

Hearing Request

Administrative Director

Division of Worker's Compensation

1515 Clay Street, Suite 1800

Oakland, CA 94612

(Two copies via hand delivery)

Hearing Request

Department of Industrial Relations

Officer of Director

Anti-Fraud unit

1515 clay Street, Suite 1700

Oakland, CA 94612

Request for a hearing on Notice of Provider Suspension

My name is Eduardo Abad.

I live at ~~603~~ 230 EDDY ST. APT. 603
SF CA 94102

Labor Code section 139.21(a)(1) is not applicable to me because I am not a physician, practitioner or provider

My benefits should not be suspended

Please do not suspend my benefits. In the alternative, I would like a hearing.

Eduardo Abad

Proof of Service by Mail

I declare that:

I am (resident of / employed in) the county of San Francisco, California.

I am over the age of eighteen years, my (business / residence) address is:

535 Minna Street Apt 202
San Francisco, 94103

On SEPT. 13th 2018, I served the attached Hearing Request
on the parties listed below in said case, by placing a true copy thereof enclosed in
a sealed envelope with postage thereon fully paid, in the United State mail at
_____ addressed as follows:

Hearing Request
Administrative Director
Division of Worker's Compensation
1515 Clay Street, Suite 1800
Oakland, CA 94612
(Two copies via hand delivery)

Hearing Request
Department of Industrial Relations
Officer of Director
Anti-Fraud unit
1515 clay Street, Suite 1700
Oakland, CA 94612

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on

(date) SEPT. 13th 2018, at SAN FRANCISCO, California.

Type or print name Daniel Abad

Signature 