Representing injured workers since 1956

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:

[x] 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:

RECEIVED
JUN - 4 1996
DIVISION OF
WORKERS' COMPENSATION
STOCKTON OFFICE

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

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS

WORKERS' COMPENSATION APPEALS BOARD

SEE REVERSE SIDE FOR INSTRUCTIONS

CASE No. STK 124216

APPLICATION FOR ADJUDICATION OF CLAIM

(PRINT OR TYPE NAMES AND ADDRESSES)

RECEIVED
JUN - 4 1996
DIVISION OF
WORKERS COMPENSATION
STOCKTON OFFICE

Mr. Thomas Beard
(APPLICANT, IF OTHER THAN INJURED EMPLOYEE)

Social Security No.: 558-76-6159

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

Stockton, CA 95203
(APPLICANT'S ADDRESS AND ZIP CODE)

vs.

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

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

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

392 D Conners Court
Chico,, CA 95929
(INSURANCE CARRIER OR ADJUSTING AGENCY'S ADDRESS)

IT IS CLAIMED THAT:

1. The injured employee, born 09/24/49 (DATE OF BIRTH), while employed as a control tech (OCCUPATION AT TIME OF INJURY)
   on 6/22/95 (DATE OF INJURY) at Stockton, CA (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)
2. 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)
3. 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)
   (SEPARATELY STATE VALUE PER WEEK OR MONTH OF TIPS, MEALS, LODGING OR OTHER ADVANTAGES REGULARLY RECEIVED)
4. 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)
5. Compensation was paid Y (YES) ___ (NO) $unknown (TOTAL PAID) $ ___ (WEEKLY RATE) ___ (DATE OF LAST PAYMENT)
6. Unemployment insurance or unemployment compensation disability benefits have been received since the date of injury ___ (YES) N (NO)
7. Medical treatment was received Y (YES) ___ (NO) ongoing (DATE OF LAST TREATMENT) All treatment was furnished by the Employer or Insurance Company Y (YES) ___ (NO) Other treatment was provided or paid for by ___ (NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE) Did Medi-Cal pay for any health care related to this claim ___ (YES) N (NO) doctors not provided or paid for by employer or insurance company who treated or examined for this injury are ___ (STATE NAMES AND ADDRESSES OF SUCH DOCTORS AND NAMES OF HOSPITALS TO WHICH SUCH DOCTORS ADMITTED INJURED)
8. 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)
9. 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 (CITY), California, 05/29/96 (DATE)

David G.W. Belden
(APPLICANT'S ATTORNEY)
2315 Capitol Avenue
Sacramento, CA 95816
(ADDRESS AND TELEPHONE NUMBER OF ATTORNEY)
Farrell, Fraulob & Brown 916-442-5835

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

DIA WCAB FORM 1 (REV 7/81)

84 32595

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

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 you 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 COMPENSACIÓN 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. *Describa la lesión y la parte del cuerpo afectada.* left knee
   Fell while inspecting ditch for mosquitos

ado Tom Beard

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

r. _____

ha en que el empleador supo por primera vez de la lesión o accidente. _____

e. Fecha en que se le entregó al empleado la petición. _____

ha en que el empleado devolvió la petición completada al empleador. _____

or adjusting agency. Nombre y dirección de la compañía de seguros o agencia administradora _____

Firma del representante del empleador. _____

15. Telephone. *Teléfono.* _____

n and provide copies
ent or representative
receipt of completed

OF LIABILITY

Empleador: Se requiere que Ud. feche esta forma y que provéa 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

Original (Copia del Empleador)
DWC Form 1 (REV. 4/93)

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 Joaquin Mosquito + Vector Control
Street & Number	7754 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	6/3/96

DWC 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 Beard

Attorney 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 Toyan 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

CHRISTINE DRUBE