LAW OFFICES
DRASIN, YEE & SANTIAGO
3415 SOUTH SEPULVEDA BLVD., SUITE 440
LOS ANGELES, CALIFORNIA 90034
(310) 473-2355 FAX (310) 478-2682
www.DYSLawgroup.com

LARRY DRASIN * (1934 – 2014)
GREGORY N. SANTIAGO *
TOM S. YEE
Thomas Marsden, Legal Assistant

* Certified Specialist Workers' Compensation Law
The State Bar of California Board of Legal Specialization

Re: Your claim for Worker's Compensation benefits.

It was a pleasure speaking with you, enclosed are the necessary workers' compensation forms needed to get started with your claim:

1. Client Information Sheet: Please fill out this form completely on all pages. Please print clearly.
2. Fee Disclosure Statement: Please sign where indicated.
3. Addendum to Fee Disclosure Statement: Please sign where indicated.
4. Declaration Per Labor Code Section 4906 (g): Please sign where indicated.
5. Authorization (Consent to Release Information): Please sign where indicated.
6. Worker's Compensation Claim Form (DWC 1): Please sign where indicated.
7. Authorized Representative Designation for Independent Medical Review: Please sign where indicated.
8. Notice Pursuant to Title 8, CCR. Section 10773: Please sign where indicated.
9. Medical Mileage Form: Please keep this form and return it to us when the entire page is completed.
10. EDD: Claim for Disability Insurance Benefits: Please submit these to the doctor so you can open a claim for disability payments.

Kindly return all forms requested, to our office in the enclosed envelope as soon as possible so that we may proceed with the claim.

Very truly yours,

DRASIN, YEE, & SANTIAGO

Gregory Santiago

GREGORY N. SANTIAGO, ESQ.
GSantiago@DYSLawgroup.com

GNS/wo
enclosures

CLIENT INFORMATION SHEET

Referred by: (Name of individual or Union local):

Name: _____

Address: _____

City: _____ State_____ Zip Code_____

Home Phone: ( ) _____ Work: ( ) _____

Cell: ( ) _____ Birth Date: _____ Sex: _____

E-Mail Address: _____Local #: _____

Social Security #: _____ Driver's License #: _____

Employer's Name: _____

Employer's Address: _____

_____

Date of Injury if occurred on a specific date: _____

Period of injury if occurred as a result of continuous trauma over a long period of

Time: _____

Part (s) of body injured: _____

_____

How did injury occur: _____

Occupation at time of injury: _____

Date of hire: _____ last day worked: _____

Estimated retirement date:_____ Supervisor's name:_____

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Please check all that apply:

- ☐ Head
- ☐ Eye/Vision
- ☐ Neck
- ☐ Heart / Cardiovascular
- ☐ Back-Upper
- ☐ Back-Mid
- ☐ Back-Lower
- ☐ Hip / Pelvis-Left Side
- ☐ Hip / Pelvis-Right Side
- ☐ Shoulder-Left
- ☐ Shoulder-Right
- ☐ Elbow-Left
- ☐ Elbow-Right
- ☐ Forearm-Left
- ☐ Forearm-Right
- ☐ Wrist-Left
- ☐ Wrist-Right
- ☐ Hand-Left
- ☐ Hand-Right
- ☐ Fingers-Left Hand
- ☐ Fingers-Right Hand
- ☐ Thigh-Left
- ☐ Thigh-Right
- ☐ Knee-Left
- ☐ Knee-Right
- ☐ Calf-Left
- ☐ Calf-Right
- ☐ Calf-Right
- ☐ Ankle-Left
- ☐ Ankle-Right
- ☐ Foot-Left
- ☐ Foot Right
- ☐ Toes-Left Foot
- ☐ Toes-Right Foot
- ☐ Psychological / Stress Related Conditions
- ☐ Sexual Dysfunction
- ☐ Sleep Disturbances
- ☐ Digestive: Gastro-Intestinal
- ☐ Digestive: Hernia
- ☐ Digestive: Colon / Rectum
- ☐ Headaches / Migraines
- ☐ Eye-Left
- ☐ Eye-Right
- ☐ Respiratory / Lung Disease
- ☐ Ear / Hearing Loss / Tinnitus
- ☐ Vertigo
- ☐ Neurological Impairment
- ☐ Jaw / TMJ
- ☐ Skin / Dermatological
- ☐ Chronic Pain – RSD / Post Traumatic Neuralgia
- ☐ Fibromyalgia
- ☐ General Pain (18.00.00.00)
- ☐ Hypertension
- ☐ Diabetes

Hourly rate of pay at time of injury: _____

Average number of hours worked per week at time of injury: _____

Place of injury: _____

Workers' Compensation Insurance carrier, if known: _____

Adjuster Name: _____ Claim Number: _____

Phone No. (_____) _____

Address: _____

_____

MPN WEBSITE ADDRESS (if known) www: _____

Did you notify your employer or Workers' Compensation carrier of the injury? _____

Is yes, when? _____ Whom did you report it to: _____

(If you have a copy of the claim form, please attach it to this Client Information Sheet.)

