 PIONEER BLVD. 500 SANTA FE SPRINGS CA 90670
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* At the end of my shift I felt a strong sharp pain in the pelvic hip area and I had to sit in the vehicle for a while until I was able to move forward. As I arrived at Lido to end shift it was very difficult to walk and stand straight without experiencing pain.
7. Social Security Number. *Número de Seguro Social del Empleado.* 564 7/14/91
8. Signature of employee. *Firma del empleado.* X

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.

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

VENUE AUTHORIZATION

I hereby authorize all my workers compensation case(s) for all my injuries represented by the Workers Defenders Law Group to be filed at the Anaheim Workers' Compensation Appeals Board (AHM).

APPLICANT: X _____ (signature) 03/18/2021 (date)

APPLICANT' ATTORNEY _____ (signature) 03/25/2021 (date)

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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 _____ (signature) 03/18/2021 (date)

APPLICANT' ATTORNEY _____ (signature) 03/25/2021 (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".

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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 _____ 03/18/2021
(signature) (date)

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 _____ 03/18/2021
(signature) (date)

Employee's Printed Name: Martin Lugo Sr

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 _____ 03/25/2021
(signature) (date)

Attorney's Printed Name: Natalia Foley, Esq
LAW FIRM ADDRESS: 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

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 _____ (signature) 03/18/2021 (date)

E-FILER: NATALIA FOLEY, ESQ
UAN: WORKERS DEFENDERS ANAHEIM
ERN: 13792552
ADDRES: WORKERS DEFENDERS LAW GROUP
8018 E SANTA ANA CANYON RD STE 100 215 ANAHEIM CA 92808
TEL 714 948 5054/; 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:
8018 E SANTA ANA CANYON RD STE 100 215
ANAHEIM CA 92808

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 4/5/2021 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:

PARTIES SERVED:

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

WESTPAC LABS, INC.
10200 PIONEER BLVD. 500
SANTA FE SPRINGS CA 90670

GALLAGHER BASSETT
PO BOX 2934
CLINTON IA 52733

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
Executed on: 4/5/2021 at Los Angeles, CA

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