Telephone Interview Notes

Date Call Received		**Interviewing Attorney**	
Venue		**Injured Body Parts**	
Specific Injury		**CT Injury**	
Mechanism of Injury			
Applicant's Treatment Status			
Reason for not reporting			
Applicant Employment Status			

Attention Interpreter

You must email this sheet after telephone interview is completed to:

Mghaemi@statewidelawpc.com

Bijan@statewidelawpc.com

Failure to email this form on timely manner results in filing inaccurate claim form

Case Information

Date:			Interviewing Attorney:	B. Favakehi M. Ghaemi	
	YES	**NO**		**YES**	**NO**
Do you have an attorney for this injury?			Have you filed for this claim?		
Do you have an attorney for any other claim at this time?			Have you ever filed a Workers' compensation claim in the past 10 years?		

Information About You

First Name			Last Name		
Your preferred language:		Telephone:		Relative's Telephone:	
Email:				Relative's Name:	
Street Address:				Your Relative's Address:	
City					
Zip					
DL/ID #:				Social Security #	
Date of Birth:					

Information About Your Employer

Employer's Name:			
Employer's Street Address:			
City		Zip	
Employer's Telephone:		Name of your Supervisor:	
If you were not injured at this address, please provide the address where you suffered this injury that you are making a claim:	Street Address:		
	City:		Zip:

Information About Your Job

Your position at the time of injury			Your hourly earnings: $/HR	$		Did you work for another employer at the same time?	YES	NO
Date of hire:			Are you still working for the employer?	YES	NO	Were you terminated?	YES	NO
Last Day of Work:			How many hours you worked per week?			Did you receive over-time pay?	YES	NO
How did your employer pay you?	CASH	CHECK	Do you receive unemployment?	Yes	NO	Are you exposed to chemicals at work?	YES	NO
Briefly explain your job duties and physical activities at the job where the injury occurred.								

Information About Your Injury

Did you suffer specific injury?	YES	NO	Did you suffer injury over a period of time (CT)?			YES	NO
Date of specific Injury			Date of CT Injury	From	To		
Did you report your work injury?	YES	NO	Did you receive treatment?			YES	NO
Provide the name of the person that you reported your injury:	Person #1						
	Person #2						
If you did not report your injury, explain its reason for not reporting:							
Provide the name of people who witnessed your injury:	Witness #1						
	Witness #2						
Explain in detail how the injury occurred:							
Name all the body parts that are injured. (Claiming body parts that are not injured is against the law)							

Information About Your Medical Treatment

Medical Provider #1				
Name:			Telephone No:	
Street Address:				
City:		Zip:	Approximate Date of Service:	

Medical Provider #2				
Name:			Telephone No:	
Street Address:				
Please		Zip:	Approximate Date of Service:	

Medical Provider #3				
Name:			Telephone No:	
City:		Zip:	Approximate Date of Service:	

Additional History About Your Work Injury

Please submit this form with W-2 and Pay stub

Applicant's Name:_____ Applicant's Signature:_____

PRINT CLEAR

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.* _____

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*

STATEWIDE LAW, PC.
Attorneys at Law

Michael M. Ghaemi, Esq.
Bijan Favakehi, Esq.

Tel: (714) 723-3660
FAX: (949) 313-0908
Email: info@statewidelawpc.com

14511 Newport Ave. Suite 235
Tustin, California 92780

AUTHORITY TO RELEASE RECORDS

TO: _____

FROM: _____

DOI: _____

Please release without reservation to my Attorneys of the Statewide Law, PC. or their authorized agent(s) or representative(s), Copies of All Police Reports, Medical Reports, Itemized Statements or Bills, Hospital Records, School Records, Accident Reports, Employment Records, Loss of Wages Statements and Records, Counseling Records or Reports, and any other specific personal documents requested.

(Photo static copies of this authorization will be considered as valid as the original).

Signed By:_____because client is a minor and/or physically unable Relationship of the signed party

Signed:_____ Dated: _____

VENUE AUTHORIZATION

I hereby authorize my Workers' Compensation Case(s) for Injury(ies) dated _____to be filed at the_____workers' Compensation Appeals Board.

Dated: _____

_____
Applicant

Applicant's Attorney
Statewide Law, PC.
michel ghaemi
_____
bijan favakehi

The HIPAA RELEASE OF INFORMATION- MEDICAL

AUTHORICATION FORM

INDIVIDUAL'S NAME: _____

DATE OF BIRTH:_____

INDIVIDUAL'S ADDRESS:_____

I hereby authorize use or disclosure of protected health information about me as described below:

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

2. The following person and his representatives may receive disclosure of protected health information about me:

3. The specific information that should be disclosed is relating to my injuries in connection with my worker's compensation claim:

Any and all information you may have regarding my condition while under your observation including the history obtained, records, x-rays, reports or copies thereof relating to my examination, consultation, confinement or treatment and physical findings, diagnosis and prognosis, and to permit them to inspect and make copies or abstracts thereof. You are also authorized to send any psychiatric, drug and/or alcoholic information if applicable, and disclose protected health information from any itemized statement.

