California Workers' Compensation Coverage Research Report

Report Generated: 5/5/2022 3:04:06 PM

WCIRB California
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Report Produced by	Nichole Matteson of Insurance Company of the West
ADJ or JCN Number(s)	ADJ 16099691
Name of Injured Worker	Claudia Arana
Insurer Claim Number(s) - Date(s) of Injury	2022008186 - 04/12/2022
Insured Employer(s)	Republique

Your search performed 5/5/2022 in WCIRB Connect produced the following results:

Search #1 - Parameters

Policyholder Name	repub
Date Range	06/04/2015 - 04/12/2022
Street Address	3547 voyager
City	
Zip Code	
FEIN	
Bureau Number	

Search #1 - Selected Search Results

Policyholder Name	CA Insurer	Policy Number	Inception Date	Expiration Date	Street Address	City	Zip Code	FEIN	Bureau Number
Republique, LLC	Benchmark Insurance Company	CST5020211	10/01/2020	10/01/2021	3547 Voyager St 201	Torrance	90503	46-0982167	6-46-72-25

California Workers' Compensation Coverage Research Report

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NOTICE

These search results reflect the coverage information in the WCIRB's records available at the time the search was conducted and for the search parameters provided. If the search results indicate "No Results Found" that does not necessarily mean that the employer does not have insurance or is operating in violation of California law. The requested records may exist under another spelling, name, address, time period, or the policy may not yet have been submitted to the WCIRB. In addition, some employers are legally self-insured - inquiries regarding self-insured employers should be directed to the California Office of Self Insurance Plans at 916.464.7000.

Coverage information may not be available or complete for all employers due to limitations with the policy information, such as similar or duplicate employer names, multiple or alternate locations and addresses, or multiple employers on a single policy. Additionally, search results may not reflect recent changes because insurers have up to sixty (60) days to submit policy information to the WCIRB.

The WCIRB's record of policyholder Federal Employment Identification Numbers (FEIN) may not be complete for all policy years. Searches based solely on FEIN number may provide no results.

The result of your query is not evidence or verification of workers' compensation insurance, which should be obtained from or verified by the insurer directly. The results of a query should be confirmed both with the employer and the insurer before it is used for any purpose.

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ISO ClaimSearch
The information system for claims professionals

CLAIMDIRECTOR RESULT REPORT

A claim report identified by ClaimSearch identification number 2H005822437 was received by ISO ClaimSearch on 05/05/2022. Submission of this claim report initiated a search for similar claims. The claim(s) listed below appear(s) to be similar to the claim submitted and were used to develop the ClaimDirector score.

To simplify your evaluation of these matches, ClaimDirector scores all prior non-duplicate claims and provides a total summary score. The ClaimDirector match report below includes all scored claims up to a maximum of 25.

Reasonable procedures have been adopted to maximize the accuracy of this report. Independent investigations should be performed to evaluate the relevant data provided.

If you have any questions concerning your report, please contact Customer Support at (800) 888-4476.

Claim Characteristics

ID	Description
102	CLAUDIA ARANA's legal representative appears to match an entity on your company's Advisory List. The entity is LEE LEGAL GROUP

Score Details

Claim Rules: 0

No claim rules apply to this claim.

CLAUDIA ARANA : 800

Involved Party Rules : 800

Rules

ID	Description	Weight
102	This involved party's legal representative appears to match an entity on your company's Advisory List	+800

Matching Claims Score: 0

- There were no contributing matching claims for this Involved Party
- Elements Searched: 1 (NAME/ADDRESS)

ISO CLAIMSEARCH MATCH REPORT DETAILS

Initiating Claim

Company:	I05200024
Claim Number:	2022008186
Date/Time of Loss:	04/12/2022 00:00
Policy Number:	WVE506230600
Policy Type:	WORKERS COMPENSATION
Self Insured:	NO
Company Received Date:	05/04/2022
ISO Received Date:	05/05/2022
Loss Description:	THIS IS A LITIGATED CT CLAIM FOR 06/01/2015 - 04/1
Location of Loss:	7360 BEVERLY BLVD LOS ANGELES, CA

Involved Party:	**INSURED**
Business Name:	REPUBLIQUE LLC
Address:	3547 VOYAGER ST., #201 TORRANCE, CA 90503
TIN:	XX-0XXX02167 WAS ISSUED in Aberdeen in SD

Involved Party:	**CLAIMANT**
Name:	CLAUDIA ARANA
Address:	949 E 49TH ST LOS ANGELES, CA 90011--605

Service Provider: **EMPLOYER**
Business Name: ROSS, THOMAS
Address: 3547 VOYAGER ST
TORRANCE, CA 90503–167

Service Provider: **CLAIMANT LAWYER**
Business Name: LEE LEGAL GROUP
Address: 3055 WILSHIRE BLVD
LOS ANGELES, CA 90010

Casualty Coverage Information:

Coverage Type: INDEMNITY
Loss Type: INDEMNITY
Adjuster Company: INSURANCE COMPANY OF THE WEST
Alleged Injury / Property Damage: THIS IS A LITIGATED CT CLAIM FOR 06/01/2015 - 04/1
Part of Body: MULTIPLE BODY PARTS (INCLUDING BODY SYSTEMS & BODY PARTS) APPLIES WHEN MORE THAN ONE MAJOR BODY PART HAS BEEN AFF
ICD-9:
Cause Of Injury: 98
Product Liability: NO

CMS Information:

State Of Venue: CA
On-Going Responsibility for Medicals(ORM): NO

back

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2022008186
MPN Notification
Nichole Matteson

05/04/2022

Claudia Arana
949 E 49th St Apt 3
Los Angeles, CA 90011-6053

RE:	Employee:	Claudia Arana	Employer:	REPUBLIQUE LLC
	Date of Injury:	04/12/2022	Claim No.:	2022008186
	MPN:	3098, ICW Group Premier MPN		

Dear Ms. Arana:

INSURANCE COMPANY OF THE WEST is the Workers' compensation carrier for your employer. It has been reported to us that you may have sustained an injury on the job. We are currently evaluating your claim for eligibility of benefits. Please be advised that your employer participates in a Medical Provider Network through Harbor One. This means that for an accepted injury claim or a claim that is delayed for investigation (up to the statutory maximum), you must treat with a doctor who is part of the Medical Provider Network (LC 4600, 4616, and Reg 9767.6).

Enclosed, please find:

- Complete Written Employee Notification Regarding Medical Provider Network in Spanish and English, which provides details regarding the MPN.

If you wish to view MPN physicians in your area, you can visit our MPN website at:
https://search.harborsys.com/ICWGroupMPN

If you have any questions, please do not hesitate to contact the number listed below.

INSURANCE COMPANY OF THE WEST la compañía de Seguros de Compensación al Trabajador contratada por su patrono (en adelante Empresa). Se nos ha notificado que posiblemente Ud. ha sufrido un accidente de trabajo. En este momento estamos evaluando su caso para determinar si se le debe algún beneficio.

Mediante la presente formalmente le informamos, que su Empresa participa en la Red de Proveedores Médicos "MPN" por medio de Harbor One. Esto significa que Ud. debe solicitar y recibir tratamiento únicamente de un Médico o proveedor medico miembro de la Red, sea que su reclamo haya sido aceptado, o esté dentro del periodo de investigación (hasta el monto establecido por el Código Laboral); lo anterior con base en los artículos 4600, 4616 del Código Laboral, y 9767.6 del Código de Reglamentos de California.

Sírvase encontrar adjunto lo siguiente:

- Manual de la Red de Proveedores Médicos MPN # 102010, en español e inglés, donde encontrara más detalladamente todo lo relacionado con la Red.

Si Ud. Desea encontrar médicos dentro de la Red de Proveedores en el área de su residencia, visite nuestra página web https://search.harborsys.com/ICWGroupMPN

Por favor comuníquese con nosotros al número abajo mencionado si tiene alguna pregunta o necesita más información

Sincerely,
First Notice Unit
INSURANCE COMPANY OF THE WEST
(800) 877-1111

Enc.: DWC-1
Complete Written Employee Notification Regarding Medical Provider Network

Cc:
Lee Legal Group
3055 Wilshire BLvd Ste 1100
Los Angeles CA 90010

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05/10/2022

Claudia Arana
949 E 49th St Apt 3
Los Angeles, CA 90011-6053

Employee	Claudia Arana	Date of Injury:	6/15/2015-04/12/2022
Employer:	REPUBLIQUE LLC	Claim Number:	2022008186

NOTICE REGARDING
DELAY OF WORKERS' COMPENSATION BENEFIT

ICW Group is handling your workers' compensation claim on behalf of REPUBLIQUE LLC. This notice is to advise you of the status of disability benefits for your workers' compensation injury on the date shown above.

Worker's compensation benefits are being delayed because the information we have available is insufficient to determine entitlement to workers' compensation benefits. In order to make a decision, we need to obtain your statement, a medical evaluation to include a detailed medical report from your workers' compensation physician. We will notify you of our decision on or before 7/31/2022.

If you are represented, you may contact your attorney with any questions.

For injuries which occur on or after January 1, 1990 there is legal presumption before the Workers' Compensation Appeals Board that your claim is compensable if it is not denied within 90 days of your returning an Employee Claim Form to your employer. That presumption can be rebutted only with information that could not be discovered within the 90-day period.

For claims reported on or after April 19, 2004, regardless of the date of injury, if you submitted a claim form to your employer or claims administrator, Labor Code section 5402(c) provides that within one working day after you file the claim form, the employer shall authorize the provision of medical treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide such treatment until the claims administrator accepts or denies liability for the claim. Until the date the claim is accepted or rejected, liability for medical treatment under this Labor Code section shall be limited to a maximum of ten thousand dollars ($10,000).

Additional information may be found in the publication ***Workers' Compensation in California: A Guidebook for Injured Workers***. A complete copy of the Guidebook may be obtained on the Division of Workers' Compensation website (see URL below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation. Chapters 2, 4, and 9 of the Guidebook contain information addressing the determination of liability for a workers' compensation claim and the QME process.

Guidebook for Injured Workers:

http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html

Chapter 2: After You Get Hurt on the Job

http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter2.pdf

Chapter 4: Resolving Problems with Medical Care and Medical Reports:

http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter4.pdf

Chapter 9: For More Information and Help

http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter9.pdf

The State of California requires that you be given the following information:

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call me, Kris Schave at (925) 474-2820. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney not me, Kris Schave.

For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an information and assistance (I&A) officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call (800) 736-7401.

Keep this notice. It contains important information about your workers' compensation benefits.

