

DWC-CA form 10214 (a) Page 1 (Rev 11/2008)

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,	STATE OF CALIFORNIA ()	
١	VISION OF WORKERS' COMPENSATION	
	KERS' COMPENSATION APPEALS BOARD	
F	PULATIONS WITH REQUEST FOR AWARD	

ADJ7004227		Date of Injury	00/19/2008	
Case No.			MM/DD/YYYY	
549-23-5133				
SSN (Numbers Only)			
Venue Choice is ba	sed upon: (Completion of this s	ection is required)		-
County of reside	nce of employee (Labor Code sec	tion 5501.5(a)(1) or (d).)		
County where inj	ury occurred (Labor Code section	5501.5(a)(2) or (d).)		
County of princip	al place of business of employee's	s attorney (Labor Code se	ection 5501.5(a)(3) or (d).)
STK				
Select 3 Letter Office	Code For Place/Venue of Hearing	g (From the Document Co	over Sheet)	
Applicant (Complet	ion of this section is required)			
TIFFANY				
First Name			MI	
ANDERSON				
Last Name				
2 N AVENA AVE Address/PO Box (Ple	NUE ease leave blank spaces between	numbers, names or word	s)	
LODI			CA	95242
City			State	Zip Code
Employer #1 Inform	ation (Completion of this section	n is required)		
Insured	✓ Self-Insured	Legally Uninsured	Uninsu	ıred
	OUNTY MOSQUITO AND VI			
7759 S AIRPORT				
Employer Street Add	ress/PO Box (Please leave blank	spaces between numbers	s, names or words)	
STOCKTON			CA	95206
City			State	Zip Code
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PERMISSIBLY SELF INSURED		
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		l
m O~BOX~269120 surance Carrier Street Address/PO Box (Please leave blank spaces between numbers	s, names or words)	
ACRAMENTO	CA	95826
ty	State	Zip Code
aims Administrator Information (if known and if applicable)		
IMS INSURANCE ume (Please leave blank spaces between numbers, names or words)		<u> </u>
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ACRAMENTO	CA	95826
ACICAMIEM TO	C_{I}	73020
	State	Zip Code
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Claims Administrator Information	on (if k/wn an	id if applicable)		+
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treet Address/PO Box (Please I	eave blank spac	es between numbers, names or wor	ds)	
City		**************************************	State	Zip Code
mployer #3 Information (Comp	letion of this s	ection is required)		
_	elf-Insured	Legally Uninsured	Unins	ured
mployer Name (Please leave bl	ank spaces betw	veen numbers, names or words)		
mployer Street Address/PO Box	(Please leave t	olank spaces between numbers, nam	nes or words)	
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	•			
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City			State	Zip Code
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NC-CA form 10214 (a) Page 3 (Rev 11/20	008)			

Employer #4 Inforn					
Insured	Self-Insured	Legally Uninsured	Unin	sured	-
Employer Name (Pl	ease leave blank spaces betv	ween numbers, names or words	s)		
Employer Street Ad	dress/PO Box (Please leave	blank spaces between numbers	s, names or words)		
City			 State	Zip Code	
nsurance Carrier II (if known and if app		rrier is adjusted by claims adı	ministrator)		
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Insurance Carrier Stre	et Address/PO Box (Please leav	e blank spaces between numbers,	names or words)		
Citv			State	Zin Code	
City Claims Administrat	or Information (if known an	d if applicable)	State	Zip Code	
-	or Information (if known an	d if applicable)	State	Zip Code	
Claims Administrat			State	Zip Code	
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More than 4 Companion	Cases	
_	✓ Specific Injury	
ADJ7004221 Case Number 1	Cumulative Injury	06/19/2008 (Start Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury)
Body Part 1: 513 KNEE	Body Part 2:	Body Part 3:
Body Part 4:	Other Body Parts:	-
	Specific Injury	
Case Number 2	Cumulative Injury	(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury)
Body Part 1:	Body Part 2:	Body Part 3:
Body Part 4:	Other Body Parts:	
	Specific Injury	
Case Number 3	Cumulative Injury	(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury)
Body Part 1:	Body Part 2:	Body Part 3:
Body Part 4:	Other Body Parts:	· · · · · · · · · · · · · · · · · · ·
	Specific Injury	
Case Number 4	Cumulative Injury	(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY) (If Specific Injury, use the start date as the specific date of injury)
Body Part 1:	Body Part 2:	Body Part 3:
Body Part 4:	Other Body Parts:	
	surer(s) listed above and who so	ustained injury(ies) arising out of and in the course of employment t
RIGHT KNEE		
	(Please list all	body parts injured)

DWC-CA form 10214 (a) Page 5 (Rev 11/2008)

