# PLAINTIFF'S EXHIBIT 17-C
# DATE OF INJURY: 01/21/05

**DOI: 01/21/05**

Tiffany Anderson: INCIDENT OCCURRED AT WHITE SLOUGH, BUT EMPLOYER FALSIFIED STATING THE INJURY OCCURRED AT 7759 AIRPORT WAY, WHICH IS THE EMPLOYERS MAIN BUSINESS ADDRESS; EMPLOYEE WAS SPRAYING AT WHITE SLOUGH WITH UNKNOWN CHEMICALS

Tiffany Anderson: ALSO SEEN AT KAISER ON 1/26/05 AS AUTHORIZED BY JOHN STROH. HE ALSO INSTRUCTED ME TO FALSIFY MY TIMESHEET FOR THE KAISER VISIT, WHICH WAS AT 11:50 AM.

Tiffany Anderson: work status report notes "discharged'

Tiffany Anderson: OHS blood test noted on TA's time card, but no record of labs received

| Required Forms | Received Forms? | Y=Yes, we have a copy N= No we do not have a copy |
|---|---|---|
| DWC-1 | Y | |
| DWC-1 ACK FORM | N | |

WC CLAIM #:VE050054

| DATE OF SERVICE: Required Forms | 1/26/05 | 1/27/05 | 1/31/05 | 2/2/05 | 2/3/05 | 2/7/05 | 2/28/05 |
|---|---|---|---|---|---|---|---|
| EMPLOYER'S FIRST REPORT OF INJURY | Y | N/A | N/A | N/A | N/A | N/A | N/A |
| PATIENT'S INITIAL VISIT FORM | N | N | N | N | N | N | N |
| CONSENT AND AUTHORIZATION TO RELEASE INFORMATION-PROVIDER'S FORM | N | N | N/A | N | N/A | N | N |
| CONSENT TO TREAT AND AUTH TO RELEASE INFO TO EMPLOYER (EMPLOYER'S FORM) | Y | N/A | N/A | N/A | N/A | N/A | N/A |
| NURSE'S NOTES | N | N | N | N | N | N | N |
| DOCTOR'S NOTES (TYPED) | N | N | N | N/A | N/A | N | N |
| INJURY WORKSHEET | N | N | N | N/A | N/A | N | N |
| WORK STATUS REPORT WORKSHEET | N | N | N | N/A | N/A | N | N |
| WORK STATUS REPORT | Y | Y | Y | N/A | N/A | Y | Y |
| DOCTOR'S FIRST REPORT OF INJURY | N | N/A | N/A | N/A | N/A | N/A | N/A |
| PR-2 | N | N | N | N | N | N | N |
| FOLLOW UP APPOINTMENT INFORMATI | Y | Y | Y | N/A | N/A | Y | N/A |
| LAB RESULTS (IF APPLICABLE) | N/A | N/A | N | N/A | N/A | N/A | N/A |
| AIMS MILEAGE REIMBURSEMENT FORM | Y | Y | Y | Y | Y | Y | Y |
| CLAIM SUMMARY-PAYMENTS | N/A | N/A | N/A | N/A | N/A | N/A | Y |
| AIMS FULLY RECOVERED LETTER | N/A | N/A | N/A | N/A | N/A | N/A | N |

PROVIDER'S NAME AND LICENSE #: DR. DONALD ROSSMAN, CA#C35074

PROVIDER CASE #: 66402

TIFFANY ANDERSON

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 as the cover sheet 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 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. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabjador.*

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

**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.* Tiffany Anderson Today's Date. *Fecha de Hoy.* 1-26-05
2. Home Address. *Dirección Residencial.* 1800 S. Hutchins #304
3. City. *Ciudad.* Lodi State. *Estado.* CA Zip. *Código Postal.* 95240
4. Date of Injury. *Fecha de la lesión (accidente).* 1-21-05 Time of Injury. *Hora en que ocurrió.* _____ a.m. 12 p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* 7751 S. Airport way / unloading brush
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* head to toe rash or hives
7. Social Security Number. *Número de Seguro Social del Empleado.* 549-23-5133
8. Signature of employee. *Firma del empleado.* [signature]

**Employer—complete this section and see note below.** ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* S.J. county mosquito vector control
10. Address. *Dirección.* 7751 S. Airport way Stockton
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* 1-25-05 3:00
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* 1-26-05
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* 1-26-05
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* Declaration Insurance PO Box 29100 Fresno CA 93729
15. Insurance Policy Number. *El número de la póliza de Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* [signature]
17. Title. *Título.* Secretary 18. Telephone. *Teléfono.* 209 982-4675

**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.

***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.*

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

*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*

7/1/04 Rev.