Sincerely,

Kris Schave, Claims Specialist
INSURANCE COMPANY OF THE WEST
Ph: (925) 474-2820

Cc:
REPUBLIQUE LLC -- Attn: HR- Personal and Confidential
3547 VOYAGER ST., #201
TORRANCE, CA 90503

Lee Legal Group
3055 Wilshire BLvd Ste 1100
Los Angeles CA 90010

PROOF OF SERVICE

RE: Case: Claudia Arana v. REPUBLIQUE LLC

Claim#: 2022008186 WCAB#: ADJ16099691

I am a resident of the county of Alameda. I am over the age of eighteen years, and am not a party to the within matter. My business address is PO Box 509039, San Diego, CA 92150-9039.

On 05/10/2022 I served a copy of the following:

NOTICE REGARDING DELAY OF WORKERS' COMPENSATION BENEFIT Dated 05/10/2022

On the parties listed below:

Lee Legal Group
3055 Wilshire BLvd Ste 1100
Los Angeles CA 90010

X (BY MAIL) I caused such envelope to be deposited in the mail at San Diego, California. I am readily familiar with the company's practice for collection and processing correspondence for mailing. 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 with postage thereon fully prepaid.

X (STATE) I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that this declaration was executed at San Diego, California, on 05/10/2022.

Kathy Vance

Vance, Kathy

Cc:
REPUBLIQUE LLC -- Attn: HR- Personal and Confidential
3547 VOYAGER ST., #201
TORRANCE, CA 90503

Lee Legal Group
3055 Wilshire BLvd Ste 1100
Los Angeles CA 90010

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2022008186
Examiner Transfer – Rep
Kris Schave

05/06/2022

Claudia Arana
949 E 49th St Apt 3
Los Angeles, CA 90011-6053

Employee:	Claudia Arana
Employer:	REPUBLIQUE LLC
Date of Injury:	04/12/2022
Claim #:	2022008186

Dear Ms. Claudia Arana,

Your claim has been transferred to me for further handling. Because you are represented by counsel, please direct all communications (telephone, email or letter) to your attorney. Your attorney can contact me (or ICW's assigned attorney, if applicable) to address issues or concerns about your claim. My direct telephone line is (925) 474-2820.

Mediante la presente amablemente le notifcamos que su reclamo me ha sido transferido para su manejo. Continue comunicandose con su abogado directamente, y no con ICW. Su abogado puede contactarme a mi, o si ICW esta representado legalmente a mi abogado, por telefono o correo electronico. Mi numero de teléfono es (925) 474-2820.

Sincerely,

Kris Schave, Claims Specialist
INSURANCE COMPANY OF THE WEST
Ph: (925) 474-2820

Cc:
REPUBLIQUE LLC
3547 VOYAGER ST., #201
TORRANCE CA 90503

Lee Legal Group
3055 Wilshire BLvd Ste 1100
Los Angeles CA 90010

2022008186
Initial Packet 1
Nichole Matteson

05/04/2022

Claudia Arana
949 E 49th St Apt 3
Los Angeles, CA 90011-6053

RE: Employee: Claudia Arana
Employer: REPUBLIQUE LLC
Date Injured: 04/12/2022
Claim # 2022008186

Dear Ms. Arana:

ICW Group has received notice of your workers' compensation injury. We realize that after being injured, you may wish to know about the workers' compensation benefits available to you. It is important to note that your Claims Examiner can provide you with details about your claim, your benefits, and address any questions or concerns you may have. By now your Claims Examiner should have contacted you, however if we missed you, your Claims Examiner is Nichole Matteson. We are committed to creating the best insurance experience possible. Nichole Matteson can be reached at (858) 350-7293.

Throughout this process, it is very important that you stay in contact with your employer and with your Claims Examiner. This is especially critical after every physician visit in order to coordinate your continuing benefits and eventual return to work. Should your doctor release you to return to limited work activities or limited hours, your employer will determine work availability based on the work limitations indicated by your physician.

Enclosed, you will find a Medical Authorization for Release of Records and questionnaire. We would appreciate it if you would sign, date, and return this form to us as quickly as possible. This signed authorization permits us to obtain medical information pertinent to your workers' compensation claim. Without the medical records, we may not be able to fully process your claim. A mileage form is also included as you are entitled to mileage and bridge toll reimbursement for medical appointments and pharmacy visits.

Sincerely,

Nichole Matteson

Nichole Matteson, Triage Examiner
INSURANCE COMPANY OF THE WEST
Ph: (858) 350-7293

Copies mailed to:
Lee Legal Group
3055 Wilshire BLvd Ste 1100
Los Angeles CA 90010

Enc.

INJURED WORKER'S HISTORY OF MEDICAL PROVIDERS

RE: Employee: Claudia Arana
Employer: REPUBLIQUE LLC
Date Injured: 04/12/2022
Claim #: 2022008186

Please list the names and addresses of all doctors, hospital and chiropractors you have seen in the past. This should include family doctor, emergency room, and clinic visits as well. Please list the year you were seen if you recall it. Labor code 4663 and 4664 require that you disclose prior disabilities or impairments.

Your family doctor

_____
_____
_____

Hospitals and clinics

1. _____
_____
_____

2. _____
_____
_____

3. _____
_____
_____

Any other physicians

1. _____
_____
_____

2. _____
_____
_____

3. _____
_____
_____

4. _____
_____
_____

5. _____
_____
_____

PRIOR INJURIES (WHETHER WORK-RELATED OR NOT)

Date of Injury: _____ Body Parts Injured: _____

Amount of Settlement ($): _____ Amount of Permanent Disability (%): _____

What work preclusions/restrictions were you given by your doctor(s)? _____

_____

Doctor Name/Address: _____

_____

_____

Employer Name/Address: _____

Insurance Carrier/Administrator: _____

Attorney Name/Address: _____

Additional Comments/Info: _____

_____

Attach additional pages as needed to provide complete answers.
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.

Nichole Matteson

Nichole Matteson, Triage Examiner
INSURANCE COMPANY OF THE WEST
Ph: (858) 350-7293

Copies mailed to:
Lee Legal Group
3055 Wilshire BLvd Ste 1100
Los Angeles CA 90010

AUTHORIZATION TO USE OR DISCLOSE PROTECTED INFORMATION
- HIPAA –

I hereby authorize use of disclosure of the named individual's health information as described below.

Claudia Arana
Patient Name

Birth Date _____ SS# _____

Release From:

_____
Name of Person, Company or Organization

Release To: – Agents for
INSURANCE COMPANY OF THE WEST
Name of Person, Company or Organization
PO Box 509039
Address
San Diego, CA 92150-9039
City, State, Zip

Telephone Number _____ Fax Number _____

The following information is to be disclosed: (Please Check)

☐ Any And All Medical Records ☐ MRI, X-rays, Film
☐ Physician reports only ☐ History & Physical Examinations ☐ Radiology Reports
☐ Discharge Summary ☐ Laboratory Tests ☐ Consultation and Progress Notes
☐ Insurance Or Claim Records ☐ Employment, Payroll, Educational or Job Training
☐ Police, Arrest, Prison or Probation Records
☐ EDD -Unemployment records ☐ EDD-Disability records
☐ Any And All Records To Include Claims/ Billing Or Payment Notices For Reimbursement Of Any Medical Services Provided Under The Claimant's Health Care Plan
☐ Other medical records or health information here specified _____

Sensitive Information: I understand that this may include information relating to (Check to Authorize Release)

☐ Acquired Immune Deficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)
☐ Behavioral Health Services, Psychiatric Care, Mental Health Treatment
☐ Sexually Transmitted Disease
☐ Diagnosis/Treatment for Alcohol and/or Drug Abuse
☐ Information for research purposes

Services provided on (dates): _____

Purpose of this request:

☐ Discovery for Workers Compensation Claim
☐ Other _____

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I understand that my refusal to authorize disclosure of my personal medical information will have no effect on my enrollment/eligibility for benefits, or the amount said provider pays for the health services I receive.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization. I understand that my refusal to authorize disclosure of my personal medical information will have no effect on my enrollment, eligibility for benefits, or the amount said provider pays for the health services I receive.

Expiration: Unless otherwise cancelled, I understand that this authorization will expire on this date _, or two years from the date authorization is signed.
Other Rights: I understand that authorizing the disclosure of this information is voluntary.
I understand that I may inspect or obtain a copy of this authorization or of the information to be used or disclosed, as provided in CFR 164.524.

A PHOTOCOPY OF THIS SIGNED AUTHORIZATION WILL BE DEEMED AS EFFECTIVE AS THE ORIGINAL

Signature of Patient or Personal Representative _____ Date _____

If signed by Representative, Relationship to Patient _____

"Failure to make the records available, during business hours, within five days after the presentation of the written authorization, may subject the person or entity having custody or control of the records to liability for all reasonable expenses, including attorney's fees, incurred in any proceeding to enforce this section."
CALIFORNIA CODES EVIDENCE CODE SECTION 1158.

Medical History Questionnaire

Your Employers Workers Compensation Insurance Carrier has retained the services of to assist in the discovery process of your injury. We are required to obtain information concerning your previous medical history as well as previous employer information and prior workers compensation awards and settlements. Failure to disclose this information may affect your entitlement to future benefits.

Please identify the medical providers, addresses and phone numbers of the physicians that have treated you for this injury ***as well as any previous injuries you may have sustained over the last (10) years***. Also include the names, addresses and phone numbers of any previous Employers you have had in the last (10) years.

Name of Physician/Hospital	**Address**	**Phone Number**

Name of Employers	**Address**	**Phone Number**

Signature: _____ **Date:** _____

AUTORIZACIÓN PARA USAR O DIVULGAR INFORMACIÓN PROTEGIDA
- HIPAA –

Por el presente autorizo el uso o la divulgación de la información médica de la persona mencionada como se indica más abajo.

Claudia Arana
Nombre del paciente

Fecha de nacimiento

Núm. Seguro Social

OBTENIDA DE:

Nombre de la persona, compañía u organización

PROPORCIONADA A:
- LOS AGENTES DE
INSURANCE COMPANY OF THE WEST
Nombre de la persona, compañía u organización
PO Box 509039
Domicilio
San Diego, CA 92150-9039
Ciudad, Estado, Código Postal

Número telefónico

Número de fax

La siguiente información será divulgada: (Sírvase marcar)

- ☐ Cualquiera y todos los registros medica
- ☐ Exploración de imágenes por resonancia magnética (MRI), radiografías, negativos
- ☐ Reportes de radiología
- ☐ Reportes médicos solamente
- ☐ Historiales y exámenes físicos
- ☐ Notas de consultas y de avance
- ☐ Resumen de egreso
- ☐ Pruebas de laboratorio
- ☐ Registros de seguros o de reclamaciones
- ☐ Empleo, nómina, entrenamiento educativo o vocacional
- ☐ Registros de policía, arrestos, prisión o períodos de prueba
- ☐ EDD - registros de desempleo
- ☐ EDD - registros de incapacidad

☐ Cualquier y todos registros para incluir reclamo/facturar o el pago advierte para el reembolso de cualquier servicio médico proporcionado bajo el plan de asistencia médica del demandante.