STATEWIDE LAW, PC.
Michael Ghaemi, Esq.
Bijan Favakehi, Esq.

14511 Newport Ave. Suite 235
Tustin, California 92780
Tel:(714)723-3360
Fax:(714)849-5767

§ 10773 Authorization

Pursuant to Title 8 California Code of regulations §10773, _____ is a non-attorney employee acting as a hearing representative under the supervision of Michael Ghaemi, Esq., and Bijan Favakehi of Statewide Law, PC., the attorneys handling and directly responsible for Applicant's case. Said employee is authorized to make appearances at the Worker's Compensation Appeal Board for conferences, trials, and negotiate settlement claims.

Date: _____

_____

Applicant's Signature

_____

Applicant's Name

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. **Statewide Law, PC., presently charges 15%.**

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:

Anaheim - AHM

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 _____ 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 m.ghamei Date _____

Attorney's name bijan favakehi Statewide Law, PC

Address: **14511 Newport Ave. Suite 235, Tustin, California 92780**

Phone: **(714) 723-3660**

Estado de California
Departamento de Relaciones Industriales
División de Compensación al Trabajador

DECLARACIÓN SOBRE COBRO DE HONORARIOS

Si usted decide ser representado por un abogado, los honorarios de su abogado serán deducidos de sus beneficios. Los honorarios serán aprobados por la Junta de Apelaciones de Compensación al Trabajador teniendo en cuenta: (1) la responsabilidad asumida por el abogado; (2) el cuidado ejercido al representarlo; (3) tiempo dedicado; y (4) resultados obtenidos.

Los honorarios del abogado normalmente oscilan entre 9% a 12% de los beneficios otorgados. Nuestra tarifa de abogado es del 15%.
Hay ciertas circunstancias en las que su empleador (o la compañía de seguros del mismo) puede ser considerado responsable de pagar los honorarios de su abogado. Por ejemplo, si el empleador impugna una evaluación de incapacidad permanente obtenida cuando usted no estaba siendo representado por un abogado, su empleador puede ser responsable de pagar los honorarios del abogado al que usted haya acudido por motivo de la disputa.

Si en algún momento usted ya no desea seguir siendo representado por un abogado, puede retractar la representación por medio de una notificación al abogado. Si retracta la representación, el monto por honorarios que el juez de compensación al trabajador determine justo por cualquier trabajo que el abogado haya realizado en su caso se deducirá de lo que se le adjudique.

Su caso se encuentra registrado en la División de Compensación al Trabajador en la siguiente dirección:

Anaheim - AHM

Se le notificó al empleado la oficina del distrito donde se registrará su caso y que puede que se le solicite asistir a conferencias o audiencias en dicha dirección por su propia cuenta y cargo.

Un Funcionario de Información y Asistencia puede responder sus preguntas referentes a sus beneficios de compensación al trabajador, sin costo alguno para usted. El Funcionario puede llegar a resolver sus problemas sin necesidad de recurrir a un litigio.

Llame a esta línea gratuita: 1-800-736-7401

Firma delempleado _____ Fecha____

Nombre del empleado _____

Cualquier persona que a sabiendas haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar los beneficios o pagos de compensación al trabajador será considerado culpable de un delito grave.

Por medio del presente declaro, bajo pena de perjurio, que soy el abogado que representa al empleado arriba mencionado, o que soy abogado certificado por el Colegio de Abogados del estado de California, contratado regularmente por la firma que representará al empleado, y que le he advertido al empleado sobre sus derechos, según lo que figura arriba y en el Código del Trabajo, Sección 4906(e) y (g)(1).

Firma del abogado m.ghaemi / Bijan Javakehi Fecha _____

Nombre del abogado Statewide Law, PC

Dirección 14511 Newport Ave., Suite 235, Tustin, California 92780

Nro. de teléfono:(714)723-3660

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:		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:

STATEWIDE LAW
PC

Bijan Favakehi, Esq.
Michael Ghaemi, Esq.

Application for Adjudication of Claim

I hereby authorize attorneys from Statewide Law PC., to execute my name on the Application for Adjudication of my claim and forms, UR forms, and IMR forms on my behalf.