17-C-2

State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

ACCLAMATION INSURANCE MANAGEMENT SERVICES
209-227-1801
P.O. Box 28169
FRESNO, CA 93729

OSHA CASE NO.

FATALITY ☐

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.

California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

Please do not use this column: CASE NUMBER / OWNERSHIP / INDUSTRY / OCCUPATION / SEX / AGE / DAILY HOURS / DAYS PER WEEK / WEEKLY HOURS / WEEKLY WAGE / COUNTY / NATURE OF INJURY / PART OF BODY / SOURCE / EVENT / SECONDARY SOURCE / EXTENT OF INJURY / Date (mm/dd/yy)

**EMPLOYER**

1. FIRM NAME: SAN JOAQUIN CO. MOSQUITO & VECTOR CONTROL DISTRICT
2. MAILING ADDRESS (Number, Street, City, Zip): 7759 SOUTH AIRPORT WAY STOCKTON CA 95206
2a. Phone Number: 209 982-4675
3. LOCATION if different from Mailing Address (Number, Street, City and Zip):
3a. Location Code:
4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.: MOSQUITO CONTROL
5. State unemployment insurance acct.no:
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☒ Other Gov't, Specify: Special Dist.

**INJURY OR ILLNESS**

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy): 1/21/05
8. TIME INJURY/ILLNESS OCCURRED: ___ AM 12:__ PM
9. TIME EMPLOYEE BEGAN WORK: 7:30 AM ___ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy):
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☒ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy): 1/25/05
13. DATE RETURNED TO WORK (mm/dd/yy):
14. IF STILL OFF WORK, CHECK THIS BOX: ☒
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☒ Yes ☐ No
16. SALARY BEING CONTINUED? ☒ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE / NOTICE OF INJURY/ILLNESS (mm/dd/yy): 1/25/05
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy): 1/26/05
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning: Rash all over body
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip): District yard
20a. COUNTY: San Joaquin
21. ON EMPLOYER'S PREMISES? ☒ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.: yard area
23. Other Workers injured or ill in this event? ☐ Yes ☒ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold: weeds
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.: ~~XXXXXXXXXXXXXX~~ Standing and jumping on the weeds to pack them down in garbage dumpster.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY: same as above
27. Name and address of physician (number, street, city, zip): Dr. Rossman Dameron Occupational Health Services 525 W Acacia St Stockton CA 95203
27a. Phone Number: 209 461-3196 #3
28. Hospitalized as an inpatient overnight? ☒ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number:
29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

**EMPLOYEE**

30. EMPLOYEE NAME: Tiffany Anderson
31. SOCIAL SECURITY NUMBER: 549-23-5133
32. DATE OF BIRTH (mm/dd/yy): 08/22/70
33. HOME ADDRESS (Number, Street, City, Zip): 1830 S Hutchins #304 Lodi CA 95240
33a. PHONE NUMBER: 209 333-1037
34. SEX: ☐ Male ☒ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers): Mosquito Technician I
36. DATE OF HIRE (mm/dd/yy): 4/19/04
37. EMPLOYEE USUALLY WORKS: 8 hours per day, 5 days per week, 40 total weekly hours
37a. EMPLOYMENT STATUS: ☒ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED: salaries/wages
38. GROSS WAGES/SALARY: $ 1421. per bi-weekly
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☒ No

Completed By (type or print): Carol Aksland
Signature & Title: Carol Aksland 1-26-05

* Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.36). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

FORM 5020 (Rev7) June 2002
DISTRIBUTION: WHITE=WORKERS' COMPENSATION • CANARY=WORKERS' COMPENSATION • PINK=PERSONNEL DEPT

17-C-3

## EXAMINATION AND/OR TREATMENT AUTHORIZATION

**Employer:** SAN JOAQUIN CO. MOSQUITO & VECTOR CONTROL
7759 S Airport Way
STOCKTON CA 95206

TO DOCTOR: DAMERON OCCUPATIONAL HEALTH
420 W. Acacia St #19
STOCKTON CA 95203

DATE: 1/26/05

EMPLOYEE TIFFANY ANDERSON

DATE OF INJURY 1/21/05

Our employee, Tiffany Anderson is reported to have been injured on the above date. This person is being referred to you pursuant and subject to applicable workers' compensation laws. Please complete this entire form and return it to the injured worker.

