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 Strickland 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

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

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