Applicant: _____ Date:_____

14511 Franklin Avenue, Suite 235 Tustin, CA 92780 |Tel:(714)723-3660|Fax: (949)313-0908

ATTORNEY-CLIENT AGREEMENT

Workers' Compensation

This is the written fee agreement (the "Agreement") that California law requires attorneys to have with their clients. The Attorney will provide legal services to the undersigned Client, on the terms set forth below. This Agreement shall not take effect, and the Attorney will have no obligation to provide legal services, until Client returns a signed and dated copy of this Agreement.

1. SCOPE OF LEGAL SERVICES

Client understands and specifically agrees that the Attorney will represent the Client before the Workers' Compensation Appeals Board and the Vocational Rehabilitation Unit only. This Agreement shall apply to all workers' compensation cases where Attorney files the application for adjudication on behalf of Client and where Attorney becomes the attorney-of-record before the Workers' Compensation Appeals Board. Attorney shall represent Client to obtain vocational rehabilitation benefits and will represent Client in any proceedings before the Vocational Rehabilitation Unit. Client understands that Client may choose not to be represented by an attorney during the vocational rehabilitation process. Attorney shall represent Client until the award is issued by the Workers' Compensation Appeals Board and the completion of vocational rehabilitation. After the award is issued by the Workers' Compensation Appeals Board and any appropriate post-trial motions and vocational rehabilitation benefits are stopped the Attorney shall no longer represent Client. Attorney shall not represent Client for a Petition for Reconsideration or any appeal unless Attorney and Client enter into an additional written agreement.

2. LIMITATION PERIOD TO COMMENCE LEGAL ACTION IN COURT OTHER THAN THE WORKERS' COMPENSATION APPEALS BOARD

Client acknowledges that whenever a person is injured because of the carelessness, negligence, or other legal fault of someone else, there is a possibility that the injured person and others may be able to recover money, called "damages" from those whose fault contributed to causing the injury. Such damages must be pursued in a legal proceeding, usually a lawsuit, that is separate and different from the workers' compensation proceeding. Damages are not always obtainable but when they are, they sometimes produce a significant amount of additional money for the injured person. Attorney does not represent Client and has not undertaken to advise Client concerning the possibility of recovering damages other than obtaining benefits before the Workers' Compensation Appeals Board. Client should discuss with another attorney the possibility that Client may benefit from pursuing a lawsuit to recover damages. The damages claim may be lost forever unless the correct legal documents are filed with the correct agency or court within the proper time limit. The time limit to file the documents is called the statute of limitations. If Client does not protect these rights by filing the proper documents before the statute of limitation expires the claim will be forever lost. The statute of limitation varies depending on the type of claim and the agency with which the claim must be filed. It can be as little as six months. If a claim must be filed with a government agency it must be filed within six months. No action has been or will be taken by

Attorney to stop or to toll or to protect Client's rights from the expiration of the statute of limitation period. No recommendations are made as to any particular attorney Client should consult. Attorney will cooperate with any attorney that is chosen by Client, but will not undertake any action to see that your claim is properly handled by the consulting attorney.

3. LIMITATION OF REPRESENTATION

Attorney does not and is not representing Client on any other matter unless there is a separate written agreement as to that matter. It is understood, and Client specifically agrees that Attorney does not represent Client for any legal action other than before the Workers' Compensation Appeals Board including but not limited to the following types of legal actions:

(a) Any civil action other than in the Workers' Compensation Appeals Board against any employer or other party that has caused, has contributed to, or is responsible for damages to Client. This includes any civil lawsuit for the defective designer, manufacturer, distribution, or sale of any equipment or machine that has caused or contributed to injury to Client;

(b) Any civil lawsuit against any employer for wrongful termination of employment, or for the violation of any federal or state law against discrimination based upon disability including the Americans with Disabilities Act (ADA) and the California Fair Employment and Housing Act (FEHA);

(c) Any civil lawsuit against any health care provider for medical malpractice;

(d) Any lawsuit against any attorney for legal malpractice.

(e) Any claim for benefits from any employer, governmental or private disability or retirement plan;

(f) Any claim under the Long Shore and Harbor Workers' Compensation Act, the Jones Act,or Railway Labor Act claims;

Client acknowledges that Attorney has explained and discussed each of the above types of claims and lawsuits and is satisfied with the explanation. Client acknowledges that these types of claims and lawsuits exist, and that Attorney has advised Client to immediately seek the advice of another attorney regarding these possible claims and lawsuits.

4. REFERRAL FEE AGREEMENT

If Attorney refers Client to a specific attorney for legal representation other than at the Workers' Compensation Appeals Board, Attorney may have an agreement with that attorney for the division of attorney fee. Attorney shall receive from the referring attorney an agreed-upon fee recovered by the referred attorney. The total fee to Client is not increased solely by this provision for the division of fees. This fee division is accordance with the Rules of Professional Conduct. Client agrees to this division of fees.