AUTHORIZED SIGNATURE Carol Christensen DEPT OFFICE

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* **TO THE TREATING PHYSICIAN:** The Employer provides, whenever possible, modified work (light duty), for employees who are unable to perform their regular duties due to illness or injury. Because of varied activities, work can usually be found within the employee's limitations while he/she is recuperating.

### THE FOLLOWING PORTION TO BE COMPLETED BY THE PHYSICIAN

A. ☐ Patient may return to work with no work restrictions

Date of next doctor's appointment _____

B. ☐ Patient may be capable of performing a light duty work assignment. The following work restrictions apply until ____/____/____. _____

C. ☒ Patient is not capable of returning to regular work or modified work because allergic reaction

Expected period of disability (use specific dates) _____

Date of next doctor's appointment 1/27/05

SIGNATURE Donald Kerman MD
TREATING PHYSICIAN

THIS FORM MUST BE COMPLETED AND RETURNED IMMEDIATELY BY THE EMPLOYEE TO THE PERSONNEL DEPARTMENT FOR VALIDATION.

PLEASE FORWARD YOUR DOCTOR'S FIRST REPORT OF INJURY OR ILLNESS TO OUR ADMINISTRATOR:
**ACCLAMATION INSURANCE MANAGEMENT SERVICES**
P.O. Box 28100
Fresno, CA 93729

SIGNATURE & TITLE

A 3012 (9-94)

DISTRIBUTION AFTER COMPLETION: White - AIMS, Yellow - Personnel Office, Pink - Doctor

17-C-4

Dameron Hospital Occupational Health Services
525 W. Acacia St., Stockton, CA 95203

# WORK STATUS REPORT

**Employee Name:** Anderson, Tiffany
**Social Security No.:** 549-23-5133
**Employer:** SJ Mosquito and Vector Control
**Date of Injury:** 01/21/2005
**Clinic Case Number:** 66402

**Date of Visit:** 01/26/2005
**Time In:** 08:25 am **Time Out:** 09:57 am
**Guarantor:** AIMS - Fresno 8046
**Claim Number:** Pending

## CLINICAL STATUS

**Diagnosis:** Allergic Reaction

Since the last visit, this patient's condition has:

## EVALUATION AND TREATMENT PLAN

**Physical / Occupational Therapy:**

**Recommended Evaluation / Diagnostic Studies:**

## WORK STATUS

**Work Status:** Off balance of shift; return to full w **From:** 01/26/2005 **To:** 01/27/2005

RTN - 1-27-05

**Work Restrictions:**

**Estimated return to full duty:**

## DISPOSITION

**Disposition:**

**Next Scheduled Appointment:** 08:00 am 1/27/2005

*"I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury."*

*Signed,*

Donald Rossman, (Original signature on file)

**Doctor's Phone:** (209) 461-3196 opt. 3
**Doctor's Fax:** (209) 461-7529
**Case Coordinator Phone:** (209) 461-3196 opt.1

17-C-5

# Dameron Hospital Association
## Occupational Health Department

*** Next Appointment Information ***
(Información para su siguiente cita)

**For:** Anderson, Tiffany **Today's Date:** 1/26/2005

**Next Appointment Date:** **Case Number:** 66402

**Location:** ☐ Suite 2 (1st Floor) (209) 461-3196 x3 ☐ Suite 19 (2nd Floor) (209) 461-3196 x2

***Linacia Building***
***420 W. Acacia***

S.E. corner of Lincoln & Acacia
*(En la esquina Sureste de la calle Lincoln y Acacia)*

**Your appointment**

- Please arrive to your appointment on time.
- Please do not bring children or more than one family member to your appointment.
- If you need to change your appointment, please call us as soon as possible.
- If you do not keep your appointment, we must assume that you have recovered from your injury and you will be returned to full work duties until you return for a follow up visit.

**Parking**

- Parking is available street side, or in our above ground or underground parking lot. There is no charge for parking.

