Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

If you are injured or become ill because of your job, you are entitled to workers' compensation benefits.

Complete the "Employee" section and give the form to your employer. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from your employer. You may contact the State's Office of Benefit Assistance and Enforcement at 1-800-736-7401 if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the reverse of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

RECEIVED FEB 0 4 1992

EMPLOYEE:

1. Name David Russel Mendosa Today's Date 2/4/92
2. Home Address
3. City State Zip
4. Date of Injury 1/22/92 Time of Injury 8 a.m. p.m.
5. Address/Place where injury happened Escalon area -
6. Describe injury and part of body affected neck - back - left arm - numbness in left hand - neck & back pain -
7. Signature of employee David Mendosa

EMPLOYER: *COMPLETE THIS SECTION AND GIVE THE EMPLOYEE A COPY IMMEDIATELY AS A RECEIPT.*

8. Name and address of employer SAN JOAQUIN COUNTY MOSQUITO ABATEMENT DISTRICT
   7759 S. Airport Way Stockton, CA 95206 3918
9. Date employer first knew of injury
10. Date claim form was provided to employee 2/4/92
11. Date employer received claim form 2/4/92
12. Name and address of insurance carrier or adjusting agency Keenan & Associates
    392 D Connors Court Chico, CA 95926
13. Signature of Employer Representative
14. Title 15. Telephone 982 4675

EMPLOYER: You are required to date this form and provide copies to your insurer and to the employee, dependent or representative who filed the claim within one working day of receipt of completed form from employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

DWC Form 1 (1/1/90)

STATE OF CALIFORNIA
Department of Industrial Relations
INDUSTRIAL MEDICAL COUNCIL
P.O. Box 603
San Francisco, California 94101-0603
1-800-794-6900

QUALIFIED MEDICAL EVALUATOR'S FINDINGS SUMMARY FORM

TO THE QME: You are required by law to summarize the medical findings from your medical evaluation on a form prescribed by the Industrial Medical Council (IMC). The IMC has prescribed this form for this purpose. Please complete this form in its entirety, noting that you are legally required to include: the date the appointment call was made, the date of the initial examination, the date of the referral for medical testing or medical consultation, the date the medical reports or consultation reports were received by the evaluator, and the date of the report. In addition, you are required to serve the medical evaluation and the summary form on the employee, the claims administrator, the Office of Benefit Determination of the Division of Workers' Compensation, and the Executive Medical Director. Completing and serving this form shall not affect any obligation imposed by the Rules of Practice and Procedure of the Workers' Compensation Appeals Board.

EMPLOYEE'S NAME: DONALD MEIDINGER **DATE OF INJURY** 1/27/92

Employee's Social Security Number: 566-82-1221 **CLAIM NUMBER** 693-92-0003

Employee's Address:

EMPLOYER'S NAME: SAN JOSE COUNTY MOSQUITO ABATEMENT DISTRICT

Employer's Address: 7759 SOUTH AIRPORT WAY, STOCKTON, CA 95206

CLAIMS ADMINISTRATOR / CARRIER / SELF-INSURER (NAME): ELENA PIAZZISI, KEENAN & ASSOCIATES

Claims Administrator / Carrier / Self-Insurer Address: 392 D. CONNORS COURT, CHICO, CA 95926

FORMAL MEDICAL EVALUATION SUMMARY:

Objective Findings: SEE REPORT

Subjective Findings: SEE REPORT

Are these findings consistent with the industrial injury? [ ] YES [ ] NO

Is apportionment indicated? [ ] YES [ ] NO

Date of the Appointment Call: 4/14/93
Date of Initial Examination: 5/25/93
Date of Referral for Medical Testing / Consultation (if any): ...
Date Medical Tests / Reports / Consultation received by QME:...
Date QME's Medical-Legal Report Served on All Parties: 6/14/93

COPY TO:
[X] **EMPLOYEE**
[X] **CLAIMS ADMINISTRATOR**
[X] **OFFICE OF BENEFIT DETERMINATION (DWC)**
[X] **EXECUTIVE MEDICAL DIRECTOR (IMC)**

Signature of QME: Donald W. Seymour M.D. Date: 14 Jun 93

Name of QME (print/type): DONALD SEYMOUR, M.D. - ORTHOPEDIC EVALUATION CENTER

Address: 1199 Bush Street, Suite 300, San Francisco, CA 94109

Telephone: (415) 202-1920

IMC FORM 1002 (New 5-91)