Did you lose time from work? _____

If yes, from (dates) _____ to _____

Additional dates _____

Did you receive compensation while off work? _____

If so, how much on a weekly basis: _____

Are you currently working at the same position? _____

Are you receiving compensation now? _____ If not, when did it stop _____

Have you filed for State Disability benefits? _____

Have you received State Disability benefits? _____

Have you filed for unemployment benefits? _____

Have you received unemployment benefits? _____

Are you now working for a different employer? _____ If so, name and address of new employer? _____

_____

Name, address and phone # of emergency contact_____

_____

Are you fluent in English? _____ If not, what language do you prefer to Speak? _____

Was medical treatment received? _____ If so, date of last treatment _____

Name, address and phone number of all physicians or facilities where you have Received treatment for this injury:

_____

_____

_____

_____

_____

Was all treatment provided by your employer or Workers' Compensation carrier? _____

Was any medical treatment paid for by you? _____Was any medical treatment paid by your private insurance company? _____ If so, state the name of your private insurance company _____

Name and address of all doctors who have treated you within the last five years:

Have you ever filed other Workers' Compensation claims? _____

If yes, please provide the date (s) of injury, parts (s) of body injured and if known, the case number:

Have you had any personal injury claims? _____ If yes, please provide the dates of injury and parts of body injured:

Below, please list all expenses you, yourself, have paid for this injury:

(Please attach any receipts you may have which correspond to these expenses)

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 9% to 12% of the benefits awarded.

There are certain circumstances where your employer (or his/her insurer) may be liable to pay your attorney's fees. For example, if the employer disputes a permanent disability evaluation obtained when you were not represented by an attorney, your employer may be liable for any attorney fees you incur because of the dispute.

If at any time you no longer wish to be represented by the attorney, you may withdraw from representation by notifying the attorney. If you withdraw from representation, the fee amount found by a workers' compensation judge to be the fair value of any work the attorney did in your case will be deducted from your award.

Your case is being filed at the Division of Workers' Compensation at the following location:

Marina del Rey - MD

The employee has been advised of the district office at which his or her case will be filed and that he or she may be required to attend conferences or hearings at this location at his or her own expense.

An Information and Assistance Officer may be able to answer your questions concerning your workers' compensation benefits at no charge to you. The Officer may be able to resolve your problems without the need for litigation.

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

Employee's Signature X _____ Date _____

Employee's Name _____

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying worker' compensation benefits or payments is guilty of a felony.

I hereby declare under penalty of perjury that I am the attorney representing the above-named employee, or am an attorney licensed by the State Bar of California regularly employed by the firm by which the employee will be represented, and have advised the employee of their rights as set forth above and in Labor Code section 4906(e) and (g)(1).

Attorney's Signature:_____ Date_____

Attorney's name_____

Address 3415 S. Sepulveda Blvd., Suite 440, Los Angeles, CA 90034_____

Phone No. (310) 473-2355_____

ADDENDUM TO
FEE DISCLOSURE STATEMENT

You are not required to be represented by an attorney in the handling of your workers' compensation case.

Attorney's Fees

The judge may set the fee at 15%, and I will be requesting a fee of 15% of the benefits awarded.

I have read and consent to the above fee request:

Employee's Signature X_____ Date _____

Employee's Name _____

Referral Fees

If you were referred to the attorney representing you in this case by another attorney, the referring attorney may receive up to twenty-five percent (25%) of the fee received for settlement of your partial permanent disability claim. This sharing of fees will in no way increase the total fee charged in this case. By signing below, you are acknowledging that you have been advised of this fee division.

Employee's Signature X_____ Date _____

Employee's Name _____

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, that I have met with or personally spoken with the above-named employee, and have advised the employee of their rights as set forth above and in Labor Code section 4906(e) and (g)(1).

Attorney's Signature _____ Date _____

Attorney's Name _____

_____ Address 3415 S. Sepulveda Blvd., Suite 440, Los Angeles, CA 90034

Phone No. (310) 473-2355

DECLARATION PER LABOR CODE SECTION 4906 (g)

I have not violated Section 4906 (g) of the California Labor Code.

I have not offered, delivered, received or accepted any rebate, 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.

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

X_____
Applicant

I have not violated Section 4906(g) of the California Labor Code.