**Please bring all medications you are currently taking to your next visit.**

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**Su cita**

- Por favor llegue a su cita a tiempo.
- Por favor que no le acompañen niños ni mas de un miembro de su familia a su cita.
- Si necesita cambiar su cita, llamenos cuanto antes.
- Si falta a su cita, asumiremos que se a recuperado de su lesion y sera puesto de nuevo en trabajo regular y sin resctricciones hasta que se ponga en contacto con esta oficina para hacer una cita nueva.

**Estacionamiento**

- Hay estacionamiento disponible en la calle, al lado de la clinica y tambien en la parte baja del edificio. No tendra que pagar por estacionamiento.

**Favor de traer toda la medicina que esta tomando a su siguiente cita.**

17-C-6

Dameron Hospital Occupational Health Services
525 W. Acacia St., Stockton, CA 95203

# WORK STATUS REPORT

**Employee Name:** Anderson, Tiffany
**Social Security No.:** 549-23-5133
**Employer:** SJ Mosquito and Vector Control
**Date of Injury:** 01/21/2005
**Clinic Case Number:** 66402

**Date of Visit:** 01/27/2005
**Time In:** 07:46 am **Time Out:** 08:27 am
**Guarantor:** AIMS - Fresno 8046
**Claim Number:** Pending

## CLINICAL STATUS

**Diagnosis:** Allergic Reaction

Since the last visit, this patient's condition has:

## EVALUATION AND TREATMENT PLAN

**Physical / Occupational Therapy:**

**Recommended Evaluation / Diagnostic Studies:**

## WORK STATUS

**Work Status:** Full work duties **From:** 01/27/2005 **To:** 01/31/2005

**Work Restrictions:**

**Estimated return to full duty:**

## DISPOSITION

**Disposition:**

**Next Scheduled Appointment:** 08:00 am 1/31/2005

*"I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury."*

*Signed,*

Donald Rossman, (Original signature on file)

**Doctor's Phone:** (209) 461-3196 opt. 3
**Doctor's Fax:** (209) 461-7529
**Case Coordinator Phone:** (209) 461-3196 opt.1

17-C-D

# AN JOAQUIN COUNT
# MOSQUITO AND VECTOR CONTROL DISTRICT
## Daily Timesheet

Name: Tiffany Andersson
Employee No.: 3066
Date: 1-31-05 mon.

Veh. # 32 In 143:65 Out 142:34 13
Veh. # ____ In ___:___ Out ___:___

| Time In | Time Out | Total Time | Location/Activity |
|---|---|---|---|
| 7:30 | 7:45 | :15 | yard |
| 8:00 | 8:55 | :55 | Cameron O.H.S. blood test |
| 9:15 | 9:30 | :15 | McDonald Isl. |
| 9:30 | 9:45 | :15 | break McDonald Isl |
| 9:45 | 11:10 | 1:25 | McDonald Isl |
| 12:00 | 12:30 | :30 | lunch Howard Rd |
| 12:30 | 1:30 | 1:00 | Howard Rd |
| 1:45 | 2:30 | :45 | Bacon Isl |
| 2:30 | 2:45 | :15 | break Tracy Blvd |
| 3:25 | 4:00 | :35 | yard |
| : | : | : | |
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| Hours Worked | | Hours taken off | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Regular Time Worked | O.V.T. Hrs. Worked | Vacation Time | Sick Time | Family Time | Over-Time | Without Pay | Workers Comp. | Grand Total Hours |
| 8:___ | ___:___ | ___:___ | ___:___ | ___:___ | ___:___ | ___:___ | ___:___ | 8:___ |

17-C-8

Dameron Hospital Occupational Health Services
525 W. Acacia St., Stockton, CA 95203

# WORK STATUS REPORT

**Employee Name:** Anderson, Tiffany K
**Social Security No.:** 549-23-5133
**Employer:** SJ Mosquito and Vector Control
**Date of Injury:** 01/21/2005
**Clinic Case Number:** 66402

**Date of Visit:** 01/31/2005
**Time In:** 08:00 am **Time Out:** 08:47 am
**Guarantor:** AIMS - Fresno 8046
**Claim Number:** Pending

## CLINICAL STATUS

**Diagnosis:** Allergic Reaction

Since the last visit, this patient's condition has:

## EVALUATION AND TREATMENT PLAN

**Physical / Occupational Therapy:**

**Recommended Evaluation / Diagnostic Studies:**

## WORK STATUS

**Work Status:** Full work duties **From:** 01/31/2005 **To:** 02/03/2005

**Work Restrictions:**

**Estimated return to full duty:**

## DISPOSITION

**Disposition:**

**Next Scheduled Appointment:** 08:00 am 2/ 7/2005

*"I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury."*

*Signed,*

Donald Rossman, (Original signature on file)

**Doctor's Phone:** (209) 461-3196 opt. 3
**Doctor's Fax:** (209) 461-7529
**Case Coordinator Phone:** (209) 461-3196 opt.1

17-C-9

# SAN JOAQUIN COUNTY
# MOSQUITO AND VECTOR CONTROL DISTRICT
## Daily Timesheet

Name: T Anderson
Employee No.: 306
Date: 2-2-05

Veh. # 32 Veh. # ____
In 14535 In ___:___
Out 14445 Out ___:___
90

| Time In | Time Out | Total Time | Location/Activity |
|---|---|---|---|
| 7:30 | 7:45 | :15 | yard |
| 8:05 | 10:05 | 2:05 | Cameron HepA / tetnus |
| 10:15 | 10:20 | :5 | yard / |
| 10:20 | 10:35 | :15 | yard / break |
| 10:35 | 10:55 | :20 | Yard / |
| 11:30 | 12:00 | :30 | 072N8E15003 |
| 12:00 | 12:30 | :30 | lunch Fine Rd |
| 12:30 | 2:30 | 2:00 | 072N8E15003 |
| 2:45 | 3:00 | :15 | break / Hwy26 |
| 3:00 | 3:15 | :15 | 072N8E15003 |
| 3:45 | 4:00 | :15 | yard |
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| Hours Worked | | Hours taken off | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Regular Time Worked | O.V.T. Hrs. Worked | Vacation Time | Sick Time | Family Time | Over-Time | Without Pay | Workers Comp. | Grand Total Hours |
| 8:___ | ___:___ | ___:___ | ___:___ | ___:___ | ___:___ | ___:___ | ___:___ | 8___:___ |

C

17-C-10

# AN JOAQUIN COUNT
# MOSQUITO AND VECTOR CONTROL DISTRICT
## Daily Timesheet

Name: Tiffany Andersson Veh. # 32 Veh. # _____
Employee No.: 3066 In ___:___ In ___:___
Date: 2-3-05 thurs. Out ___:___ Out ___:___
Nameson 9:00 / white slough

| Time In | Time Out | Total Time | Location/Activity |
|---|---|---|---|
| 7:30 | 9:30 | 2:00 | yard prep for white slough |
| 9:30 | 9:45 | :15 | break yard |
| 9:45 | 10:00 | :15 | yard |
| 10:35 | 12:00 | :25 | white slough / brush work |
| 12:00 | 12:20 | :30 | white slough / lunch |
| 12:30 | 2:40 | 2:10 | white slough / brush work |
| 3:15 | 4:00 | :45 | yard / unloaded brush |
| : | : | : | |
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| Hours Worked | | Hours taken off | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Regular Time Worked | O.V.T. Hrs. Worked | Vacation Time | Sick Time | Family Time | Over-Time | Without Pay | Workers Comp. | Grand Total Hours |
| 8:___ | ___:___ | ___:___ | ___:___ | ___:___ | ___:___ | ___:___ | ___:___ | 8:___ |

17-C-11

Dameron Hospital Occupational Health Services
525 W. Acacia St., Stockton, CA 95203

# WORK STATUS REPORT

**Employee Name:** Anderson, Tiffany K
**Social Security No.:** 549-23-5133
**Employer:** SJ Mosquito and Vector Control
**Date of Injury:** 01/21/2005
**Clinic Case Number:** 66402

**Date of Visit:** 02/07/2005
**Time In:** 09:04 am **Time Out:** 09:32 am
**Guarantor:** AIMS - Fresno 8046
**Claim Number:** Pending

## CLINICAL STATUS

**Diagnosis:** Allergic Reaction

Since the last visit, this patient's condition has:

## EVALUATION AND TREATMENT PLAN

**Physical / Occupational Therapy:**

**Recommended Evaluation / Diagnostic Studies:**

## WORK STATUS

**Work Status:** Full work duties **From:** 02/07/2005 **To:** 02/14/2005

**Work Restrictions:**

**Estimated return to full duty:**

## DISPOSITION

**Disposition:**

**Next Scheduled Appointment:** 09:40 am 2/28/2005

*"I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury."*

*Signed,*

Donald Rossman, (Original signature on file)

