WCAB Case No(s). ADJ 11540526

STEEVIO BARDAKJIAN, VS. **COUNTY OF LOS ANGELES; permissibly self-insured, administered by Sedgwick Claims Management Services, Inc.,**

APPLICANT, DEFENDANT(S).

AWARD

AN AWARD is made in favor of **STEEVIO BARDAKJIAN** against **COUNTY OF LOS ANGELES, permissibly self-insured, administered by Sedgwick Claims Management Services, Inc.**, of:

(A) Additional temporary disability indemnity in accordance with paragraph 2(a) above,

(B) Permanent disability indemnity in accordance with paragraph 3 above, less the sum of **$12,495.38**, payable to applicant's attorney as the reasonable value of services rendered,

☒ Fees are to be commuted pursuant to paragraph 6.

(C) Liens in accordance with paragraph 7 above,

(D) Further medical treatment in accordance with paragraph 4 above,

(E) Reimbursement for medical-legal expenses in accordance with paragraph 5 above,

(F) Stipulations in paragraphs 8 and 9 are approved.

(G) The matter is ordered off calendar / ~~set for status/lien conference~~.

Date: **August 23, 2024**

DAVID L. POLLAK
WORKERS' COMPENSATION
ADMINISTRATIVE LAW JUDGE

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
STIPULATIONS WITH REQUEST FOR AWARD

ADJ11540526
Case No.

Date of Injury 07/3/2018
MM/DD/YYYY

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).)

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

Applicant (Completion of this section is required)

STEEVIO
First Name

MI

BARDAKJIAN
Last Name

25367 SPLENDIDO CT
Address/PO Box (Please leave blank spaces between numbers, names or words)

STEVENSON RANCH
City

CA
State

91381
Zip Code

Employer #1 Information (Completion of this section is required)

☐ Insured ☒ Self-Insured ☐ Legally Uninsured ☐ Uninsured

OLIVE VIEW MEDICAL
Employer Name (Please leave blank spaces between numbers, names or words)

14445 OLIVE VIEW DRIVE
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

SYLMAR
City

CA
State

91342
Zip Code

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

PERMISSIBLY SELF INSURED
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

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

City | State | Zip Code

Claims Administrator Information (If known and if applicable)

SEDGWICK ORANGE
Name (Please leave blank spaces between numbers, names or words)

PO BOX 11028
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

ORANGE | CA | 92856
City | State | Zip Code

Employer #2 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

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

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

City | State | Zip Code

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

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

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

City | State | Zip Code

Claims Administrator Information (if known and if applicable)

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

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

City State Zip Code

Employer #3 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

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

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

City State Zip Code

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

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

Claims Administrator Information (if known and if applicable)

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

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

City State Zip Code

Employer #4 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

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

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

City State Zip Code

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

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

Claims Administrator Information (if known and if applicable)

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

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

City State Zip Code

The parties hereto stipulate to the issuance of an Award and/or Order, based upon the following facts, and waive the requirements of Labor Code section 5313:

1. STEEVIO
Employees First Name

BARDAKJIAN
Employees Last Name

birth date 05/23/1970
MM/DD/YYYY

while employed at LOS ANGELES COUNTY, CA
State

as a(n) NURSE, 212 in
Occupation Group

☐ More than 4 Companion Cases

☒ Specific Injury

ADJ11540526 — Case Number 1

☐ Cumulative Injury

07/03/2018 — (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: LUMBAR SPINE Body Part 2: RIGHT KNEE Body Part 3: RIGHT HIP

Body Part 4: _____ Other Body Parts: _____

☐ Specific Injury

_____ Case Number 2

☐ 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: _____

☐ Specific Injury

_____ Case Number 3

☐ 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: _____

☐ 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: _____

by the employer(s) and their insurer(s) listed above and who sustained injury(ies) arising out of and in the course of employment to

LUMBAR SPINE AND RIGHT KNEE ONLY PER REPORTING OF AME LEE WOODS

APPLICANT STIPULATES TO TREAT WITHIN THE MPN SUBJECT TO UR AND IMR.

(Please list all body parts injured)

2. The injury (ies) caused temporary disability for the period 01/08/2019 (MM/DD/YYYY) through 04/22/2019 (MM/DD/YYYY) for which indemnity has been paid at $ 1,215.27 (Indemnity Paid) per week.

2(a). The injury(ies) caused additional temporary disability for the period 03/22/2021 (MM/DD/YYYY) through 6/5/2022 (MM/DD/YYYY) at the rate of $ 1,356.31 (Rate) in the amount of $ _____ (Indemnity Paid)

3. The injury(ies) caused permanent disability of 52 % for which indemnity is payable at $ 290.00 (Indemnity Rate) per week beginning 06/13/2022 (MM/DD/YYYY) in the sum of $ 83,302.50, less credit for such payments previously made. ☐ And a life pension of $ _____ per week thereafter.

An informal rating ☐ has / ☒ has not (Select one) been previously issued in case no(s) _____.

4. There ☒ is ☐ is Not a need for medical treatment to cure or relieve from the effects of said injury (ies).

5. Medical-legal expenses and/or liens are payable by defendant as follows:

DEFENDANTS TO ADJUST OR LITIGATE ALL OFFICIAL LIENS OF RECORD TIMELY FILED ON DATE OF AWARD. DISTRICT OFFICE TO RETAIN JURISDICTION.