5. RESPONSIBILITIES

Client agrees to be truthful with Attorney, to cooperate, to keep Attorney informed of developments, to abide by this Agreement, and to keep Attorney informed of Client's address, telephone number, and whereabouts. Client agrees to appear at all proceedings when Attorney

deems it necessary, and to generally cooperate fully with Attorney in all matters related to the preparation and presentation of Client's claims.

6. LEGAL FEES

Client and Attorney acknowledge that no fee has been demanded and that no fee has been paid to the Attorney and that there is not an agreement for legal fees. Client understands that the Workers' Compensation Appeals Board shall determine and set or approve the legal fee to be paid to Attorney, which shall be in a reasonable amount. Client agrees that Attorney will request that the board approve as a reasonable fee 15% of any settlement by compromise and release, stipulation, or award. If the Employer is uninsured, Attorney will request that the board approve 18% of any settlement. If there is no recovery, client will not be charged a fee. No attorney fee is to be deducted from temporary total disability benefits that are voluntarily paid by the employer or the employer's insurance company before an award. Legal fees in a workers' compensation case are not set by law and Client and Attorney may negotiate a fee agreement. Any agreement other than this Agreement for legal fees must be in writing and submitted to the board for approval within 10 days. Client shall receive written notice of any request for fee increase. If Client chooses to be represented by Attorney for vocational rehabilitation benefits, Attorney shall also request a fee for legal services rendered in obtaining those benefits for Client. The fee requested shall be based upon an hourly rate of $350.00 per hour but shall not exceed 10% of the total amount of vocational rehabilitation maintenance allowance.

The Attorney shall request that 10% of vocational rehabilitation maintenance allowance be withheld until a reasonable attorney fee is determined or approved by the board. A fee of 15% will be requested by the Attorney from any recovery, settlement, or award that is an increase in benefits or penalty for discrimination under Labor Code 132a, for unreasonable delay in providing benefits, and for serious and willful misconduct by the employer. Client acknowledges that Attorney may be awarded additional fees by the board for the deposition of Client but that this amount is not deducted from any amounts due Client.

7. DISCHARGE OR WITHDRAWAL

Client may discharge Attorney at any time upon receipt by Attorney (a) of written notice, if no board documents have been filed, or, (b), if Attorney has filed documents with the board, of a substitution of attorney form signed by the Client agreeing to the substitution and signed by a new attorney or Client representing themselves. Attorney may withdraw from representation of Client (a) with Client's consent by signing a substitution of attorney form, or (b) with or without Client's consent by approval of the board, or (c) if no documents have been filed with the board by Attorney, upon reasonable notice to Client. In the event of discharge or withdrawal Attorney will immediately after receiving the signed notice or form, cease to render additional services. Client agrees that Attorney shall be entitled to be paid a reasonable attorney fee consistent with this Agreement for legal services provided by Attorney to Client from the effective date of Agreement until the date of discharge or withdrawal. Client agrees that Attorney shall have a lien for attorney fee, costs and disbursements on Client's compensation and vocational rehabilitation benefits.

8. NO GUARANTEE OF RESULTS

Nothing in this Agreement and nothing in Attorney's statements to Client will be construed as a promise or guarantee about the outcome of Client's matter. Attorney makes no such promises or guarantees. There can be no assurance that Client will recover any sum or sums in this matter. Attorney comments about the outcome of Client's matter are expressions of opinion only.

9. ARBITRATION

It is agreed that all disputes arising from this agreement and the representation by Attorney including a dispute as to fees and any malpractice by the Attorney shall be submitted to binding arbitration pursuant to the provisions of Title 9 of Part III of the California Code of Civil Procedure (section 1280 et seq.). Also, such arbitration shall provide for neutral arbitrator(s), adequate discovery for both parties, and a written award (stating briefly the findings of fact and conclusions of laws on which such award is based).

10. EFFECTIVE DATE

This Agreement will take effect when Client has signed and dated this Agreement and returned it to Attorney, but its effective date will be retroactive to the date Attorney first performed services. Even if this Agreement does not take effect, Client will be obligated for reasonable value of any services Attorney may have performed for Client. By signing this document Client acknowledges that he or she has read and understood it completely and that Client has fully discussed this agreement with Attorney and is satisfied with the explanation and understands its consequences and knowingly accepts its terms and conditions.

Dated: _____ _____

Client

Dated: _____ m.ghaemi

Attorney bijan javakeshi

DECLARATION PURSUANT TO LABOR CODE SECTION 4906(h)

Pursuant to Labor Code Section 4906(h), I declare under penalty of perjury that I have not violated Section 139.3 and I 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.

Date: _____

_____
Signature

Before signing this form, you should be aware that: "Any person who makes or causes to be made 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."