STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS

WORKERS' COMPENSATION APPEALS BOARD

SEE REVERSE SIDE FOR INSTRUCTIONS

APPLICATION FOR ADJUDICATION OF CLAIM
(PRINT OR TYPE NAMES AND ADDRESSES)

CASE No. Unassigned

M s. Maria Del Rosario Santillan

Social Security No.: None

(APPLICANT, IF OTHER THAN INJURED EMPLOYEE)

vs.

Premier Staffing

(EMPLOYER - STATE IF SELF-INSURED)

York Insurance

(EMPLOYER'S INSURANCE CARRIER OR, IF SELF-INSURED, ADJUSTING AGENCY)

9431 Nance Ave., # P
Downey, CA 90241
(INJURED EMPLOYEE'S ADDRESS AND ZIP CODE)

(APPLICANT'S ADDRESS AND ZIP CODE)

10970 Arrow Route, Suite. 101
Rancho Cucamonga, CA 91730
(EMPLOYER'S ADDRESS AND ZIP CODE)

P.O. Box 619079
Roseville, CA 95661
(INSURANCE CARRIER OR ADJUSTING AGENCY'S ADDRESS)

IT IS CLAIMED THAT:

1. The injured employee, born 03/26/1967 (DATE OF BIRTH), while employed as a Warehouse Supervisor (OCCUPATION AT TIME OF INJURY)
on 02/22/2013 (DATE OF INJURY) at 255 W. Victoria Street., Compton, CA 90220 (ADDRESS) (CITY) (STATE) (ZIP CODE)
By the employer sustained injury arising out of and in the course of employment to
Lumbar, Cervical, Thoracic Spine
(STATE WHAT PARTS OF BODY WERE INJURED)
2. The injury occurred as follows: White lifting; Lumbar, Thoracic, Cervical Spine
(EXPLAIN WHAT EMPLOYEE WAS DOING AT TIME OF INJURY AND HOW INJURY WAS RECEIVED)
3. Actual earnings at time of injury were: $9.00 per hour @ 40 hours per week
(GIVE WEEKLY OR MONTHLY SALARY OR HOURLY RATE AND NUMBER OF HOURS WORKED PER WEEK)
(SEPARATELY STATE VALUE PER WEEK OR MONTH OF TIPS, MEALS, LODGING OR OTHER ADVANTAGES REGULARLY RECEIVED)
4. The injury caused disability as follows: Unknown
(SPECIFY LAST DAY OFF WORK DUE TO THIS INJURY AND BEGINNING AND ENDING DATES OF ALL PERIODS OFF DUE TO THIS INJURY)
5. Compensation was paid ____ (YES) N (NO) $ N (TOTAL PAID) $ N (WEEKLY RATE) N (DATE OF LAST PAYMENT)
6. Unemployment insurance or unemployment compensation disability benefits have been received since the date of injury ____ (YES) N (NO)
7. Medical treatment was received Y (YES) ____ (NO) Unknown (DATE OF LAST TREATMENT) All treatment was furnished by the Employer or Insurance Company ____ (YES) N (NO) Other treatment was provided or paid for by
Self-Procured
(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE) Did Medi-Cal pay for any health care related to this claim ____ (YES) N (NO) doctors not provided or paid for by employer or insurance company who treated or examined for this injury are Cuevas Chiropractic; Los Angeles Community Hospital
(STATE NAMES AND ADDRESSES OF SUCH DOCTORS AND NAMES OF HOSPITALS TO WHICH SUCH DOCTORS ADMITTED INJURIES)
8. Other cases have been filed for industrial injuries by this employee as follows:
None
(SPECIFY CASE NUMBER AND CITY WHERE FILED)
9. This application is filed because of a disagreement regarding liability for: Temporary disability indemnity X
Permanent disability indemnity X Reimbursement for medical expense X Medical Treatment X
Compensation at proper rate X Rehabilitation X Other (Specify) ____
Penalties, interest and travel expenses.
AND APPLICANT REQUESTS A HEARING AND AWARD OF THE SAME, AND FOR ALL OTHER APPROPRIATE BENEFITS PROVIDED BY LAW

Dated at Los Angeles (CITY) California, 07/03/2014 (DATE)

Barry H. Hinden
(APPLICANT'S ATTORNEY)

Barry Harris Hinden
Hinden & Broslavsky
4661 W. Pico Blvd
Los Angeles, CA 90019, (323) 954-1800
(ADDRESS AND TELEPHONE NUMBER OF ATTORNEY)

Signature on File
(APPLICANT'S SIGNATURE)

Maria Del Rosario Santillan

DIA WCAB FORM 1 (REV. 7/81)

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