☐ Otros historiales médicos o información médica aquí especificada _____

Información delicada: Entiendo que esto podrá incluir información en relación a (marque para autorizar su divulgación)

- ☐ síndrome de inmunodeficiencia adquirida (SIDA) o infección con el virus de inmunodeficiencia humana (VIH)
- ☐ servicios de salud del comportamiento, cuidado psiquiátrico, tratamiento de salud mental
- ☐ enfermedades transmitidas sexualmente
- ☐ diagnóstico/tratamiento de alcoholismo y/o drogadicción
- ☐ información para propósitos de investigación

Servicios proporcionados en (fechas): _____

Propósito de esta solicitud:

☐ Procedimiento para obtener información para una reclamación de Compensación por Accidentes de Trabajo

☐ Otro _____

Re-revelación: Entiendo que el recipiente no puede utilizar lícitamente aún más ni puede revelar la información de la salud a menos que otra autorización sea obtenida de mí ni a menos que tal uso ni la revelación sean requeridos específicamente ni son permitidos por la ley. Entiendo que mi negativa para autorizar la revelación de mi información médica personal no tendrá efecto en mi matriculación elegibilidad para beneficios, ni la cantidad dijo que proveedor paga por los servicios de sanidad que recibo.
Derecho de revocar: Entiendo que tengo el derecho de revocar esta autorización en cualquier momento. Entiendo que si revoco esta autorización, lo debo hacer por escrito. Entiendo que la revocación no será aplicable a información que ya fue divulgada con base en esta autorización.
Fecha de vencimiento: A menos que sea cancelada de alguna otra forma, entiendo que esta autorización vencerá en esta fecha: _____
Otros derechos: Entiendo que la autorización para la divulgación de esta información es voluntaria.
Entiendo que podré revisar u obtener una copia de la información a ser usada o divulgada, de acuerdo a lo establecido en el Código de Reglamentos Federales 164.524.

UNA COPIA FOTOSTÁTICA DE ESTA AUTORIZACIÓN FIRMADA SE CONSIDERARÁ TAN EFECTIVA COMO EL DOCUMENTO ORIGINAL

_____ _____
Firma del paciente o representante personal Fecha

_____
Si es firmada por el representante, cuál es su relación con el paciente

"El fracaso para hacer los registros disponibles, durante horas de negocio, dentro de cinco días después de que la presentación de la autorización escrita, pueda sujetar a la persona o la entidad que tienen la custodia o el control de los registros a la obligación para todos gastos razonables, inclusive honorarios de abogado, contrajeron en cualquier acto para imponer esta sección."
--CALIFORNIA CODIFICA LA SECCION DE CODIGO DE EVIDENCIA 1158.

Cuestionario de Historia Médica

Su compania del Seguro de Compensación de Trabajadores de Empleadores ha retenido los servicios de para participar en el proceso del descubrimiento de su herida. Somos requeridos a obtener información con respect a su historia clínica previa así como información previa de empleador y premios previos de compensación de trabajadores y con respecto a los arreglos. El fracaso para revelar que esta información puede afectar su derecho a beneficios futuros.

Identifique por favor a los proveedores médicos, las direcciones y los números de teléfono de los médicos que han tratado usted para esta **herida así como alguna herida previa que usted puede haber sostenido sobre los últimos (10) años.** Incluya también los nombres, las direcciones y los números de teléfono de cualquier Empleador previo que usted ha tenido en el último (10) años.

El nombre del Médico/Hospital	**Dirección**	**Número de teléfono**

El nombre del Empleadores	**Dirección**	**Número de teléfono**

Firma: _____ **Fecha:** _____

Claudia Arana
Injured worker's name /
Nombre de la persona lesionada

2022008186
Claim number / Número de reclamo

Medical mileage expense form
Formulario de gastos de viajes para asuntos médicos

If you have to travel to get treatment for your work injury, you are entitled to re-payment of your travel costs. The mileage rate is 58.5 cents ($0.585) per mile. Mileage for reasonable travel to the pharmacy, parking, bridge tolls, public transportation and other travel-related costs are also included. Complete this form. Attach receipts. Send the original to the insurance company and keep a copy. **Do not** send the original or a copy to the local Workers' Compensation Appeals Board (WCAB) or the information and assistance officer. If your travel costs are not paid within 60 days, contact the information and assistance officer.

Si tiene que viajar para recibir tratamiento por una lesión en el trabajo, usted tiene derecho a recibir un reembolso de 58.5 centavos ($0.585) por milla. Millas por un viaje de distancia razonable a la farmacia, estacionamiento, pago de peajes, transporte público y otros viajes y costos relacionados están también incluidos. Complete este formulario y adjunte los recibos. Envíe la forma original a la compañía de seguros y guarde una copia. **No envíe** el original o la copia a la oficina local de la Junta de Apelaciones de Compensación del Trabajador (WCAB). Si sus gastos de viajes no son pagados dentro de 60 días, llame al representante de información y asistencia.

Date/ Fecha	**Traveled from** (include address) **Viaje desde** (incluya dirección)	**Traveled to** (include name and address of doctor, hospital, therapist, etc.) **Viaje a** (incluya nombre y dirección del medico, hospital, terapeuta, etc.)	**Round trip mileage/ Millaje viaje redondo**	**Parking/ Estacionamiento**	**Tolls/ Peaje**
Sample: 1/1/22	Sample: 1515 Maple, San Francisco	Sample: Dr. Sherman, 190 Oak, San Francisco	Sample: 14 mi	Sample: $2.50	Sample: $

California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Total miles / *Número de millas viajadas en total*		x $0.585/ mile =	$
		Total Parking / *Estacionamiento pagado en total*	$
		Total Tolls / *Peajes pagados en Total*	$
	Total reimbursement requested/ *Reembolso solicitado en total*		$

Las Leyes de California establecen que la siguiente declaración aparezca en este formulario: Cualquier persona que a sabiendas presente reclamos falsos o fraudulentos para el pago de una pérdida, es culpable de un delito y podría ser sujeto a multas y encarcelamiento en una prisión estatal.

Signature / Firma	
Printed name / Imprima su nombre	
Date / Fecha	

Cc:
Lee Legal Group
3055 Wilshire BLvd Ste 1100
Los Angeles CA 90010

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ICWGROUP
Insurance Companies

05/16/2022

REPUBLIQUE LLC
Attn: HR – Personal and Confidential
3547 VOYAGER ST., #201
TORRANCE, CA $InsuredZipCode$

RE: Employee: Claudia Arana
Employer: REPUBLIQUE LLC
Date Injured: 04/12/2022
Claim #: 2022008186

Dear REPUBLIQUE LLC:

Enclosed please find a copy of a petition for award under California Labor Code Section 132a in connection with the above captioned claim. California Labor Code Section 132a protects injured workers who have filed a workers' compensation claim (or who intend to file a claim) against employer retaliation and discrimination. Additionally, California law does not permit insurance companies to insure against liability for Section 132a awards. We recommend that you take prompt action and retain legal counsel, at your expense, to provide you with appropriate legal advice and defense as you are responsible for responding to and defending against the allegations delineated in the petition.

The following outlines the WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY sections of your policy which exclude coverage for claims involving Section 132a:

PART ONE - WORKERS' COMPENSATION INSURANCE

(Page 2 of your policy contains the following language):

F. **Payments You Must Make**
You are responsible for any payments in excess of the benefits regularly provided by the workers' compensation law, including those required because:

4. "you discharge, coerce or otherwise discriminate against any employee in violation of the workers' compensation law."

(Page 1 of your policy contains the following language):

C. **We Will Defend** (states in part):
"We have no duty to defend a claim, proceeding, or suit that is not covered by this insurance."

PART TWO – EMPLOYERS LIABILITY INSURANCE

(pages 2 and 3 of your policy contain the following language):

C. **Exclusions**
This insurance does not cover:

7. Damages arising out of the discharge, coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, or any personnel practices, policies, acts or omissions.

D. **We Will Defend** (states in part):
"We have no duty to defend a claim, proceeding, or suit that is not covered by this insurance."

The allegations in the petition dated fall within the exclusions of coverage and liability for payment as described in the policy provisions cited above. As such, you are responsible for any payment that may be due as a result of this petition. Additionally, since the policy does not provide coverage for these potential damages, the defense provision of the policy would also not apply.

You should retain legal counsel at your expense to provide you with appropriate legal advice and defense of this matter immediately.

Sincerely,

Kris Schave, Claims Specialist
INSURANCE COMPANY OF THE WEST
Ph: (925) 474-2820

Enclosure: 132A Petition

Cc:

Lee Legal Group
3055 Wilshire BLvd Ste 1100
Los Angeles CA 90010

BRADFORD AND BARTHEL, LLP
PO BOX 348450
Sacramento CA 95834

2022008186
Declaration Per Labor Code Section 4906 (H) Form
kvance

05/16/2022

REPUBLIQUE LLC
3547 VOYAGER ST., #201
TORRANCE, CA 90503

RE:	Employee:	Claudia Arana	Date Injured:	04/12/2022
	Employer:	REPUBLIQUE LLC	Claim #:	2022008186
			WCAB#:	ADJ16099691

Dear REPUBLIQUE LLC:

Workers' Compensation legislation designed to reduce fraud requires the employer to sign a declaration under penalty of perjury each time an application or an answer is filed with the Appeals Board.

The declaration indicates you have not violated Labor Code Section 139.3, which basically indicates you have not influenced an examination or evaluation by a physician, other examiner or evaluator. Attached is a declaration which AN OFFICER OF THE COMPANY SHOULD SIGN and return to us immediately so we can properly protect your interests in this litigation.

Basically, you are indicating that you have not exchanged any type of compensation or inducement for services of any medical examiner in this case beyond the usual charges allowed for the examinations under the law. You may mail the signed declaration to ICW at the address, fax, or email noted below.

Please call if you have any questions. It is very important that we receive your signed copy back immediately so we can proceed with this litigation on your behalf. Thank you for your cooperation.

Sincerely,

Kris Schave, Claims Specialist
INSURANCE COMPANY OF THE WEST
Ph: (925) 474-2820

cc:
BRADFORD AND BARTHEL, LLP
PO BOX 348450
Sacramento CA 95834

Enc. Return Envelope
Declaration Per Labor Code Section 4906 (H)

DECLARATION PER LABOR CODE SECTION 4906 (H)

RE: Employee: Claudia Arana
Employer: REPUBLIQUE LLC
Date Injured: 04/12/2022
Claim #: 2022008186
WCAB #: ADJ16099691

Pursuant to the requirements of Labor Code Section 4906 (h), defendants, REPUBLIQUE LLC AND INSURANCE COMPANY OF THE WEST declares as follows:

Under penalty of perjury, I declare that I have not violated Section 139.3 of the Labor Code and 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.

