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injured workers
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**FARRELL
FRAULOB
& BROWN**

A Professional Law Corporation

May 29, 1996

WORKERS' COMPENSATION APPEALS BOARD
31 E Chanel Street
Stockton, CA 95202

RE: Thomas Beard vs. San Joaquin Mosquito and Vector Control
W.C.A.B. No: Unassigned

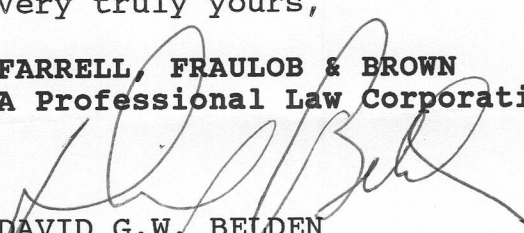
Greetings Judge:

Your attention is directed to the enclosed documents:

- Please file Application(s) for Adjudication of Claim.
- It is requested that this matter be set for hearing in accordance with the attached Declaration of Readiness to Proceed, previously filed on May 16, 1996.
- Please file the medical reports of:
- Please note the new address of the applicant:
- Other:

Very truly yours,

FARRELL, FRAULOB & BROWN
A Professional Law Corporation


DAVID G.W. BELDEN
Attorney at Law

cc: FILE
KEENAN & ASSOCIATES
CLIENT

2315 Capitol Ave.
Sacramento,
CA 95816-5812

P.O. Box 160467
Sacramento,
CA 95816-0467

Telephone
916-442-5835

FAX
916-442-0834

RECEIVED
JUN - 4 1996
DIVISION OF
WORKERS COMPENSATION
STOCKTON OFFICE

WORKERS' COMPENSATION APPEALS BOARD

SEE REVERSE SIDE
FOR INSTRUCTIONS

APPLICATION FOR ADJUDICATION OF CLAIM
(PRINT OR TYPE NAMES AND ADDRESSES)

CASE No. STK 124216

M r. Thomas Beard

Social Security No.: 558-76-6159

2937 Toyon Drive
(INJURED EMPLOYEE'S ADDRESS AND ZIP CODE)

Stockton, CA 95203

(APPLICANT, IF OTHER THAN INJURED EMPLOYEE)

7759 S. Airport Way
Stockton, CA 95206
(APPLICANT'S ADDRESS AND ZIP CODE)

San Joaquin Mosquito and Vector Control
(EMPLOYER--STATE IF SELF-INSURED)

392 D Conners Court
Chico, CA 95929
(EMPLOYER'S ADDRESS AND ZIP CODE)

Keenan & Associates
(EMPLOYER'S INSURANCE CARRIER OR, IF SELF-INSURED, ADJUSTING AGENCY)

(INSURANCE CARRIER OR ADJUSTING AGENCY'S ADDRESS)

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STOCKTON OFFICE

IT IS CLAIMED THAT:

- The injured employee, born 09/24/49, while employed as a control tech
(DATE OF BIRTH) (OCCUPATION AT TIME OF INJURY)
on 6/22/95 at Stockton, CA
(DATE OF INJURY) (ADDRESS) (CITY) (STATE) (ZIP CODE)
By the employer sustained injury arising out of and in the course of employment to
left knee
(STATE WHAT PARTS OF BODY WERE INJURED)
- The injury occurred as follows: inspecting a ditch for mosquitos and fell hurting knee
(EXPLAIN WHAT EMPLOYEE WAS DOING AT TIME OF INJURY AND HOW INJURY WAS RECEIVED)
- Actual earnings at time of injury were: \$16.69 per hour, maximum for TD
(GIVE WEEKLY OR MONTHLY SALARY OF HOURLY RATE AND NUMBER OF HOURS WORKED PER WEEK)
- The injury caused disability as follows: TD/PD
(SPECIFY LAST DAY OFF WORK DUE TO THIS INJURY AND BEGINNING AND ENDING DATES OF ALL PERIODS OFF DUE TO THIS INJURY)
- Compensation was paid Y \$unknown \$
(YES) (NO) (TOTAL PAID) (WEEKLY RATE) (DATE OF LAST PAYMENT)
- Unemployment insurance or unemployment compensation disability benefits have been received since the date of injury
N
(YES) (NO)
- Medical treatment was received Y ongoing All treatment was furnished by
(YES) (NO) (DATE OF LAST TREATMENT)
the Employer or Insurance Company Y Other treatment was provided or paid for by
(YES) (NO)
 Did Medi-Cal pay for any health care
(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)
- related to this claim N doctors not provided or paid for by employer or insurance company who treated or examined
(YES) (NO)
for this injury are
(STATE NAMES AND ADDRESSES OF SUCH DOCTORS AND NAMES OF HOSPITALS TO WHICH SUCH DOCTORS ADMITTED INJURED)
- Other cases have been filed for industrial injuries by this employee as follows:
left knee, 1989, CT - 1/18/96
(SPECIFY CASE NUMBER AND CITY WHERE FILED)
- This application is filed because of a disagreement regarding liability for: Temporary disability indemnity X
Permanent disability indemnity X Reimbursement for medical expense Medical treatment X
Compensation at proper rate X Rehabilitation X Other (Specify) All Benefits
AND APPLICANT REQUESTS A HEARING AND AWARD OF