**Doctor's Phone:** (209) 461-3196 opt. 3
**Doctor's Fax:** (209) 461-7529
**Case Coordinator Phone:** (209) 461-3196 opt.1

DH-WSR 8/1/00

17-C-12

Dameron Hospital Occupational Health Services
525 W. Acacia St., Stockton, CA 95203

# WORK STATUS REPORT

**Employee Name:** Anderson, Tiffany K
**Social Security No.:** 549-23-5133
**Employer:** SJ Mosquito and Vector Contro
**Date of Injury:** 01/21/2005
**Clinic Case Number:** 66402
**Date of Visit:** 02/28/2005
**Time In:** 09:40 am **Time Out:** 10:17 am
**Guarantor:** AIMS - Fresno 8046
**Claim Number:** Pending

## CLINICAL STATUS

**Diagnosis:** Allergic Reaction

Since the last visit, this patient's condition has:

## EVALUATION AND TREATMENT PLAN

**Physical / Occupational Therapy:**

**Recommended Evaluation / Diagnostic Studies:**

## WORK STATUS

**Work Status:** Full work duties **From:** 02/28/2005 **To:** 02/28/2005

**Work Restrictions:**

EC
3/1/05

**Estimated return to full duty:**

## DISPOSITION

**Disposition:** Final Discharge,P&S, no residuals PR2 to follow

**Next Scheduled Appointment:**

*"I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury."*

*Signed,*
Donald Rossman, (Original signature on file)

**Doctor's Phone:** (209) 461-3196 opt. 3
**Doctor's Fax:** (209) 461-7529
**Case Coordinator Phone:** (209) 461-3196 opt 1

DH-WSR 8/14/02

17-C-13

AIMS™
ACCLAMATION INSURANCE
MANAGEMENT SERVICES

January 28, 2005

Tiffany Anderson
1830 S. Hutchins, #304
Lodi, CA 95240

Employee: Tiffany Anderson
Employer: San Joaquin Co. Mosquito/Vector Control District
D/Injury: 01-21-05
Claim No. VE050054

Dear Ms. Tiffany Anderson:

Acclamation Insurance Management Services is the Workers' Compensation administrator for your Employer, San Joaquin Co. Mosquito/Vector Control District.

We are sorry to learn of your recent injury at work. We have enclosed a pamphlet, "Facts for Injured Workers", which explains your workers' compensation benefits.

Since this has been accepted as a work related injury, you are entitled to reimbursement for transportation expenses to obtain medical treatment at .34 cents per mile, pursuant to California Labor Code Section 4600. To have this expense reimbursed to you, please complete and return the enclosed form to us. We will then review it for payment. Please make sure the reimbursement request is clearly and accurately itemized and is signed and dated by you.

We wish you a speedy recovery.

If you have any questions or wish additional information, please contact our office by calling (800) 559-9891.

Sincerely,

Theresa Antoyan
Claims Assistant
TA

cc: Employer: San Joaquin Co. Mosquito/Vector Control District
File

P.O. Box 28100
Fresno, CA 93729
(559) 227-9891
FAX (559) 227-1579
CAL. LIC. 2772984

17-C-14

ACCLAMATION INSURANCE
MANAGEMENT SERVICES

January 28, 2004 *

Tiffany Anderson
1830 S. Hutchins #304
Lodi, CA 95240

EMPLOYER: San Joaquin Co. Mosquito/Vector Control Dist. CLAIM#: VE050054 D/INJURY: 01-21-05

Under the California Workers' Compensation Law, you are entitled to reimbursement of reasonable mileage to and from medical appointments or treatment for your industrial injury or illness. Mileage will be reimbursed at the rate of 34¢ per mile.