Signed Kris Schave
INSURANCE COMPANY OF THE WEST

05/16/2022

Signed REPUBLIQUE LLC

Dated

Cc:
BRADFORD AND BARTHEL, LLP
PO BOX 348450
Sacramento CA 95834

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2022008186
Physician Designation and Reporting Duties with Return to Work DELAY
kvance

05/13/2022

SOUTHERN CALIFORNIA MEDICAL GR
3320 SOUTH HILL STREET
LOS ANGELES, CA 90007

RE:	Employee:	Claudia Arana
	Employer:	REPUBLIQUE LLC
	Date Injured:	04/12/2022
	Claim #:	2022008186
	ADJ#/WCAB:	ADJ16099691

Dear SOUTHERN CALIFORNIA MEDICAL GR:

You have been designated as the treating physician for the above referenced injury. While we have determined that you are a member of ICW Group Premier MPN network, the claim injury has not been accepted and is currently being delayed pending investigation. There are currently no medical records to enclose for your review. Labor code section 5402 provides that an employer/carrier must authorize up to $10,000 in treatment during the delay period.

Please be advised that Labor Code Section 4061.5 states that "The treating physician primarily responsible for managing the care of the injured worker or the physician designated by that treating physician shall, in accordance with rules promulgated by the administrative director, render opinions on all medical issues necessary to determine eligibility for compensation. In the event that there is more than one treating physician, a single report shall be prepared by the physician primarily responsible for managing the injured worker's care that incorporates the findings of the various treating physicians."

Please allow this to serve as written authorization for treatment as a Primary Treating Physician designation under Labor Code §4600 to the following limited body parts only:

Description of injury: Back,,Bilateral shoulders, Nervous system

Patient's Demographics as follows:

Address: 949 E 49th St Apt 3
Los Angeles, CA 90011-6053

Phone:

If the claim is litigated, please copy your medical reports as follows:

Applicant's Counsel: Lee Legal Group

Defense Counsel: BRADFORD AND BARTHEL, LLP

Our Billing Address is as follows:

ICW Group
P.O. Box 2965
Clinton, IA 52733-2965

Utilization Review:
Labor Code Section 4610 requires that employers/carriers establish a utilization review (UR) process for determining whether to approve, delay, deny, or modify a request for treatment by the treating physician. We have established a UR process through Mitchell Managed Care Services.

All treatment requests should be submitted to Mitchell's Utilization Review at:

- **UR Phone: 800-407-0704**
- **UR Fax: 800-362-7229**

MPN Rules/Procedures:
ICW is a participant in the ICW Group Premier Network (MPN), the network selected by ICW Group to provide care to participating injured workers. Labor Code 4616 -4616.7 outlines the MPN rules and requirements.

The patient has the right to change doctors within the network upon request. The patient has the right to request a 2nd and 3rd opinion if they disagree with part or all of a treatment plan. We are happy to handle all the details of that process and to keep you apprised along the way. We just want you to be aware that such requests could be made by this patient. If the patient makes any of these requests to you, please refer the patient to us so the process can be completed timely.

If this MPN process is new to you, or if you or your staff have any questions about it, we are here to help. Please call so we may answer your questions and provide whatever assistance you may need to facilitate care of this patient or, you may contact ICW Group Premier MPN directly at 855-521-7083, or to the website at: https://search.harborsys.com/ICWGroupMPN

In addition, please note that all referrals you make to specialists or consultant physicians must be made to members of the ICW Group Premier Network MPN. We would appreciate being notified of such referrals in advance. We would also request that you obtain our authorization prior to scheduling any referrals, performing testing or referring the patient for physical therapy.

Rules Regarding Medical Treatment
Under California Law, the employer must provide medical, surgical, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches and apparatus, including artificial members, which are reasonably required to cure or relieve the injured worker from the effects of the injury. The Medical Treatment Utilization Schedule (MTUS), Regulations section 9792.20 through 9792.27.23, contain medical treatment guidelines and rules for determining what is reasonable and necessary medical care. These guidelines were adopted by Administrative Director Order and developed by the American College of Occupational and Environmental Medicine (ACOEM), occupational medicine practice guidelines.

The American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines, Second Edition, are presumed correct on the issue of extent and scope of medical treatment in employers' required utilization review plans. Other appropriate medical treatment guidelines may also be used to support utilization review decisions, as set forth in Labor Code section 4604.5. Pre-authorization of treatment is required. You are required to submit your treatment plans in writing to us before proceeding with treatment. Treatment requested may

be submitted to Utilization Review by us to determine appropriateness and authorization. Treatment not authorized will be objected to and will not be paid.

Reporting Requirements of Primary Treating Physician:
Title 8 CCR 9785 describes the duties of the primary treating physician. A copy of this section is enclosed. Please note that the employee's eligibility for workers' compensation benefits depends upon your cooperation in submitting not only a timely initial written report to us, but also periodic written reports. Both must contain sufficient detail, as set forth in Rule 9785. Any delay in submitting your reports may result in a delay in benefits due the injured employee.

After receipt of reports as required by section 9785 of the Rules and Regulations, bills that reflect reasonable and authorized charges will receive prompt attention. Your bills will be audited in accordance with the Official Fee Schedule as adopted by the Administrative Director, Department of Industrial Relations, Division of Workers' Compensation.

For injuries occurring on or after January 1, 2014 when the disability from all conditions for which compensation is claimed has become permanent and stationary and that the injury has caused permanent partial disability, the attached DWC-AD 10133.36 Form is a required and is to be completed and attached to a comprehensive medical evaluation (does not replace the comprehensive medical-legal evaluations).

If you have any questions, please contact me at (925) 474-2820.

Sincerely,

Kris Schave, Claims Specialist
Ph: (925) 474-2820

Enc.: 9785 Guidelines
Physician's Return-to-Work & Voucher Report Instructions (DWC - AD 10133.36)
Medical Records

Cc:
Claudia Arana, 949 E 49th St Apt 3, Los Angeles, CA 90011-6053
Lee Legal Group, 3055 Wilshire BLvd Ste 1100, Los Angeles, CA 90010
BRADFORD AND BARTHEL, LLP , PO BOX 348450 , Sacramento, CA 95834

§9785. Reporting Duties of the Primary Treating Physician.

(a) For the purposes of this section, the following definitions apply:

(1) The "primary treating physician" is the physician who is primarily responsible for managing the care of an employee, and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter. The primary treating physician is the physician selected by the employer, the employee pursuant to Article 2 (commencing with section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code, or under the contract or procedures applicable to a Health Care Organization certified under section 4600.5 of the Labor Code, or in accordance with the physician selection procedures contained in the medical provider network pursuant to Labor Code section 4616. For injuries on or after January 1, 2004, a chiropractor shall not be a primary treating physician after the employee has received 24 chiropractic visits, unless the employer has authorized additional visits in writing. This prohibition shall not apply to the provision of postsurgical physical medicine prescribed by the employee's surgeon, or physician designated by the surgeon pursuant to the postsurgical component of the medical treatment utilization schedule adopted by the Administrative Director pursuant to Labor Code section 5307.27. For purposes of this subdivision, the term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management.

(2) A "secondary physician" is any physician other than the primary treating physician who examines or provides treatment to the employee, but is not primarily responsible for continuing management of the care of the employee. For injuries on or after January 1, 2004, a chiropractor shall not be a secondary treating physician after the employee has received 24 chiropractic visits, unless the employer has authorized, in writing, additional visits. This prohibition shall not apply to the provision of postsurgical physical medicine prescribed by the employee's surgeon, or physician designated by the surgeon pursuant to the postsurgical component of the medical treatment utilization schedule adopted by the Administrative Director pursuant to Labor Code section 5307.27. For purposes of this subdivision, the term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management.

(3) "Claims administrator" is a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third-party administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(4) "Medical determination" means, for the purpose of this section, a decision made by the primary treating physician regarding any and all medical issues necessary to determine the employee's eligibility for compensation. Such issues include but are not limited to the scope and extent of an employee's continuing medical treatment, the decision whether to release the employee from care, the point in time at which the employee has reached permanent and stationary status, and the necessity for future medical treatment.

(5) "Released from care" means a determination by the primary treating physician that the employee's condition has reached a permanent and stationary status with no need for continuing or future medical treatment.

(6) "Continuing medical treatment" is occurring or presently planned treatment that is reasonably required to cure or relieve the employee from the effects of the injury.

(7) "Future medical treatment" is treatment which is anticipated at some time in the future and is reasonably required to cure or relieve the employee from the effects of the injury.

(8) "Permanent and stationary status" is the point when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized, and unlikely to change substantially in the next year with or without medical treatment.
(b)(1) An employee shall have no more than one primary treating physician at a time.
(2) An employee may designate a new primary treating physician of his or her choice pursuant to Labor Code §§ 4600 or 4600.3 provided the primary treating physician has determined that there is a need for:

(A) continuing medical treatment; or
(B) future medical treatment. The employee may designate a new primary treating physician to render future medical treatment either prior to or at the time such treatment becomes necessary.

(3) If the employee disputes a medical determination made by the primary treating physician, including a determination that the employee should be released from care, the dispute shall be resolved under the applicable procedures set forth at Labor Code sections 4060, 4061 4062, 4600.5, 4616.3, or 4616.4. If the employee objects to a decision made pursuant to Labor Code section 4610 to modify, delay, or deny a treatment recommendation, the dispute shall be resolved by independent medical review pursuant to Labor Code section 4610.5, if applicable, or otherwise pursuant to Labor Code section 4062.

(4) If the claims administrator disputes a medical determination made by the primary treating physician, the dispute shall be resolved under the applicable procedures set forth at Labor Code sections 4060, 4061, 4062, and 4610.

(c) The primary treating physician, or a physician designated by the primary treating physician, shall make reports to the claims administrator as required in this section. A primary treating physician has fulfilled his or her reporting duties under this section by sending one copy of a required report to the claims administrator. A claims administrator may designate any person or entity to be the recipient of its copy of the required report.

(d) The primary treating physician shall render opinions on all medical issues necessary to determine the employee's eligibility for compensation in the manner prescribed in subdivisions (e), (f) and (g) of this section. The primary treating physician may transmit reports to the claims administrator by mail or FAX or by any other means satisfactory to the claims administrator, including electronic transmission.

