STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
COMPROMISE AND RELEASE

Case Number 1

Case Number 4

Case Number 2

Case Number 5

Case Number 3

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).)

AHM

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

Employee(Completion of this section is required)

First Name MI

Last Name

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

ORANGE CA 92868

City State Zip Code

Employer Information (Completion of this section is required)

☒ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

. INC.

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

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

ORANGE CA 92865

City State Zip Code

Applicant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Law Firm Number

Law Firm Name

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

City State Zip Code

Defendant's Attorney or Authorized Representative:

☒ Law Firm/Attorney ☐ Non Attorney Representative

CHRISTOPHER
First Name

VINCENT
Last Name

12784131
Law Firm Number

DIETZ GILMOR ORANGE
Law Firm Name

2230 W. CHAPMAN AVENUE
Address/PO Box (Please leave blank spaces between numbers, names or words)

ORANGE
City

CA
State

92868
Zip Code

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

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

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

City State Zip Code

Claims Administrator Information (if known and if applicable)

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

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

City State Zip Code

IT IS CLAIMED THAT:

1. The injured employee, born ______ (DATE OF BIRTH: MM/DD/YYYY), alleges that while employed as a(n)

HOST, sustained injury
(OCCUPATION AT THE TIME OF INJURY)

arising out of and in the course of employment at the locations and during the dates listed below:

(State with specificity the date(s) of injury(ies) and what part(s) of body, conditions or systems are being settled.)

☒ Specific Injury

Case Number 1 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 100 HEAD Body Part 2: 110 BRAIN Body Part 3: 160 SKULL

Body Part 4: ______ Other Body Parts: Cognitive Impairment

The injury occurred at JOBSITE
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

______ City, CA State ______ Zip Code.

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ Specific Injury

Case Number 5 ☐ Cumulative Injury ______ (Start Date: MM/DD/YYYY) ______ (End Date: MM/DD/YYYY)

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

Body Part 1: ______ Body Part 2: ______ Body Part 3: ______

Body Part 4: ______ Other Body Parts: ______

The injury occurred at ______
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

______ City ______ State ______ Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

2. Upon approval of this compromise agreement by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge and payment in accordance with the provisions hereof, the employee releases and forever discharges the above-named employer(s) and insurance carrier(s) from all claims and causes of action, whether now known or ascertained or which may hereafter arise or develop as a result of the above-referenced injury(ies), including any and all liability of the employer(s) and the insurance carrier(s) and each of them to the dependents, heirs, executors, representatives, administrators or assigns of the employee. Execution of this form has no effect on claims that are not within the scope of the workers' compensation law or claims that are not subject to the exclusivity provisions of the workers' compensation law, unless otherwise expressly stated.

3. This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury set forth in Paragraph No. 1 and further explained in Paragraph No. 9 despite any language to the contrary elsewhere in this document or any addendum.

4. Unless otherwise expressly stated, approval of this agreement RELEASES ANY AND ALL CLAIMS OF APPLICANT'S DEPENDENTS TO DEATH BENEFITS RELATING TO THE INJURY OR INJURIES COVERED BY THIS COMPROMISE AGREEMENT. The parties have considered the release of these benefits in arriving at the sum in Paragraph 7. Any addendum duplicating this language pursuant to Sumner v WCAB (1983) 48 CCC 369 is unnecessary and shall not be attached.

5. Unless otherwise expressly ordered by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge, approval of this agreement does not release any claim applicant may have for vocational rehabilitation benefits or supplemental job displacement benefits.

6. The parties represent that the following facts are true: (If facts are disputed, state what each party contends under Paragraph No. 9.)

EARNINGS AT TIME OF INJURY $ 281.57

TEMPORARY DISABILITY INDEMNITY PAID $ 6,006.72 Weekly Rate $ 187.71

Period(s) Paid 03/15/2019 (Start Date: MM/DD/YYYY) 10/08/2019 (End Date: MM/DD/YYYY)

PERMANENT DISABILITY INDEMNITY PAID $0 Weekly Rate $ N/A

Period(s) Paid N/A (Start Date: MM/DD/YYYY) End date N/A (End Date: MM/DD/YYYY)

TOTAL MEDICAL BILLS PAID $ 79,843.71 Total Unpaid Medical Expense to be Paid By: PER PARAGRAPH 8

Unless otherwise specified herein, the employer will pay no medical expenses incurred after approval of this agreement.

7. The parties agree to settle the above claim(s) on account of the injury(ies) by the payment of the SUM OF

$ 20,000.00
Settlement Amount

The following amounts are to be deducted from the settlement amount:

$ ______________ for permanent disability advances through ______________

$ ______________ for temporary disability indemnity overpayment, if any.

$ ______________ payable to ______________

$ ______________ payable to ______________

$ ______________ payable to ______________

$ ______________ payable to ______________

$ ______________ requested as applicant's attorney's fee.

LEAVING A BALANCE OF $ 20,000.00 , after deducting the amounts set forth above and less further permanent disability advances made after the date set forth above. Interest under Labor Code section 5800 is included if the sums set forth herein are paid within 30 days after the date of approval of this agreement.

