

STATE OF CALIFORNIA  
DIVISION OF WORKERS' COMPENSATION  
WORKERS' COMPENSATION APPEALS BOARD  
STIPULATIONS WITH REQUEST FOR AWARD

ADJ7004227

Case No.

Date of Injury 06/19/2008

MM/DD/YYYY

549-23-5133

SSN (Numbers Only)

Venue Choice is based upon: (Completion of this section is required)

- ☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)
- ☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)
- ☒ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

STK

Select 3 Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Applicant (Completion of this section is required)

TIFFANY

First Name

MI

ANDERSON

Last Name

2 N AVENA AVENUE

Address/PO Box (Please leave blank spaces between numbers, names or words)

LODI

City

CA

State

95242

Zip Code

Employer #1 Information (Completion of this section is required)

- ☐ Insured ☒ Self-Insured ☐ Legally Uninsured ☐ Uninsured

SAN JOAQUIN COUNTY MOSQUITO AND VECTOR CONTROL DISTRICT

Employer Name (Please leave blank spaces between numbers, names or words)

7759 S AIRPORT WAY

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

STOCKTON

City

CA

State

95206

Zip Code

Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)

PERMISSIBLY SELF INSURED

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

PO BOX 269120

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

SACRAMENTO

City

CA

State

95826

Zip Code

Claims Administrator Information (if known and if applicable)

AIMS INSURANCE

Name (Please leave blank spaces between numbers, names or words)

PO BOX 269120

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

SACRAMENTO

City

CA

State

95826

Zip Code

Employer #2 Information (Completion of this section is required)

☐ Insured

☐ Self-Insured

☐ Legally Uninsured

☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Insurance Carrier Information

(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

**Claims Administrator Information (if known and if applicable)**

\_\_\_\_\_  
Name (Please leave blank spaces between numbers, names or words)

\_\_\_\_\_  
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

\_\_\_\_\_  
City State Zip Code

**Employer #3 Information (Completion of this section is required)**

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

\_\_\_\_\_  
Employer Name (Please leave blank spaces between numbers, names or words)

\_\_\_\_\_  
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

\_\_\_\_\_  
City State Zip Code

**Insurance Carrier Information**  
(if known and if applicable - include even if carrier is adjusted by claims administrator)

\_\_\_\_\_  
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

\_\_\_\_\_  
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

\_\_\_\_\_  
City State Zip Code

**Claims Administrator Information (if known and if applicable)**

\_\_\_\_\_  
Name (Please leave blank spaces between numbers, names or words)

\_\_\_\_\_  
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

\_\_\_\_\_  
City State Zip Code

**Employer #4 Information (Completion of this section is required)**

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured



Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

**Insurance Carrier Information**  
(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

**Claims Administrator Information (if known and if applicable)**

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

The parties hereto stipulate to the issuance of an Award and/or Order, based upon the following facts, and waive the requirements of Labor Code section 5313:



1. TIFFANY

Employees First Name

ANDERSON

Employees Last Name

birth date 08/22/1970  
MM/DD/YYYY

while employed at STOCKTON CONTROL DISTRICT CA  
State

as a(n) TECHNICIAN I Occupation , Group in



☐ More than 4 Companion Cases

☒ Specific Injury

ADJ7004221

Case Number 1

☐ Cumulative Injury

06/19/2008

(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: 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:

by the employer(s) and their insurer(s) listed above and who sustained injury(ies) arising out of and in the course of employment to

RIGHT KNEE

(Please list all body parts injured)

2. The injury (ies) caused temporary disability for the period 06/20/2008 through  
MM/DD/YYYY

08/13/2010 for which indemnity has been paid at \$ 602.59 per week.  
MM/DD/YYYY Indemnity Paid

2(a). The injury(ies) caused additional temporary disability for the period n/a  
MM/DD/YYYY

through n/a at the rate of \$ Rate in the amount of \$ Indemnity Paid  
MM/DD/YYYY

3. The injury(ies) caused permanent disability of 4 % for which indemnity is payable at \$ 230.00  
per week beginning ALL DUE AND PAYABLE in the sum of \$ 2,760.00, less credit for such payments  
MM/DD/YYYY

previously made. ☐ And a life pension of \$ Life Pension per week thereafter.

Labor Code §4658(d) adjustment:

☐ Increase rate to \$ as of MM/DD/YYYY

☒ Decrease rate to \$ 195.50 as of MM/DD/YYYY All due and payable \$2,346.00 less  
temporary disability credit of \$4,571.42,  
less permanent disability payout for  
ADJ7010682 (DOI: 3/26/09) of \$1,173.00,  
leaving a total indemnity credit of \$1,052.42.

☐ Not Applicable

An informal rating ☐ has / ☒ has not (Select one) been previously issued in case no(s) \_\_\_\_\_.

4. There ☒ is ☐ is Not a need for medical treatment to cure or relieve from the effects of said injury (ies).

5. Medical-legal expenses and/or liens are payable by defendant as follows:

FUTURE MEDICAL TREATMENT TO APPLICANT'S RIGHT KNEE ONLY

6. Applicant's attorney requests a fee of \$ 414.00

☐ Fees to be commuted as follows:

7. Liens Against compensation are payable as follows:

NONE KNOWN.

8. Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

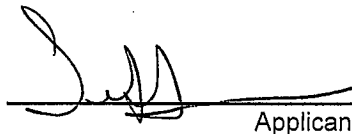
9. Other stipulations:

SEE ATTACHED ADDENDUM INCORPORATED HEREIN

+

Dated

12-23-10  
MM/DD/YYYY

  
Applicant

Applicant's Attorney or Authorized Representative:

☒ Law Firm/Attorney

☐ Non Attorney Representative

+

RONALD

First Name

STEIN

Last Name

4813094

Firm Number

RONALD STEIN STOCKTON

Law Firm name

4521 QUAIL LAKES DRIVE

Address/PO Box (Please leave blank spaces between numbers, names or words)

STOCKTON

City

CA

State

95207

Zip Code

Dated

12/23/10  
MM/DD/YYYY



Applicant Attorney Signature

+

Defendant's Attorney or Authorized Representative:

☒ Law Firm/Attorney ☐ Non Attorney Representative

ERIC

First Name

HELPHREY

Last Name

5185268

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

City

CA

State

95815

Zip Code

Dated

11/11/11  
MM/DD/YYYY

Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

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

Dated

MM/DD/YYYY

Defense Attorney Signature



**Defendant's Attorney or Authorized Representative:**

☐ Law Firm/Attorney ☐ Non Attorney Representative

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

Dated

MM/DD/YYYY

Defense Attorney Signature

**Interpreter Licence Number:**

Interpreter Name

Interpreter License Number

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