(e)(1) Within 5 working days following initial examination, a primary treating physician shall submit a written report to the claims administrator on the form entitled "Doctor's First Report of Occupational Injury or Illness," Form 5021. Emergency and urgent care physicians shall also submit a Form 5021 to the claims administrator following the initial visit to the treatment facility. On line 24 of the Doctor's First Report, or on the reverse side of the form, the physician shall (A) list methods, frequency, and duration of planned treatment(s), (B) specify planned consultations or referrals, surgery or hospitalization and (C) specify the type, frequency and duration of planned physical medicine services (e.g., physical therapy, manipulation, acupuncture). For dates of service prior to October 1, 2015, use Form 5021 (Rev. 4 1992). For dates of service on or after October 1, 2015, use Form 5021 (Rev. 5 2015). Although ICD-10 coding is required on or after October 1, 2015, for a twelve-month period ending October 1, 2016, no medical treatment or medical-legal bill shall be denied based solely on an error in the level of specificity of the ICD-10 diagnosis code(s) used. Providers may use either version of the form until December 31, 2015. As of January 1, 2016, providers must use the 2015 version of the form.

(2) Each new primary treating physician shall submit a Form 5021 following the initial examination in accordance with subdivision (e)(1).

(3) Secondary physicians, physical therapists, and other health care providers to whom the employee is referred shall report to the primary treating physician in the manner required by the primary treating physician.

(4) The primary treating physician shall be responsible for obtaining all of the reports of secondary physicians and shall, unless good cause is shown, within 20 days of receipt of each report incorporate, or comment upon, the findings and opinions of the other physicians in the primary treating physician's report and submit all of the reports to the claims administrator.

(f) A primary treating physician shall, unless good cause is shown, within 20 days report to the claims administrator when any one or more of the following occurs:

(1) The employee's condition undergoes a previously unexpected significant change;

(2) There is any significant change in the treatment plan reported, including, but not limited to, (A) an extension of duration or frequency of treatment, (B) a new need for hospitalization or surgery, (C) a new need for referral to or consultation by another physician, (D) a change in methods of treatment or in required physical medicine services, or (E) a need for rental or purchase of durable medical equipment or orthotic devices;

(3) The employee's condition permits return to modified or regular work;
(4) The employee's condition requires him or her to leave work, or requires changes in work restrictions or modifications;

(5) The employee is released from care;

(6) The primary treating physician concludes that the employee's permanent disability precludes, or is likely to preclude, the employee from engaging in the employee's usual occupation or the occupation in which the employee was engaged at the time of the injury;

(7) The claims administrator reasonably requests appropriate additional information that is necessary to administer the claim. "Necessary" information is that which directly affects the provision of compensation benefits as defined in Labor Code Section 3207.

(8) When continuing medical treatment is provided, a progress report shall be made no later than forty-five days from the last report of any type under this section even if no event described in paragraphs (1) to (7) has occurred. If an examination has occurred, the report shall be signed and transmitted within 20 days of the examination.

Except for a response to a request for information made pursuant to subdivision (f)(7), reports required under this subdivision shall be submitted on the "Primary Treating Physician's Progress Report" form (Form PR-2) contained in Section 9785.2, or in the form of a narrative report. If a narrative report is used, it must be entitled "Primary Treating Physician's Progress Report" in bold-faced type, must indicate clearly the reason the report is being submitted, and must contain the same information using the same subject headings in the same order as Form PR-2. A response to a request for information made pursuant to subdivision (f)(7) may be made in letter format. A narrative report and a letter format response to a request for information must contain the same declaration under penalty of perjury that is set forth in the Form PR-2: "I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3."

For dates of service prior to October 1, 2015, use Form PR-2 (Rev. 06-05). For dates of service on or after October 1, 2015, use Form PR-2 (Rev. 2015). Although ICD-10 coding is required on or after October 1, 2015, for a twelve-month period ending October 1, 2016, no medical treatment or medical-legal bill shall be denied based solely on an error in the level of specificity of the ICD-10 diagnosis code(s) used. Providers may use either version of the form until December 31, 2015. As of January 1, 2016, providers must use the 2015 version of the form.

By mutual agreement between the physician and the claims administrator, the physician may make reports in any manner and form.

(g) As applicable in section 9792.9.1, a written request for authorization of medical treatment for a specific course of proposed medical treatment, or a written confirmation of an oral request for a specific course of proposed medical treatment, must be set forth on the "Request for Authorization," DWC Form RFA, contained in section 9785.5. A written confirmation of an oral request shall be clearly marked at the top that it is written confirmation of an oral request. The DWC Form RFA must include as an attachment documentation substantiating the need for the requested treatment.

(h) When the primary treating physician determines that the employee's condition is permanent and stationary, the physician shall, unless good cause is shown, report within 20 days from the date of examination any findings concerning the existence and extent of permanent impairment and limitations and any need for continuing and/or future medical care resulting from the injury. The information may be submitted on the "Primary Treating Physician's Permanent and Stationary Report" form (DWC Form PR-3 or DWC Form PR-4) contained in section 9785.3 or section 9785.4, or in such other manner which provides all the information required by Title 8, California Code of Regulations, section 10606. For permanent disability evaluation performed pursuant to the permanent disability evaluation schedule adopted on or after January 1, 2005, the primary treating physician's reports concerning the existence and extent of permanent impairment shall describe the impairment in accordance with the AMA Guides to the Evaluation on Permanent Impairment, 5th Edition (DWC Form PR-4). Qualified Medical Evaluators and Agreed Medical Evaluators may not use DWC Form PR-3 or DWC Form PR-4 to report medical-legal evaluations.

For dates of service prior to October 1, 2015, use Form PR-3 (Rev. 06-05) or PR-4 (Rev. 06-05), as applicable. For dates of service on or after October 1, 2015, use Form PR-3 (Rev. 2015) or PR-4 (Rev. 2015), as applicable. Although ICD-10 coding is required on or after October 1, 2015, for a twelve-month period ending October 1, 2016, no medical treatment or medical-legal bill shall be denied based solely on an error in the level of specificity of the ICD-10 diagnosis code(s) used. Providers may use either version of the form until December 31, 2015. As of January 1, 2016, providers must use the 2015 version of the form.

(i) The primary treating physician, upon finding that the employee is permanent and stationary as to all conditions and that the injury has resulted in permanent partial disability, shall complete the "Physician's Return-to-Work & Voucher Report" (DWC-AD 10133.36) and attach the form to the report required under subdivision (h).

(j) Any controversies concerning this section shall be resolved pursuant to Labor Code Section 4603 or 4604, whichever is appropriate.

(k) Claims administrators shall reimburse primary treating physicians for their reports submitted pursuant to this section as required by the Official Medical Fee Schedule.

Note: Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code. Reference: Sections 4061, 4061.5, 4062, 4600, 4600.3, 4603.2, 4604.5, 4610.5, 4658.7, 4660, 4662, 4663 and 4664, Labor Code.

Physician's Return-to-Work & Voucher Report

For injuries occurring on or after January 1, 2013

☐ The Employee is P&S from all conditions and the injury has caused permanent partial disability

Employee Last Name	Employee First Name	MI	Date of Injury
Arana	Claudia		04/12/2022

Claims Administrator:	Claims Representative:
INSURANCE COMPANY OF THE WEST	Kris Schave

Employer name:	Employer Street Address:
REPUBLIQUE LLC	3547 VOYAGER ST., #201

Employer City:	State	Zip Code	Claim No.
TORRANCE	CA	90503	2022008186

☐ The Employee can return to regular work

☐ The Employee can work with restrictions:

	Hours:	1-2	2-4	4-6	6-8	None
Stand		☐	☐	☐	☐	☐
Walk		☐	☐	☐	☐	☐
Sit		☐	☐	☐	☐	☐
Bend		☐	☐	☐	☐	☐
Climb		☐	☐	☐	☐	☐
Twist		☐	☐	☐	☐	☐
Reach		☐	☐	☐	☐	☐
Crawl		☐	☐	☐	☐	☐
Drive		☐	☐	☐	☐	☐
Reach		☐	☐	☐	☐	☐
R/L/Bilat Hand(s) (circle):	*Grasp*	☐	☐	☐	☐	☐
R/L/Bilat Hand(s) (circle):	*Push/Pull*	☐	☐	☐	☐	☐
Other: _____	(See Below)	☐	☐	☐	☐	☐

Lift/Carry restrictions: May not lift/carry at a height of _____ more than _____ lbs. for more than _____ hours per day.

Describe in what ways the impaired activities are limited:

If a Job Description has been provided, please complete: ☐ *Regular* ☐ *Modified* ☐ *Alternative Work*

Job Title: _____ *Work Location:* _____

Are the work capacities and activity restriction compatible with the physical requirements set forth in the provided job description? ☐ *Yes* ☐ *No, explain below*

Physician's Name _____ Role of Doctor (PTP,QME,AME) _____

Physician's Signature _____ Date _____

State of California
Division of Workers' Compensation

Physician's Return-to-Work & Voucher Report
Instructions FOR INJURIES OCCURRING ON OR AFTER 1/1/13
DWC -AD 10133.36

Who is responsible for filling out this form? The first physician (primary treating physician, Agreed Medical Evaluator, or Qualified Medical Evaluator) who finds tha.t the disability from all conditions for which compensation is claimed has become permanent and stationary (or has reached maximum medical improvement) and finds that the injury has caused permanent partial disability.

What is the purpose of this form? The purpose of the form is to fully inform the employer of the work capacities and activity restrictions resulting from the injury that are relevant to potential regular work, modified work, or alternative work. The information contained on the form is for voucher purposes and is not considered in any permanent impairment rating or any permanent disability indemnity.

Is this a mandatory form? This is a mandatory attachment to the first medical report finding that the disability from all conditions for which compensation is claimed has become permanent and stationary and that the injury has caused permanent partial disability. This form should be attached to a comprehensive medical-legal evaluation and does not replace such comprehensive medical-legal evaluations.

When does the form need to be completed? This form does not need to be completed until all conditions for which compensation is claimed have become permanent and stationary.

If the employer or claims administrator has provided the physician with a job description providing physical requirements of the employee's regular work, proposed modified work, or proposed alternative work, the physician will evaluate and describe in the form whether the work capacities and activity restrictions are compatible with the physical requirements set forth in that job description. The bottom portion of the form does not need to be completed if the physician has not been provided with a job description.

Completing the employee's work restrictions: The physician should indicate work restrictions in terms of how many hours a particular activity is restricted during an 8-hour work day. For hand restrictions, the physician should indicate whether the restrictions are for the right hand, left hand, or both.

Other restrictions can include psychiatric restrictions, chemical exposure, use of equipment, or any other restrictions.

How does the employer receive the form? The claims administrator will forward the form to the employer

Cc:
Claudia Arana
949 E 49th St Apt 3
Los Angeles, CA 90011-6053

Lee Legal Group
3055 Wilshire BLvd Ste 1100
Los Angeles CA 90010

BRADFORD AND BARTHEL, LLP
PO BOX 348450
Sacramento CA 95834

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2022008186
Initial Packet 2
Nichole Matteson

05/04/2022

REPUBLIQUE LLC
Attn: HR – Personal & Confidential
3547 VOYAGER ST., #201,
TORRANCE, CA 90503

RE: Employee: Claudia Arana
Employer: REPUBLIQUE LLC
Date Injured: 04/12/2022
Claim #: 2022008186

Dear Employer:

It is the goal of INSURANCE COMPANY OF THE WEST to provide timely, appropriate benefits to your injured workers.