2. The injury (ies) cau	sed tempora	ry disability for the	period		6/20/2008 M/DD/YYYY	through	
08/13/201	0	for which indemn	ity has been pa	aid at \$	602.59	per week.	
MM/DD/YYYY		-			Indemnity Paid	por wook.	
2(a). The injury(ies) ca	used additio	nal temporary disal	bility for the pe	riod		n/a D/YYYY	
through	n/a MM/DD/YYYY	at the rat	e of \$	tate	_ in the amount	of \$ Indemnit	y Paid
3. The injury(ies) caus	ed permane	nt disability of 4	(% for wl	nich indemnity is	payable at \$	230.00
per week beginning	ALL DU	E AND PAYABI			2,760.00		Indemnity Rate such payments
previously made.		nension of \$	pe	er week	thereafter.		
Labor Code §4658(c	– l) adjustmen		ife Pension				
Increase rate to	\$	as of		-			
Decrease rate to	\$ 195.50	as of	MM/DD/	t	all due and pa emporary disal ess permanent	oility credit disability pa	of \$4,571.42, ayout for
Not Applicable			MM/DD/		DJ7010682 (DO:		f \$1,173.00, redit of \$1,052.42
4.There ✓ is ☐ is 5. Medical-legal exper FUTURE MEDICA	nses and/or I	iens are payable by	/ defendant as	follows:		said injury (ies)	
6. Applicant's attorney	requests a f	ee of \$ 414.	00				
Fees to be commu	ted as follow	/S:					
7. Liens Against comp	ensation are	payable as follows	:			·	
NONE KNOWN.	, ,				Parties and		
		·					
NA/O O A 5 10011 (-) 5	- 0 /D-: 11 /CCC						

8.Any accrued claims for Labor Code s 5814 penalties are included in this se	ettle it unless exp	ressly excluded.
9.Other stipulations:		
SEE ATTACHED ADDENDUM INCORPORATED HEREIN		
	•	
·		
	N	
Dated 12-23-10	J)	
MM/DD/YYYY	Applicant	****
	NAME: 1	
Applicant's Attorney or Authorized Representative:		ſ
✓ Law Firm/Attorney		
		ť
RONALD First Name	_	
THOCKNAMO		
STEIN		
Last Name		
4813094		
Firm Number		
		•
RONALD STEIN STOCKTON Law Firm name		<u> </u>
4521 QUAIL LAKES DRIVE		÷
Address/PO Box (Please leave blank spaces between numbers, names or words)		_
STOCKTON	CA	95207
City	State	Zip Code
\mathcal{L}		
Dated		
/ MM/DD/YYYY A	pplicant Attorney Sig	gnature
DWC-CA form 10214 (a) Page 7 (Rev 11/2008)		

	· ·		
Defendant's Attorney or Authorized R esentative:	()		
✓ Law Firm/Attorney Non Attorney Representative			
			
ERIC			_
First Name			ļ

HELPHREY			
Last Name			
#40##60			
5185268 Firm Number			
Firm Number			
STOCKWELL HARRIS SACRAMENTO			
Law Firm Name		·	
·			
1545 RIVER PARK DRIVE SUITE 330			
Address/PO Box (Please leave blank spaces between numbers, names or words)			
, , , , , , , , , , , , , , , , , , , ,			
SACRAMENTO	CA	95815	
City	State	Zip Code	
Dated /////			
/MM/DD/YYYY	Defense Attorney	Cianatura /	
	Defense Attorney	Signature	
Defendant's Attorney or Authorized Representative:			
Law Firm/Attorney Non Attorney Representative			
Law Firm/Attorney Non Attorney Representative			
Law Firm/Attorney Non Attorney Representative First Name			
First Name			
First Name			
First Name Last Name			
First Name			
First Name Last Name			
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First Name Last Name Firm Number Law Firm Name Address/PO Box (Please leave blank spaces between numbers, names or words)			
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First Name Last Name Firm Number Law Firm Name Address/PO Box (Please leave blank spaces between numbers, names or words) City	State	Zip Code	
First Name Last Name Firm Number Law Firm Name Address/PO Box (Please leave blank spaces between numbers, names or words) City Dated	State Defense Attorne		
First Name Last Name Firm Number Law Firm Name Address/PO Box (Please leave blank spaces between numbers, names or words) City Dated			

Defendant's Attorney or Authorized R		
Law Firm/Attorney Non Attorney Representative		ļ
First Name		
Last Name	,	
Last Name		
Firm Number		
Law Firm Name		
Address/PO Box (Please leave blank spaces between numbers, names or w	ords)	
City	State	Zip Code
Dated		
MINIMULATER	Defense Attorney S	gnature
Interpreter Licence Number:		
Interpreter Name	Interpreter Licen	se Number

RE: WCAB: ANDERSON, TIFFANY VS. SAN JOAQUIN COUNTY MVCD

ADJ7010682; ADJ7004221;

ADDENDUM TO STIPULATIONS WITH REQUEST FOR AWARD – PARAGRAPH 9

Permanent disability is based on Panel QME Dr. Tabaddor dated June 8, 2010, August 20, 2010 and September 7, 2010 at 2% permanent disability. This settlement resolves any and all claims for temporary disability (medical, TPD, TTD, wage loss, or any other form of TD) through the date of the award. This settlement resolves any and all claims of penalty(s), filed or not, including but not limited to Labor Code Sections 4650 and 5814 related to untimely payment and/or alleged failure to pay TD, PD, medicallegal or medical treatment, mileage/transportation, out-of-pocket expenses, home care/housekeeping or any other benefit. Any previously submitted claims for benefits need to be resubmitted with time as specified by the labor code to pay. The parties stipulate that there are no other claims or issues for workers' compensation benefits at this time. The parties stipulate no interest will be owing on accrued sums if payment is made within 30 days of this award.

Defendant entitled to a future indemnity credit of \$2,225.42 against the case cited herein as well as ADJ7004227 (date of injury: June 19, 2008). The applicant dismisses any claims or rights to workers' compensation benefits regarding the third right knee claim on or about July 2, 2009 (ADJ7004221). Defendant enjoys a future indemnity claim asserted in either ADJ7004227 (date of injury: June 19, 2008) or ADJ7010682 (date of injury: March 26, 2009). The attorney fees of \$621.00 will be paid in addition to the sums outlined herein.