I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage dividend, discount, or otherwise, as compensation or inducement for any referred examination or evaluation.

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

_____
Attorney for Applicant

DRASIN, YEE & SANTIAGO
3415 S. Sepulveda Blvd., Suite 440 Los Angeles, CA 90034
Phone Number: (310) 473-2355 fax: (310) 478-2682

AUTHORIZATION

Individual: _____ **AKA:** _____

SSN: _____ **Date of Birth:** _____

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that this Authorization is voluntary. I also understand that the released information may be subject to re-disclosure by the recipients and no longer protected by federal privacy regulations pursuant to the Evidence Code, Code of Civil Procedures, Labor Code or any other State of California Code sections relative to the issues regarding the copying of my records.

Specific Description of Information: This release applies to all documents, records, reports, X-Rays or other films, photographs, billings, studies, prescriptions or correspondence relating to my treatment, examination, or hospitalization, including but not limited to all physical or psychiatric conditions. I give my approval for any and all employment, payroll, educational, and/or job training records as may be deemed necessary by my legal representatives. Additionally, I approve the release of any and all police reports/records, arrest records, jail/prison records and probation reports/records. This Authorization applies to all records both prior to and after the date of signature. Nothing shall be removed, deleted, altered or withheld.

Disclosing Facility: _____

Purpose of Requested Disclosure: At the request of the individual, the information sought will be used for the purpose of aiding said person and/or law firm in establishing proper representation to individual authorizing the release to claim benefits for related injuries or for benefits of other related matters. The representing legal council has assigned ***Matrix Document Imaging, Inc.*** as the Discovery Agent for any and all types of information being requested in this Authorization to pursue proper litigation.

Expiration Date: This Authorization is valid for a period of 3 years from the date signed below.

Right to Revoke: The Individual has the right to revoke this Authorization at any time by submitting a written ***Notice of Revocation*** to *Matrix Document Imaging, Inc.* The Individual also has the right to refuse to sign this Authorization, knowing that such refusal to sign, will not affect the Individual's ability to obtain treatment(s), payment(s), or eligibility for benefits. The person signing this Authorization has received a copy. A reproduced copy of this Authorization shall be as valid as the original.

Limitations On Disclosure by Provider: This Authorization does not permit provider to allow the copying of requested records by another copy service or business associate as stated in the *Health Insurance Portability and Accountability Act* "**HIPAA**". This Authorization does not permit the disclosure of information to any person, entity, provider or insurance company other than the representative copying records on behalf of *Matrix Document Imaging, Inc.* Any and all prior signed Authorizations will be revoked.

SIGNATURE: X _____ **DATE:** _____

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 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.

***Empleado:** Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al (800) 736-7401 para oir información gravada. Una explicación de los beneficios de compensación de trabajadores está incluido 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 benficios 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 caja apropiada. 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 "felonia".

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

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
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.* X _____

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 adminstradora 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*

Authorized Representative Designation for Independent Medical Review
(To accompany the Application for Independent Medical Review, DWC Form IMR)

Section I. To be completed by the Employee:

Employee Name (Print):	

I wish to designate

Name of Individual (Print):	

to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation, and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application, to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application.

In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature:	X	Date:

Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee's behalf.

I accept the above designation to act as the above-named Employee's authorized representative regarding their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

Name:		
I am a/an:		
(Professional status or relationship to the Employee, e.g., attorney, relative, etc.)		
Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	
State Bar Number (if applicable):		
Representative Signature:		Date:

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NOTICE PURSUANT TO TITLE 8,

CCR, § 10773

Dear Honorable Judge:

Please be advised that the applicant has been informed that Thomas Marsden, is a non-attorney representative working for DRASIN, YEE & SANTIAGO, under the direct supervision of GREGORY N. SANTIAGO and TOM S. YEE who are licensed attorneys.

Applicant hereby consents to Thomas Marsden's representation regarding all matters before the Workers' Compensation Appeals Board, including appearances before the Workers' Compensation Appeals Board, preparation of documents, including settlement documents.

Date: _____ Applicant: X_____

Estimado Juez,

Por favor sea informado que el/la applicante esta informado/a que Thomas Marsden no es abogado. Trabaja para DRASIN, YEE & SANTIAGO bajo la supervision directa de GREGORY N. SANTIAGO y TOM S. YEE, quien son Abogados con licencias.

El Applicante accepta y esta consiente, que Tom Marsden representara todo lo que esta relacionado en el caso industrial ante la Division Industrial, incluiendo fechas de corte ante la Division Industrial, preparacion de documentos, incluiendo los documentos de negociacion.

Fecha: _____ Applicante: _____