The enclosed requests and notices describe issues pertinent to the handling of the claim for the employee noted above. Please review and provide each of the items and reply accordingly if you have not already done so. You may disregard if the employee has lost less than three days of work and this claim was determined to be a Medical Only.

- Completed "Employer's First Report of Injury" (form 5020).
- Did the employee return a completed "Employee's Claim for Workers' Compensation Benefits" (DWC-1) form? If yes, please provide a copy to us.
- Please complete and submit the attached statement of wages within 14 days.
- A complete copy of the employee's personnel file.
- Witness Statement
- Please complete and return the enclosed Job Description.
- Please ensure that you are displaying the DWC-7 MPN Posting and Complete Employee Written Notice Regarding Medical Provider Network (MPN) at each specific location where you have employees at, and can provide the name of a potential witness who can testify at the WCAB that the postings are properly displayed, if ever necessary.

Sincerely,

Nichole Matteson

Nichole Matteson, Triage Examiner
INSURANCE COMPANY OF THE WEST
Ph: (858) 350-7293

Enc.

State of California
Division of Workers' Compensation

DESCRIPTION OF EMPLOYEE'S JOB DUTIES
DWC - AD 10133.33

INSTRUCTIONS: This form shall be developed jointly by the employer and employee and is intended to describe the employee's job duties. The completed form will be reviewed to determine whether the employee is able to return to work.

Employee Last Name _____ Employee First Name _____ MI ____ Claim #: _____

Employer Name _____ Job Address _____

Job Title: _____ Hrs. Worked Per Day _____ Hrs. Worked Per Week _____

Description of Job Responsibilities: (Describe All Job Duties):

Please check one: Regular Duty ☐ Modified Duty ☐ Alternative Work ☐

1. Check the frequency of activity required of the employee to perform the job.

ACTIVITY (Hours per day)	NEVER 0 HOURS	OCCASIONALLY UP TO 3 HOURS	FREQUENTLY 3-6 HOURS	CONSTANTLY 6-8+ hours
Sitting	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Bending (neck)	☐	☐	☐	☐
Bending (waist)	☐	☐	☐	☐
Squatting	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Twisting (neck)	☐	☐	☐	☐
Twisting (waist)	☐	☐	☐	☐
Hand Use: Dominant Hand: ☐ Left ☐ Right	☐	☐	☐	☐
Repetitive use of hand required	☐	☐	☐	☐
Simple Grasping (right hand)	☐	☐	☐	☐
Simple Grasping (left hand)	☐	☐	☐	☐
Power Grasping (right hand)	☐	☐	☐	☐
Power Grasping (left hand)	☐	☐	☐	☐
Fine Manipulation (right hand)	☐	☐	☐	☐
Fine Manipulation (left hand)	☐	☐	☐	☐
Pushing & Pulling (right hand)	☐	☐	☐	☐
Pushing & Pulling (left hand)	☐	☐	☐	☐
Reaching (above shoulder)	☐	☐	☐	☐
Reaching (below shoulder)	☐	☐	☐	☐
Keyboarding with both hands	☐	☐	☐	☐

2. Please indicate the daily Lifting and Carrying requirements of the job: Indicate the height the object is lifted from floor, table or overhead location and the distance the object is carried.

	LIFTING					CARRYING				
	Never 0 hrs.	Occasionally up to 3 hrs.	Frequently 3-6 hrs.	Constantly 6-8+ hrs.	Height	Never 0 hrs.	Occasionally up to 3 hrs.	Frequently 3-6 hrs.	Constantly 6-8+ hrs.	Distance
0 - 10 lbs	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____
11 - 25 lbs.	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____
26 - 50 lbs.	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____
51 - 75 lbs.	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____
76 - 100 lbs.	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____
100+ lbs.	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____

Describe the heaviest item required to carry and the distance to be carried:

3. Please indicate if your job requires:

	YES	NO	(IF YES, PLEASE BRIEFLY DESCRIBE)
a. Driving cars, trucks, forklifts and other equipment?	☐	☐	_____
b. Working around equipment and machinery?	☐	☐	_____
c. Walking on uneven ground?	☐	☐	_____
d. Exposure to excessive noise?	☐	☐	_____
e. Exposure to extremes in temperature, humidity or wetness?	☐	☐	_____
f. Exposure to dust, gas, fumes, or chemicals?	☐	☐	_____
g. Working at heights?	☐	☐	_____
h. Operation of foot controls or repetitive foot movement?	☐	☐	_____
i. Use of special visual or auditory protective equipment?	☐	☐	_____
j. Working with bio-hazards such as: blood borne pathogens, sewage, hospital waste, etc.?	☐	☐	_____

Employee Comments

Employer Comments:

Employer Contact Name: _____ Employer Contact Title: _____

Employer Representative Signature: _____ Date: _____

Employee's Signature: _____ Date: _____

STATEMENT OF WEEKLY WAGES

RE:				
	Claimant:	Claudia Arana	Last Date Worked:	
	Claim Number:	2022008186	Date Returned to Work:	
	Date of Injury:	04/12/2022		
	Current Rate of Pay:		Date Terminated:	

Per *California Labor Code Section 4453*, disability benefits are computed on the basis of average weekly earnings. In order for us to handle cases in accordance with this law, we need you to complete the following chart, by weeks, for all payments made by you to the above mentioned employee.

PLEASE SUBMIT THIS TO US **WITHIN 14 DAYS**. Include **12 months prior** to the date of injury or from date of hire. Other payments could include: **1. Food and Drink; 2. Lodging; 3. Gas and Mileage; 4. Other Benefits**

PAY PERIOD	GROSS WAGES	RATE OF PAY	HOURS	BONUS/ OTHER PAYMENTS	PAY PERIOD	GROSS WAGES	RATE OF PAY	HOURS	BONUS/ OTHER PAYMENTS
FORWARD					TOTAL				

SIGNED: _____ DATE: _____

C0106 (06/16)

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Lee Legal Group
3055 Wilshire Blvd. Suite 1040
Los Angeles CA, 90010

Tel: (213) 788-3311
Fax: (213) 788-3312

April 27, 2022

HOLA RIVERA LLC DBA PETTY CASH TAQUERIA & BAR
3547 Voyager St, 201
Torrance, CA 90503

RE: **Employee: CLAUDIA ARANA**
Employer: HOLA RIVERA LLC DBA PETTY CASH TAQUERIA & BAR
D/Injury: CT 06/01/2015-04/12/2022
Claim #: Pending
WCAB#: Pending

Dear Employer or Employer's Representative:

Please be advised that this office represents the above-named individual in regard to the aforementioned injury that occurred while working with your company.

Please serve this office with all medical reports in your possession and control and any and all relevant employment investigation records. Consider this an ongoing demand.

Please turn the original of this letter with all of its many attachments to your workers' compensation insurance carrier(s) whose policy (ies) were in effect at any time during the dates of the claimed injury (ies) immediately, retaining a copy of same for your own files.

California Labor Code Section 132a, together with the Federal Americans with Disabilities Act (ADA) and the California Fair Employment and Housing Act (FEHA) forbid you to fire or discriminate against an injured worker or disabled worker until, among other things, his medical condition has been declared stable. Violation of such laws can subject you to heavy monetary damages before Workers' Compensation Appeals Board, or Federal or State civil courts.

By law, you have one day from the receipt of the claim form (s) in which to fill out the bottom portion thereof (and, in so doing, most especially telling us the name and address of your workers compensation insurance carrier), then dating and signing it and mailing it back to us; and you have fourteen (14) days from the date of the receipt of the same item in which to send us a legally proper response to claim form.

Pursuant to Labor Code 5402 (c), within one working day you must authorize medical treatment up to $10,000, until liability is accepted or rejected. Failure to provide

and/or authorize medical treatment under this statute will be deemed a waiver of your right to control medical treatment.

Failure to fulfill the above requirements on your part on a timely basis entails various penalties mandated by law and you should check immediately with your workers' compensation insurance carrier about what those penalties are and otherwise cooperate fully with that carrier to respond to these documents on a timely basis.

If this case cannot be settled amicably, we will insist on the following three penalties, among others: (1) LC Section 4650 (d) an automatic 10% penalty for failure to pay temporary disability benefits whether or not the delay was reasonable; (2) LC Section 5814 an additional 10% penalty for failure to pay temporary disability benefits or any other benefit but only when the failure is not reasonable; and (3) LC Section 4262 automatic penalty for failure to timely provide vocational rehabilitation maintenance allowance. Other penalties up to $400,000.00 may also be assessed.

By service of this letter and attachments, demand is hereby made upon the employer and/or its workers' compensation insurance carrier for the following:

1. Temporary disability benefits right now, and later when appropriate, maintenance allowance and permanent disability advances.

2. Transportation expenses to medical providers

3. Vocational Rehabilitation benefits.

Contact this office so that we may agree upon a Qualified Rehabilitation Representative (QRR), who can then meet with our client, in our presence, to review rehabilitation benefits, and among other things, prepare a Description of Employee Job Duties (RU-91). Do not have anyone meet with our client directly, to discuss this matter without our permission and without contacting us first. Also, please withhold 15% of Vocational Rehabilitation Maintenance Allowance as well as all retroactive benefits outside the cap for our attorney fees.

Demand is hereby made that you refer the injured worker to appropriate medical provider within 24 hours from the receipt of this letter. Your failure to do so, will be deemed a waiver and relinquishment of your right to medical control. This injured worker will then obtain medical treatment on his/her own and you will be responsible for all such bills. Under Labor Code Section 4601 and 4600.3 (e) and other relevant Labor Code sections, please consider this a formal employee request for change of defense treating doctor within five working days; and formal employee request for an independent consulting physician of his own choice at the employer's expense in a serious case, or for a second opinion on a matter of diagnosis. Please be informed that due to your continued failure to comply with all applicable laws our client will be taking charge of his/her own medical treatment immediately on one or more of the bases listed below. Please also see the "Notice of the designation of the new Primary Treating Physician and proposed first appointment". The bases for applicant's assuming control of his own medical treatment at this point in time are multiple, including one or more of the following sections of the Labor Code: (1) right to choose own treating doctor after 30 days (LC Section 4600), or 90 days (LC Section 4600.03 (c) (1) effective 8/1/94 under certain conditions; (2) right to choose own treating doctor if

the employer ignores request to change defense treating doctor within five working days (LC Section 4601; LC Section 4600.3 (e) effective 8/1/94 under certain conditions); (3) right to the service of an independent consulting physicians of his own choice at the employer's expense in any service case, or right to a second opinion on matter of diagnosis (LC Section 46601; LC Section4600.3 (e) effective 8/1/94 under certain conditions; (4) right to choose his own doctor when emergency treatment is necessary (AD Rule 9780.2; LC Section 4600.3 (a) (2) effective 8/1/94 under certain conditions); (5) employer failure to post notice re medical care (LC Section 3550 and 3551); (6) employer neglect or refusal seasonably to provide medical care (LC Section 4600); where medical treatment provide by the employer has been ineffective or unsuccessful (the Nino case, 43 CCC 408 {W/D-1978}) employee designates own physician in writing prior to injury (LC section 4600, 4601(b), 4600.3(a); employee's right to change his own initially chosen for choice doctor the Tidwell case, 48CCC 801 (W/D-1983); employer waiver of right to control of the treatment or agreement to employee choice. (ADR rule 9780.1).

