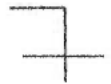




STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
COMPROMISE AND RELEASE



ADJ9241028

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).)

SAC

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

Employee(Completion of this section is required)

JOSEPH

First Name

MI

RANGEL

Last Name

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

City

State

Zip Code

Employer Information (Completion of this section is required)

- ☐ Insured ☒ Self-Insured ☐ Legally Uninsured ☐ Uninsured

CITY OF CITRUS HEIGHTS POLICE DEPARTMENT

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

6237 FOUNTAIN SQUARE DRIVE

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

CITRUS HEIGHTS

City

CA
State

95621
Zip Code

Applicant's Attorney or Authorized Representative:

☒ Law Firm/Attorney ☐ Non Attorney Representative

EDWARD

First Name

LESTER

Last Name

5216187

Law Firm Number

MASTAGNI HOLSTEDT SACRAMENTO

Law Firm Name

1912 I STREET

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

SACRAMENTO

City

CA

State

95811

Zip Code

Defendant's Attorney or Authorized Representative:

☒ Law Firm/Attorney ☐ Non Attorney Representative

GERALD

First Name

LENAHAN

Last Name

4870202

Law Firm Number

LENAHAN LEE SACRAMENTO

Law Firm Name

1030 15TH ST STE 300

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

SACRAMENTO

City

CA

State

95814

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)

ATHENS ADMINSTRATORS CONCORD

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

PO BOX 696

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

CONCORD

City

CA

State

94522

Zip Code

IT IS CLAIMED THAT:

1. The injured employee, born [REDACTED], alleges that while employed as a(n)

(DATE OF BIRTH: MM/DD/YYYY)



POLICE OFFICER

(OCCUPATION AT THE TIME OF INJURY)

, sustained 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

10/25/2012

(Start Date: MM/DD/YYYY)

10/25/2013

(End Date: MM/DD/YYYY)

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

Body Part 1: 841 STRESS

Body Part 2:

Body Part 3:

Body Part 4: 420 BACK

Other Body Parts:

The injury occurred at JOBSITE

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

CITRUS HEIGHTS

City

CA

State

95621

Zip Code

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

☐ Specific Injury

Case Number 2 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

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.

☐ Specific Injury

Case Number 3 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

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.

☐ Specific Injury

Case Number 4 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

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.

☐ 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 \$ 1,563.20

TEMPORARY DISABILITY INDEMNITY PAID 95,680.36 Weekly Rate \$ 1,042.13

(first year 4850)

Period(s) Paid 10/26/2013 01/03/2015
(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

PERMANENT DISABILITY INDEMNITY PAID 0.00 Weekly Rate \$ _____

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

TOTAL MEDICAL BILLS PAID \$ 24,132.84 Total Unpaid Medical Expense to be Paid By: _____

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

\$ 60,000.00
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 _____

\$ 9,000.- requested as applicant's attorney's fee.

LEAVING A BALANCE OF \$ 51,000, 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):

THERE ARE NO KNOWN LIENS TO THE PARTIES. A REVIEW OF THE EAMS WEBSITE AS OF 1/18/15 SHOWS NO LIENS FILED.

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 THE APPLICANT OR HIS/HER REPRESENTATIVE AND DEFENDANTS OR THEIR REPRESENTATIVES ARE INCLUDED WITHIN THIS SETTLEMENT.

Applicant Defendant

gml earnings
gml temporary disability

gml jurisdiction
gml apportionment
gml employment

gml injury AOE/COE
gml serious and willful misconduct

gml discrimination (Labor Code §132a)
gml statute of limitations

gml future medical treatment

gml other L.C. §4850 benefits, L.C. §132(a) claim, any possible

gml permanent disability claim to sanctions, penalties, L.C. §

gml self-procured medical treatment, except as provided in Paragraph 7 4650 s.a.p., or

gml vocational rehabilitation benefits/supplemental job displacement benefits interest

COMMENTS: Defendant's consent to this C & R is expressly conditioned upon applicant's execution of a separate civil release resolving a pending disciplinary action and an agreement between the city and applicant to sever the employment relationship with each party waiving and releasing any claim against the other. Applicant's consent is conditioned upon the city's consent to a P.E.R.S. industrial retirement with an effective date of Feb 1, 2015. Applicant's injury is plead as cumulative, but the injury arises, in

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

Part or whole, out of a specific shooting incident 10/25/2013. It

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.

is the intent of parties to settle and release any and all injuries to the spine and psyche, whether the result of specific injury, cumulative injury, and any combination of potential injuries thru applicant's last date of employment with the city of Citrus Heights.

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 19 day of FEBRUARY, 2015 at 1630 HRS

[Signature] 2/19/15
Witness 1 (Date)
[Signature] 2/20/15
Witness 2 (Date)

Interpreter (Date)

[Signature] 2/19/15
Applicant (Employee) (Date)
Edward W. Lester 02/20/15
Attorney for Applicant (Date)

Attorney for Defendant (Date)

Attorney for Defendant (Date)

Attorney for Defendant (Date)

Attorney for Defendant (Date)

ACKNOWLEDGMENT

State of California

County of _____)

On _____ before me, _____
(insert name and title of the officer)

personally appeared _____
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are
subscribed to the within instrument and acknowledged to me that he/she/they executed the same in
his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the
person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing
paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)