8. Liens not mentioned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary):

DEFENDANT TO ADJUST, LITIGATE OR SETTLE ALL LIENS TIMELY FILED SUBJECT TO ALL AVAILABLE DEFENSES AFFIRMATIVE AND OTHERWISE PROVIDED BY THE CALIFORNIA LABOR CODE. NOTHING IN THIS SETTLEMENT SHALL BE CONSTRUED AS A WAIVER BY DEFENDANT OF ITS RIGHT TO ASSERT APPLICABLE DEFENSES. APPLICANT IS RESPONSIBLE FOR ALL TREATMENT COSTS FROM DATE OF AWARD APPROVING COMPROMISE AND RELEASE.

ALL PENALTIES AND INTEREST WAIVED IF PAID WITHIN 30 DAYS OF RECEIPT OF THE ORDER APPROVING COMPROMISE AND RELEASE.

9. The parties wish to settle these matters to avoid the costs, hazards and delays of further litigation, and agree that a serious dispute exists as to the following issues (initial only those that apply). ONLY ISSUES INITIALED BY APPLICANT OR HIS/HER REPRESENTATIVE AND DEFENDANTS, REPRESENTATIVES ARE INCLUDED WITHIN THIS SETTLEMENT.

Applicant	Defendant	
		earnings
	CJV	temporary disability
		jurisdiction
	CJV	apportionment
		employment
	CJV	injury AOE/COE
	CJV	serious and willful misconduct
	CJV	discrimination (Labor Code §132a)
	CJV	statute of limitations
	CJV	future medical treatment
	CJV	other OUT OF POCKET COSTS, PENALTIES, 5710 FEES, INTEREST, MILEAGE
	CJV	permanent disability 11% FOR HEAD/COGNITIVE IMPAIRMENT PER PQME DR.
	CJV	self-procured medical treatment, except as provided in Paragraph 7
		vocational rehabilitation benefits/supplemental job displacement benefits

COMMENTS:

THE PARTIES WISH TO FOREGO THE COSTS AND RISKS OF LITIGATION AND RESOLVE ALL ISSUES BY WAY OF THIS AGREEMENT. THIS AGREEMENT RESOLVES ANY AND ALL ISSUES RELATED TO ANY AND ALL SPECIES OF BENEFITS DUE TO THE APPLICANT FOR ALL INJURIES SUSTAINED DURING HIS EMPLOYMENT WITH THE ABOVE NAMED DEFENDANT.

THE APPLICANT STIPULATES TO RECEIVING PROPER NOTICE OF THE MPN AND THAT THERE WAS NO DENIAL OF CARE. SETTLEMENT IS BASED ON THE REPORT OF NEUROLOGICAL PANEL QME DR. RATED AS FOLLOWS:

13.04.00.00 - 8 - 11 - 240G - 13 - 11%

THERE IS NO 132A CLAIM, NO SERIOUS AND WILLFUL CLAIM, AND NO PSYCH CLAIM. APPLICANT STIPULATES TO HAVING NO OTHER CLAIMS AGAINST DEFENDANTS.

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

10. It is agreed by all parties hereto that the filing of this document is the filing of an application, and that the workers' compensation administrative law judge may in its discretion set the matter for hearing as a regular application, reserving to the parties the right to put in issue any of the facts admitted herein and that if hearing is held with this document used as an application, the defendants shall have available to them all defenses that were available as of the date of filing of this document, and that the workers' compensation administrative law judge may thereafter either approve this Compromise and Release or disapprove it and issue Findings and Award after hearing has been held and the matter regularly submitted for decision.

11. WARNING TO EMPLOYEE: SETTLEMENT OF YOUR WORKERS' COMPENSATION CLAIM BY COMPROMISE AND RELEASE MAY AFFECT OTHER BENEFITS YOU ARE RECEIVING TO WHICH YOU BECOME ENTITLED TO RECEIVE IN THE FUTURE FROM SOURCES OTHER THAN WORKERS' COMPENSATION, INCLUDING BUT NOT LIMITED TO SOCIAL SECURITY, MEDICARE AND LONG-TERM DISABILITY BENEFITS.

THE APPLICANT'S (EMPLOYEE'S) SIGNATURE MUST BE ATTESTED TO BY TWO DISINTERESTED PERSONS OR ACKNOWLEDGED BEFORE A NOTARY PUBLIC

By signing this agreement, applicant (employee) acknowledges that he/she has read and understands this agreement and has had any questions he/she may have had about this agreement answered to his/her satisfaction.

Witness the signature hereof this 12 day of March, 2021 at 7:42 p.m.

Witness 1	(Date)	Applicant (Employee)	3/12/2021 (Date)
Witness 2	(Date)	Attorney for Applicant	(Date)
Interpreter	(Date)	Attorney for Defendant	3/15/2021 (Date)
		Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)

STATE OF CALIFORNIA
WORKERS' COMPENSATION APPEALS BOARD

Applicant vs. Inc.; administered by *Defendants.*	Case No. **DECLARATION OF DEFENDANT RE: RESOLUTION OF LIENS**

I, Christopher Vincent - Dietz, Gilmor & Chazen, am the attorney or representative for defendant Corporation, administered by in the above-entitled matter.

I have made the following good faith efforts to resolve each of the liens in this case. List ALL lien claims below. Use supplemental pages as necessary.

Lien Claimant	Nature and Date of Lien Resolution Efforts	Result
EDD	Called on 2/16/2021 at (714) 558-4989 and spoke to confirmed no lien or balance.	NO LIEN
NO KNOWN LIENS		

I declare under penalty of perjury that the foregoing is true and correct and that this affidavit was executed at

ORANGE, California on 03/15/2021

Christopher Vincent - Dietz, Gilmor & Chazen