Please be further informed that is illegal to fire an injured worker because he has filed, or states he is going to file, a claim or application for workers' compensation benefits and it is also illegal to discriminate against such worker in any manner. By law, you must place our client, an injured worker, on work related injury disability leave until such time as his doctors indicate whether he is permanent & stationary (condition has stabilized), he can return to work under what restriction/limitations. If you have already fired out client, we hereby demand immediate reinstatement and that he be put on the above-described type of leave absence.

A brief word about our discovery program; Applicant has as much right to pursue discovery as the defense and even greater need for same because the employer and carrier adjusting agency have many more opportunities and obligations to generate written documents relevant to this case and applicant's rights than does the applicant with regard to defendant's rights.

At this time, we ask you to supply us with the following documents within thirty (30) days from today's date:

1. Any and all claims forms prepared and submitted by applicant regarding injuries or accidents on the job.

2. Any and all reports of injury or accident reports prepared by applicant or in connection with any of applicant's injuries or accidents on the job.

3. Any and all medical records concerning applicant.

4. Any and all vocational rehabilitation notices, documents or records concerning applicant.

5. Any and all ADA (Americans with Disabilities Act) notices, documents or records concerning applicant.

6. Earnings information concerning applicant, including a wage statement, W'2's, etc.

7. Any and all job descriptions, job analyses, or analyses of the essential functions of the job, concerning applicant's work for your company.

8. Any and all statements taken from applicant about the facts or applicant's accident (s) or injury (ies) on the job, his medical treatment in connection with same, or any other information relevant to a Workers Compensation claim or case.

9. Any and all witness statements taken from applicant's co-workers or any other person relevant to any of the issues in applicant's workers' compensation case (s). We are entitled to same under Moreno vs. City of L.A.

10. Any and all sub-rosa films taken of applicant, and any and all reports about the same.

11. A copy of applicant's complete personnel file with your company. We are entitled to same under LC Section 1198.5, copy attached.

Please consider this an ongoing demand and send us the documents and responses as they develop but in no event later than 30 days from the date.

Thank you in advance for your considered attention to this letter with attachments and for your anticipated courtesy and cooperation in replying thereto at your earliest possible convenience and in accordance with the deadlines established by applicable law.

Very truly yours,

Derek Lee
Attorney at Law

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State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:
Insurance Company of The West, P.O. Box 509039, SAN DIEGO, CA, 92150-9039

OSHA CASE NO.

FATALITY ☐

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.

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME: REPUBLIQUE LLC
1a. Policy Number: WVE-5062306-00
2. MAILING ADDRESS: (Number, Street, City, Zip): 3547 VOYAGER ST., #201, TORRANCE, CA, 90503
2a. Phone Number: 3103710001
3. LOCATION if different from Mailing Address (Number, Street, City and Zip): 3547 VOYAGER ST., #201 TORRANCE CA 90503
3a. Location Code: 003
4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.:
5. State unemployment insurance acct.no:
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy): 04/12/2022
8. TIME INJURY/ILLNESS OCCURRED: _____ AM _____ PM
9. TIME EMPLOYEE BEGAN WORK: _____ AM _____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy):
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy):
13. DATE RETURNED TO WORK (mm/dd/yy):
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☑ No
16. SALARY BEING CONTINUED? ☐ Yes ☑ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy): 05/04/2022
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy):
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning: Mult: Multiple Body Parts
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip): 7360 Beverly Blvd, Los Angeles, CA, 90035
20a. COUNTY: Los Angeles
21. ON EMPLOYER'S PREMISES? ☐ Yes ☑ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.:
23. Other Workers injured or ill in this event? ☐ Yes ☐ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold: Unspecified
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.: Unspecified
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY: This is a litigated CT claim for 06/01/2015 - 04/12/2022 for body parts: back, shoulders, nervous system-stress, and nervous system- psych.
27. Name and address of physician (number, street, city, zip):
27a. Phone Number:
28. Hospitalized as an inpatient overnight? ☑ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip):
28a. Phone Number:
29. Employee treated in emergency room? ☐ Yes ☑ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME: Claudia Arana
31. SOCIAL SECURITY NUMBER: 000-00-0006
32. DATE OF BIRTH (mm/dd/yy): 07/07/1986
33. HOME ADDRESS (Number, Street, City,Zip): 949 E 49th St, Apt 3, Los Angeles, CA, 90011-6053
33a. PHONE NUMBER:
34. SEX ☐ Male ☑ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers): COOK - any industry (322)
36. DATE OF HIRE (mm/dd/yy):
37. EMPLOYEE USUALLY WORKS 0.00 hours per day, 0.0 days per week, 0.0 total weekly hours
37a. EMPLOYMENT STATUS ☑ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED: 907909
38. GROSS WAGES/SALARY $ 0.00 per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Completed By (type or print)	Signature & Title	Date (mm/dd/yy)
Nichole Matteson	Triage Examiner	

Please do not use this column
CASE NUMBER
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
EVENT
SECONDARY SOURCE
EXTENT OF INJURY

• Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

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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 in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

Any person who makes any false or fraudulent statement or material misrepresentation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a crime.

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 División de Compensación al Trabajador al (800) 736-7401 para oir información grabada. Una explicación de los beneficios de compensación de trabajadores está incluida en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la casilla apropiado. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

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.* Claudia Arana Today's Date. *Fecha de Hoy* 04/20/22
2. Home Address. *Dirección Residencial.* 949 E 49TH ST Apt 3
3. City *Ciudad.* Los Angeles State. *Estado.* CA Zip. *Código Postal* 90011
4. Date of Injury. *Fecha de la lesión (accidente).* 06/01/2015-04/12/2022 Time of Injury. *Hora en que ocurrió.* ____ a.m ____ p.m
5. Address and description of where injury happened. *Dirección/lugar dónde ocurrió el accidente.* AT JOB SITE
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* Due to repetitive job duties and hostile work environment applicant suffers stress, anxiety, psych, right shoulder, and back.
7. Social Security Number. *Número de Seguro Social del Empleado.* ____
8. ☐ Check if you agree to receive notices about your claim by email only. ☐ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. ____ *Correo electrónico del empleado.* ____
You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*
9. Signature of employee. *Firma del empleado.* Claudia Arana

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

10. Name of employer. *Nombre del empleador.* ____
11. Address. *Dirección.* ____
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* ____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* ____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* ____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* ____
16. Insurance Policy Number. *El número de la póliza de Seguro.* ____
17. Signature of employer representative. *Firma del representante del empleador.* ____
18. Title. *Título.* ____ 19. 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*

Rev. 1/1/2016

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STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
APPLICATION FOR ADJUDICATION OF CLAIM

☐ Amended Application

Case No.

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).)

LAO

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

Injured Worker (Completion of this section is required)

CLAUDIA

First Name MI

ARANA

Last Name

949 E 49TH ST APT 3

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

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

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

LOS ANGELES CA 90011

City State Zip Code

Applicant (If other than Injured Worker)

☐ Insurance Carrier ☐ Employer ☐ Lien Claimant

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

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

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

WCAB1

Employer Information (Completion of this section is required)

☑ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

HOLA RIVERA LLC

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

3547 VOYAGER ST STE 201

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

TORRANCE | CA | 90503

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)

INSURANCE CO OF THE WEST SAN DIEGO

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

PO BOX 509039

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

SAN DIEGO | CA | 92150

City | State | Zip Code

IT IS CLAIMED THAT (Complete all relevant information):

1. The injured worker, born 07/07/1986 (DATE OF BIRTH: MM/DD/YYYY), while employed as a(n) LINE COOK (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

☐ specific injury _____ (Date of injury: MM/DD/YYYY)

suffered a :

☑ cumulative injury which began on 06/01/2015 (Start Date: MM/DD/YYYY) and ended on 04/12/2022 (End Date: MM/DD/YYYY)

The injury occurred at 7360 BEVERLY BLVD

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

LOS ANGELES, CA 90035.

City, State, Zip Code

(State which parts of the body were injured)

Body Part 1: 841 STRESS

Body Part 2: 842 PSYCH

Body Part 3: 450 SHOULDER

Body Part 4: 420 BACK

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)

DUE TO REPETITIVE AND HOSTILE WORK ENVIRONMENT APPLICANT SUFFERS STRESS, ANXIETY, PSYCH, RIGHT SHOULDER, AND BACK.

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

_____

Name of Doctor/Hospital/Clinic 2 (Please leave blank spaces between numbers, names or words)

8. Other cases have been filed for industrial injuries by this worker 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:

- ☑ Temporary disability indemnity
- ☑ Reimbursement for medical expense
- ☑ Medical treatment
- ☑ Compensation at proper rate
- ☑ Permanent disability indemnity
- ☑ Rehabilitation
- ☑ Supplemental Job Displacement/Return to Work
- ☑ Other (Specify) LC 132A SW

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

LEE LEGAL LOS ANGELES
Law Firm or Company Name (If Applicable)

12430616
Law Firm Number (If Applicable)

DEREK
Attorney/Representative First Name

MI

LEE ESQ
Attorney/Representative Last Name

3055 WILSHIRE BLVD STE 1040
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

LOS ANGELES
City

CA
State

90010
Zip Code

Applicant Attorney/Representative Signature

Applicant Signature

Dated at LOS ANGELES, California
City

Date 04/27/2022
MM/DD/YYYY

DEREK LEE, ESQ.
STATE BAR NO. 276217
LEE LEGAL GROUP,
3055 WILSHIRE BOULEVARD SUITE 1040
LOS ANGELES CA, 90010
TEL: (213) 788-3311
FAX: (213) 788-3312

ATTORNEY FOR APPLICANT

WORKERS' COMPENSATION APPEALS BOARD

FOR THE STATE OF CALIFORNIA COUNTY OF LOS ANGELES

CLAUDIA ARANA Applicant, vs. HOLA RIVERA LLC DBA PETTY CASH TAQUERIA & BAR Defendant	Case No: UNASSIGNED **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 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 inducement for any referred examination or evaluation

Dated: 04/20/22 Claudia Arana
APPLICANT

Before signing this form, you should be aware that: "Any person who makes 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"

APPLICANT DECLARATION PURSUANT TO LABOR CODE SECTION 4906 (g)

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 12% to 18% of the benefits awarded. Applicant's attorney will request a fee of 15% to 18% depending on the complexity of the case which will be deducted from the Client's settlement or award. In all cases, where the employer is uninsured, attorney will request a fee of 18%.