6. Applicant's attorney requests a fee of $ 12,495.38

☒ Fees to be commuted as follows:

FROM THE FAR END OF THE AWARD, ~~IF NECESSARY~~
BTS

7. Liens Against compensation are payable as follows:

UNKNOWN

Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

Other stipulations:

PENALTIES AND INTEREST ARE WAIVED IF PAYMENT OF THE AWARD COMMENCES WITHIN DAYS AFTER SERVICE OF THE AWARD.

APPLICANT AGREES THAT THERE ARE NO UNPAID CLAIMS FOR PENALTIES AND INTEREST IN ANY CLASS OF BENEFIT UP TO THE DATE OF THE APPROVAL OF THE STIPULATIONS WITH REQUEST FOR AWARD. Including MegA Flex

~~APPLICANT AGREES THAT THERE ARE NO UNPAID CLAIMS FOR REIMBURSEMENT OF MEDICAL TREATMENT OR MILEAGE~~ BTS

DEFENDANTS TO TAKE CREDIT FOR ALL PDAS PAID (ACCORDING to PROOF).

SETTLEMENT IS BASED ON REPORT OF DR. WOODS THAT RATES TO 52%

Dated 08/16/2024
MM/DD/YYYY

STEEVIO BARDAKJIAN
Applicant

Applicant's Attorney or Authorized Representative:

☒ Law Firm/Attorney ☐ Non Attorney Representative

BRETT
First Name

SHERRY
Last Name

1937365
Firm Number

KOSDIN FIELDS
Law Firm name

6151 VAN NUYS BLVD
Address/PO Box (Please leave blank spaces between numbers, names or words)

VAN NUYS
City

CA
State

91401
Zip Code

Dated 8/16/2024
MM/DD/YYYY

Applicant Attorney Signature

Defendant's Attorney or Authorized Representative:

☒ Law Firm/Attorney ☐ Non Attorney Representative

CONNIE
First Name

MCHUGH
Last Name

5122463
Firm Number

LEWIS BRISBOIS / Costa Mesa
Law Firm Name

650 TOWN CENTER DRIVE, SUITE 1400
Address/PO Box (Please leave blank spaces between numbers, names or words)

COSTA MESA | CA | 92626
City | State | Zip Code

Dated 08/16/2024
MM/DD/YYYY

Connie McHugh
Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

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

City | State | Zip Code

Dated
MM/DD/YYYY

Defense Attorney Signature

EAMS Name: LEWIS BRISBOIS LOS ANGELES
EAMS Administrator: Ana Sosa
EAMS Administrator Phone No.: (213) 599-7744
EAMS Administrator Email: ana.sosa@lewisbrisbois.com

CALIFORNIA STATE COURT PROOF OF SERVICE

Steevio Bardakjian v. Olive View Medical Center; Sedgwick

ADJ11540526

STATE OF CALIFORNIA, COUNTY OF ORANGE

At the time of service, I was over 18 years of age and not a party to the action. My business address is 650 Town Center Drive, Suite 1400, Costa Mesa, California 92626.

On August 28, 2024, I served the following document(s):

- **AWARD**

I served the documents on the following persons at the following addresses (including fax numbers and e-mail addresses, if applicable):

Service List Attached

The documents were served by the following means:

☒ (BY U.S. MAIL) I enclosed the documents in a sealed envelope or package addressed to the persons at the addresses listed above and:

☒ Placed the envelope or package for collection and mailing, following our ordinary business practices. I am readily familiar with the firm's practice for collection and processing correspondence for mailing. Under that practice, on the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U.S. Postal Service, in a sealed envelope or package with the postage fully prepaid.

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

Executed on August 28, 2024, at Costa Mesa, California.

John Gerrard

SERVICE LIST

Steevio Bardakjian v. Olive View Medical Center
ADJ11540526
Claim No.: 21-900110-B
DOI: 07/03/2018
LBBS File No. 35008-534

Workers Compensation Appeals Board *(e-filed)*
6150 Van Nuys Blvd., Suite 105
Van Nuys, CA 91401

Sedgwick
Evlin Makhani
P.O. Box 11028
Orange, CA 92856

Koszdin, Fields, Sherry & Katz
6151 Van Nuys Blvd.
Van Nuys, CA 91401

Steevio Bardakjian
25367 Splendido Ct.
Stevenson Ranch, CA 91381

Olive View Medical Center
14445 Olive View Dr.
Sylmar, CA 91342

orangelitigation@sedgwick.com

lacounty@ventivcloud.com

EAMS Electronic Adjudication Management System

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)*

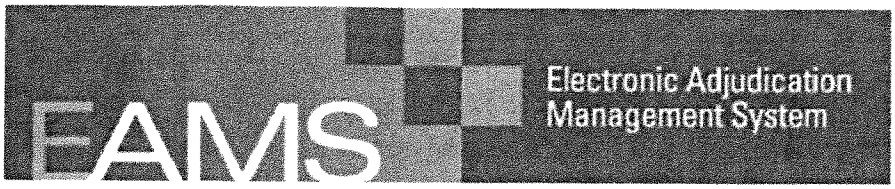
File Upload*: Browse...

Attachment

Uploaded Documents

Master Case Reference	Case ID	Case Type	Document Type	Document Title	File Name	
ADJ11540526		ADJ	LEGAL DOCS	PROOF OF SERVICE	C:\fakepath\Bardakjian, Steevio - Proof of Service of Award.pdf	Delete

Submit



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

Batch ID: 41369296 Date: 08/28/2024 12:12:49 PM

OK