THE SAME, AND FOR ALL OTHER APPROPRIATE BENEFITS PROVIDED BY LAW.
Dated at Sacramento, California, 05/29/96
(CITY) (DATE)

David G.W. Belden
(APPLICANT'S ATTORNEY)
2315 Capitol Avenue
Sacramento, CA 95816

Farrell, Fraulob & Brown 916-442-5835
(ADDRESS AND TELEPHONE NUMBER OF ATTORNEY)
DIA WCAB FORM 1 (REV 7/81)

(APPLICANT'S SIGNATURE)
David G.W. Belden for Applicant



**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.

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 felony.

**RECLAMO DEL EMPLEADO PARA BENEFICIOS
DE COMPENSACION DEL TRABAJADOR**

Si Ud. se ha lesionado o se ha enfermado en/o a causa de su trabajo, Ud. tiene derecho a recibir beneficios de compensación al trabajador.

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 fechada de su empleador. Si Ud. necesita ayuda para completar esta forma o para obtener sus beneficios, póngase en contacto con la Oficina Estatal de Asistencia para Beneficios y Ejecución de las Leyes Pertinentes llamando al 1-800-736-7401. Al dorso de esta forma se encuentra una explicación de los beneficios de compensación al trabajador.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que con conocimiento 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, "felonía".

Employee: Empleado:

1. Name. Nombre. THOMAS BEARD Today's Date. Fecha de Hoy 5/29/96

2. Home address. Dirección Residencial. 2937 Toyan Drive

3. City. Ciudad. Stockton, State. Estado. CA Zip. Código Postal. 95203

4. Date of Injury. Fecha de la lesión (accidente) 6/22/95 Time of injury. Hora en que ocurrió _____ a.m. _____ p.m.

5. Address/place where injury happened. Dirección/lugar donde ocurrió el accidente. _____
Stockton, CA

6. Describe injury and part of body affected. Describe la lesión y la parte del cuerpo afectada. left knee
Fell while inspecting ditch for mosquitos

Signature: Tom Beard

I give the employee a copy immediately as a receipt.
le inmediateamente una copia al empleado como recibo.

7. _____

8. Date when the employer first knew of the injury or accident. _____

9. Date when the petition was given to the employee. _____

10. Date when the completed petition was returned to the employer. _____

11. Name and address of the insurance company or adjusting agency. Nombre y dirección de la compañía de seguros o agencia administradora

12. Signature of the employer's representative. _____

13. Telephone. Teléfono. _____

Employer: Se requiere que Ud. firme esta forma y que provea copias a su compañía de seguros y empleado, dependiente o representante que haya presentado esta petición dentro del plazo de un día hábil desde el momento de haber sido recibida la forma completa del empleado.
EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

2 and provide copies receipt of completed
OF LIABILITY

P 354 937 023

US Postal Service
Receipt for Certified Mail
No Insurance Coverage Provided.
Do not use for International Mail (See reverse)

Sent to San Jacinto Mesquitos + Vector Control
Street & Number 7759 S. Airport Way
Post Office, State, & ZIP Code Stockton, CA 95206

Postage	\$
Certified Fee	\$
Special Delivery Fee	
Restricted Delivery Fee	
Return Receipt Showing to Whom & Date Delivered	
Return Receipt Showing to Whom, Date, & Addressee's Address	
TOTAL Postage & Fees	\$
Postmark or Date	<u>6/3/96</u>

Form 3800, April 1995

STATEMENT PURSUANT TO
LABOR CODE SECTION 4906(g)

We, the applicant and his/her attorney, declare under penalty of perjury that we have not violated Labor Code Section 139.3 and we have not offered, delivered, received, or accepted a 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.

DATED: 5/16/94

Applicant Signature:

Tom Bevilacqua

Attorney Signature:

[Handwritten Signature]

FARRELL, FRAULOB & BROWN
2315 Capitol Avenue
Sacramento, CA 95816

PROOF OF SERVICE

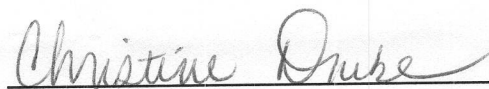
I am a citizen of the United States and employed in Sacramento County, California; I am over the age of eighteen (18) years and not a party to the within action; my business address is 2315 Capitol Avenue, Sacramento, California 95816; on this date I served the **APPLICATION FOR ADJUDICATION OF CLAIM** by placing a true copy thereof, postage prepaid, in the United States Post Office mail box at Sacramento, California, addressed as set forth below:

Thomas Beard
2937 Toyon Drive
Stockton, CA 95203

Ginny Fabale
KEENAN & ASSOCIATES
392 D Conners Court
Chico, CA 95929

I declare under penalty of perjury that the foregoing is true and correct.

Executed on June 3, 1996 at Sacramento, California.


CHRISTINE DRUBE