Please use this form to keep track of your trips and submit it to the address below.

| DATE | FROM | TO (DOCTOR'S NAME) | ROUND TRIP MILEAGE |
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TOTAL_____

If you desire additional forms, please check here _____

Signature:_____

P.O. Box 28100
Fresno, CA 93729
(559) 227-9891
FAX (559) 227-1579
CAL LIC 2772984

17-C-15

# Claim Summary - Payments

1/1/1901 - 9/23/2014

Claim No: VE050054
Loss Date: 1/21/2005
Claimant: Anderson, Tiffany
Insured: Vector JPA

## Medical

| Effective Date | Transaction Type | Check Number | Payee | From Through | Pay Amount | Running Total |
|---|---|---|---|---|---|---|
| 4/11/2005 | M47 - Physician | 2584 | DAMERON HOSPITAL ASSOCIATION | 1/31/2005 - 1/31/2005 | 13.03 | 13.03 |
| 4/11/2005 | M47 - Physician | 2584 | DAMERON HOSPITAL ASSOCIATION | 1/31/2005 - 1/31/2005 | 4.52 | 17.55 |
| 4/11/2005 | M47 - Physician | 2584 | DAMERON HOSPITAL ASSOCIATION | 1/31/2005 - 1/31/2005 | 14.54 | 32.09 |
| 4/11/2005 | M47 - Physician | 2581 | CORKY HULL MEDICAL ASSOCIATES, INC. | 1/27/2005 - 1/27/2005 | 72.25 | 104.34 |
| 4/11/2005 | M47 - Physician | 2581 | CORKY HULL MEDICAL ASSOCIATES, INC. | 1/27/2005 - 1/27/2005 | 11.69 | 116.03 |
| 4/11/2005 | M47 - Physician | 2582 | CORKY HULL MEDICAL ASSOCIATES, INC. | 2/7/2005 - 2/7/2005 | 11.69 | 127.72 |
| 4/11/2005 | M47 - Physician | 2582 | CORKY HULL MEDICAL ASSOCIATES, INC. | 2/7/2005 - 2/7/2005 | 47.60 | 175.32 |
| 4/20/2005 | M10 - DO NOT USE BR Fee | 2661 | ALLIED MANAGED CARE | 3/15/2005 - 3/15/2005 | 19.46 | 194.78 |
| 5/3/2005 | M44 - Pharmacy | 2703 | DAMERON HOSPITAL LINACIA PHARMACY | 1/26/2005 - 1/26/2005 | 8.64 | 203.42 |
| 5/3/2005 | M44 - Pharmacy | 2703 | DAMERON HOSPITAL LINACIA PHARMACY | 1/27/2005 - 1/27/2005 | 13.23 | 216.65 |
| 5/18/2005 | M47 - Physician | 2756 | CORKY HULL MEDICAL ASSOCIATES, INC. | 2/28/2005 - 2/28/2005 | 11.69 | 228.34 |
| 5/18/2005 | M47 - Physician | 2756 | CORKY HULL MEDICAL ASSOCIATES, INC. | 2/28/2005 - 2/28/2005 | 47.60 | 275.94 |
| 5/18/2005 | M10 - DO NOT USE BR Fee | 2725 | ALLIED MANAGED CARE | 4/26/2005 - 4/26/2005 | 0.09 | 276.03 |
| 3/21/2006 | M47 - Physician | 4022 | CORKY HULL MEDICAL ASSOCIATES, INC. | 1/26/2005 - 1/26/2005 | 47.60 | 323.63 |
| 3/21/2006 | M47 - Physician | 4023 | CORKY HULL MEDICAL ASSOCIATES, INC. | 1/31/2005 - 1/31/2005 | 11.69 | 335.32 |
| 3/21/2006 | M47 - Physician | 4023 | CORKY HULL MEDICAL ASSOCIATES, INC. | 1/31/2005 - 1/31/2005 | 47.60 | 382.92 |
| 3/28/2006 | M10 - DO NOT USE BR Fee | 4045 | ALLIED MANAGED CARE | 3/14/2006 - 3/14/2006 | 6.21 | 389.13 |
| 3/28/2006 | M10 - DO NOT USE BR Fee | 4045 | ALLIED MANAGED CARE | 3/14/2006 - 3/14/2006 | 2.47 | 391.60 |
| | **Totals for Medical** | | | | | $391.60 |

| | Total |
|---|---|
| **Grand Totals** | $391.60 |

*=Payment transaction which has not been committed R=Transaction is a reversal F=Transaction is a refund X=Transaction is a reversed refund



9/23/2014 4:08 PM

17-C-16

| Payment Summary | |
|---|---|
| M47 - Physician | $341.50 |
| M10 - DO NOT USE BR Fee | $28.23 |
| M44 - Pharmacy | $21.87 |
| Total | $391.60 |



*=Payment transaction which has not been committed R=Transaction is a reversal F=Transaction is a refund X=Transaction is a reversed refund



17-C-17