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: 320 W 4th Street, 9th Floor, Los Angeles CA 90013.

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 Office may be able to resolve your problems without the need for litigation.

Call this toll-free number: 1-800-736-7401

Employee's Signature Claudia Arana Date 04/20/22

Employee's Name Claudia Arana

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's compensation benefits or payments is guilty of a felony.

Your case is being filed at the Division of Workers' Compensation at the following location 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 right as set forth above and in Labor Code section 4906 (c) and (g)(1).

Attorney's Signature [signature] Date 04/20/22

Attorney's Name Derek Lee, Esq.

Address 3055 Wilshire Blvd, Ste. 1040, Los Angeles, CA 90010

Phone No. 213-788-3311

DWC Form 3 (Rev. 1/17)

DEREK LEE, ESQ.
STATE BAR NO. 276217
LEE LEGAL GROUP,
3055 WILSHIRE BOULEVARD, SUITE 1040
LOS ANGELES CA, 90010
TEL: (213) 788-3311
FAX: (213) 788-3312

ATTORNEY FOR APPLICANT

WORKERS' COMPENSATION APPEALS BOARD

CLAUDIA ARANA Applicant, vs. HOLA RIVERA LLC DBA PETTY CASH TAQUERIA & BAR Defendant	Case No: UNASSIGNED **VENUE AUTHORIZATION**

I hereby authorize my attorney, Lee Legal Group to file the Application for my claim for injury (ies) dated: 06/01/2015-04/12/2022 at the Los Angeles Worker's Compensation Appeals Board.

Dated: 04/20/22

Claudia Arana
Applicant

Dated: 04/20/22

Derek Lee, Esq.
Lee Legal Group

VENUE AUTHORIZATION

Uniform Assigned Name: LEE LEGAL LOS ANGELES
EAMS Administrator Name: DEREK LEE
EAMS Administrator's Phone: (213) 788-3311
EAMS Administrator's Email: DLEE@LEELEGAL.NET
CLAIM No. PENDING
CASE NO.: PENDING

PROOF OF SERVICE

I reside in the county of Los Angeles, State of California, I am over the age of eighteen and not a party to the within action; my business address 3055 Wilshire Blvd., Suite 1040, Los Angeles, California 90010. On the date shown below, I served the foregoing document(s), described as:

APPLICATION FOR ADJUDICATION OF CLAIM

On the intended parties in this action by placing the true copies thereof in a sealed envelope addressed as stated on the attached mailing list.

XX As follows: I am "readily familiar" with the firm's practices of collection and processing correspondence for mailing. Under that practice it would be deposited with the U. S. Postal Service on that same day with postage thereon fully prepaid at Los Angeles, California in the ordinary course of business. I am aware that on the 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 the deposit for mailing an affidavit of service thereof.

Executed on April 27, 2022 at Los Angeles, California.

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

Name: Elizabeth Victoria Signature: S Elizabeth Victoria

MAILING LIST

HOLA RIVERA LLC DBA PETTY CASH
TAQUERIA & BAR
Attn: Human Resource
3547 Voyager St
201
Torrance, CA 90503

Insurance Co of the West
Attn: New Claim
PO BOX 509039
San Diego, CA 92150

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DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD

NOTICE OF APPLICATION

DATE OF SERVICE: 04/28/2022

EAMS CASE NBR(s): ADJ16099691

DATE OF CLAIMED INJURY: 06/01/2015

EMPLOYEE: CLAUDIA ARANA

EMPLOYER: HOLA RIVERA LLC

INSURER: INSURANCE CO OF THE WEST SAN DIEGO

VENUE: LAO-ADJ, 320 W 4TH ST 9TH FL, LOS ANGELES, CA 90013

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 EAMS CASE NUMBER ON ALL CORRESPONDENCE TO THE WCAB.
THIS NOTICE CONSTITUTES A CONFORMED COPY OF THE APPLICATION.
DATE APPLICATION FILED: 04/27/2022

NOTICE TO PARTIES: **Disability Accommodation is available upon request.** Individuals with a disability requiring a reasonable accommodation (such as auxiliary aid or service or a modification of policies or procedures) to ensure effective communication and access to the programs of the Division of Workers' Compensation, should contact the **Disability Accommodation Coordinator** at the local District Office of the DWC, or the **Statewide Disability Accommodation Coordinator at 1-866-681-1459 (toll free) or through the California Relay Service, by dialing 711 or 1-800-735-2929 (TTY) or 1-800-855-3000 (TTY-Spanish).**

Accommodations can include reasonable modifications of procedures or the provision of auxiliary aids or services including, but not limited to, assistive listening devices (ALD), Computer-Aided Realtime Translation (CART), sign language interpreters, documents in alternative formats, magnifiers, and audio cassette recordings. **Accommodation requests should be made as soon as possible and at least five (5) days before the hearing, especially for requests for an ALD, a sign language interpreter, or CART.**

WC04

ICW Received: 5/2/2022

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Division of Workers' Compensation - Workers' compensation court public information search

Case detail information

EAMS case number	*Case location*	*Date of injury*	*Assigned judge*	*Archived*	*DEU*	
ADJ16099691	LAO-ADJ	06/01/2015 - 04/12/2022				View events

Injured worker first name	*Injured worker last name*	*Employer*
CLAUDIA	ARANA	HOLA RIVERA LLC

Body Part 1	420 BACK - INCLUDING BACK MUSCLES, SPINE AND SPINAL CORD
Body Part 2	450 SHOULDER(S) - (SCAPULA AND CLAVICLE)
Body Part 3	841 NERVOUS SYSTEM - STRESS
Body Part 4	842 NERVOUS SYSTEM - PSYCHIATRIC/PSYCH

Participant name	*Role*	*Address*
HOLA RIVERA LLC	EMPLOYER	3547 VOYAGER ST STE 201 TORRANCE CA 90503
INSURANCE CO OF THE WEST SAN DIEGO	CLAIMS ADMINISTRATOR	PO BOX 509039 SAN DIEGO CA 92150
LEE LEGAL LOS ANGELES	LAW FIRM	3055 WILSHIRE BLVD STE 1040 LOS ANGELES CA 90010

Exit | Previous

Division of Workers' Compensation - Workers' compensation court public information search

Case events

EAMS case number	*Case location*	
ADJ16099691	LAO-ADJ	
Injured worker first name	***Injured worker last name***	***Employer***
CLAUDIA	ARANA	HOLA RIVERA LLC

Event general description	*Detail description*	*Event date*
APPLICATION FILED	PETITION: APPLICATION FOR ADJUDICATION FILED	04/27/2022

Exit Previous

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LITIGATION REFERRAL

INSURANCE COMPANY OF THE WEST

05/16/2022

REFERRAL DETAILS:

Referral To: Michael Peabody
BRADFORD AND BARTHEL, LLP
PO BOX 348450
Sacramento, CA 95834

Referral From: Kris Schave
P.O. Box 509030
San Diego, CA 92150-9039

(925) 474-2820
kschave@icwgroup.com

CLAIMANT

Employer: REPUBLIQUE LLC
Claimant: Claudia Arana
DOH:
Body Part(s): Mult: Multiple Body Parts
TD Rate: 230.95
PD Rate: 160.00

Claim Number: 2022008186
DOI: 04/12/2022
AWW: 0.00
Periods Paid:
Periods Paid:

Occupation: COOK - any industry (322)
Coverage Dates: 10/01/2021 - 09/30/2022
Medical Paid: 0.00
Total: $0.00
Total: $0.00

INITIAL ACTION REQUIRED:

Depo[ ] Hearing [ ] Petition/Motion[ ]Walk-Thru (CA) [ ]Other[ ]

AFTER INITIAL ACTION IS COMPLETE:

Handle through Resolution[ ] Close your file [Yes]

LITIGATION

Case Venue:
Hearing Date:
Settlement Authority:

Case # (if assigned): ADJ16099691
Compensability Decision Deadline:

Applicant Attorney: Lee Legal Group
3055 Wilshire BLvd Ste 1100
Los Angeles CA 90010
Phone: (213) 788-3311

Co-Defendants (if any):

Phone:

BRADFORD & BARTHEL

MAY 19 2022

Sacramento

LITIGATION REFERRAL

INSURANCE COMPANY OF THE WEST

05/16/2022

Claim Summary/Plan of Action/Instructions for Attorney/Hearing Rep:

Referral Reason: Litigated Decision due date: 07/31/2022 Alleged Body parts: back, shoulders, nervous system-stress, and nervous system- psych This claim involves a 35-year-old cook who is alleging cumulative trauma injuries for the period 06/01/2015 - 04/12/2022 to her back, shoulders, nervous system-stress, and nervous system- psych due to repetitive job duties. It is unknown if the injured worker is still employed with our insured or if she has been terminated from employment. The employer?s initial date of knowledge of the alleged injuries is unknown. ICW coverage - 10/01/2021 - 04/12/2022

Directions for Defense Attorney: there is another file for this employer with same CT period that I already assigned to your firm Chiroy, Lucia, 2022007012. We need deposition and defend claim /AOE COE panel

Complete ICW Coverage: ICW coverage - 10/01/2021 - 04/12/2022

Brief Summary of Claim: An AOE/COE investigation is pending: Litigated Decision due date: 07/31/2022 Alleged Body parts: back, shoulders, nervous system-stress, and nervous system- psych This claim involves a 35-year-old cook who is alleging cumulative trauma injuries for the period 06/01/2015 - 04/12/2022 to her back, shoulders, nervous system-stress, and nervous system- psych due to repetitive job duties. It is unknown if the injured worker is still employed with our insured or if she has been terminated from employment. The employer?s initial date of knowledge of the alleged injuries is unknown. ICW coverage - 10/01/2021 - 04/12/2022 Pre-Existing Condition and/or Injuries: Neither are known based on the information received to date

All relevant documents are included with this referral by: Paper[ ] CD [ ]

PLEASE NOTE:

FOR ALL CLAIMS: Please do not reassign this case to another attorney in your firm without prior authorization from ICW Group and be sure to follow the case handling instructions in the ICW Group Litigation Guidelines.

FOR CALIFORNIA CLAIMS: ICW Group will be responsible for the filing and serving of documents on all parties (other than those you are required to do so at or following a hearing); setting medical appointments and exams; subpoenaing records; objecting to medical bills; or negotiating liens; unless you are given a specific authorization to perform one or more of those duties by ICW Group.