STOCKWELL
HARRIS
WOOLVERTON
MUEHL

A Professional Corporation

1545 River Park Drive, Suite 330
Sacramento, California 95815-4616
(916) 924-1862
(916) 924-3541 FAX
www.shww.com

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GEORGE WOOLVERTON
JEFFREY T. LANDRES
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DANIEL J. YSABAL *
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PAULA N. HARRIS ††
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AURORA VASQUEZ
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L. STEVEN HATTENDORF
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SHERRIE L. McCRACKEN
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DEREK A. KUHEN

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JANET ORMOND ANDRIZZI
EDITTE ALSEN
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TODD M. MOBLEY
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KYLE ROBERT HANSEN
ALEXANDER W HANSEN
SARAH L. LOPEZ
ANDREW J LYNCH
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REED R. HEUSTIS, JR.
NEDA KALHOR
SHELLY HAY ANDERSON

LIEN SPECIALISTS
TERA LOWERY
RINA DEL ROSARIO
SEAN TALIAFERRO
SHERRI L. SHABESTARI

* CERTIFIED SPECIALIST WORKERS' COMPENSATION LAW THE STATE BAR OF CALIFORNIA BOARD OF LEGAL SPECIALIZATION
† ALSO LICENSED IN THE STATE OF ILLINOIS
†† ALSO LICENSED IN THE STATE OF NEW YORK
††† ALSO LICENSED IN WASHINGTON D.C. AND THE STATE OF GEORGIA
†††† ALSO LICENSED IN THE STATE OF NEVADA
††††† ALSO LICENSED IN THE STATE OF TEXAS
†††††† ALSO LICENSED IN THE DISTRICT OF COLUMBIA AND STATE OF WASHINGTON
††††††† ALSO LICENSED IN THE STATE OF VIRGINIA
†††††††† ALSO LICENSED IN THE STATE OF PENNSYLVANIA
††††††††† ALSO LICENSED IN THE STATE OF OREGON

March 9, 2011

* Please See Attached Proof Of Service For List Of Addressee(s) *

RE: ANDERSON, TIFFANY VS. SAN JOAQUIN COUNTY MOSQUITO & VECTOR CONTROL

WCAB NO.: 1) ADJ7004221; 2) ADJ7004227; 3) ADJ7010682
CLAIM NO.: VE0700184
OUR FILE NO.: 300141-040

Dear Gentlepersons:

Pursuant to the Rules of the Division of Workers' Compensation, enclosed please find the following for your file:

1. **Stipulations with Request for Award & Award– ADJ7010682 dated March 8, 2011**

2. **Stipulations with Request for Award & Award – ADJ7004221 dated March 8, 2011**

3. **Minutes of Hearing dated March 8, 2011**

LOS ANGELES OFFICE
3580 Wilshire Boulevard, 19TH Floor
Los Angeles, California 90010
(323) 935-6669

ORANGE COUNTY OFFICE
701 South Parker Street, Suite 2200
Orange, California 92868-4736
(714) 479-1180

SAN DIEGO OFFICE
750 "B" Street, Suite 2340
San Diego, California 92101
(619) 696-1436

SAN FRANCISCO OFFICE
222 Kearny Street, 9TH Floor
San Francisco, California 94108
(415) 734-9310

SAN BERNARDINO OFFICE
735 East Carnegie Drive, Suite 270
San Bernardino, California 92408
(909) 381-5553

SAN LUIS OBISPO OFFICE
1150 Osos Street, Suite 202
San Luis Obispo, California 93401-3692
(805) 541-0440

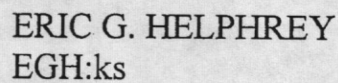
VENTURA OFFICE
2021 Sperry Avenue, Suite 46
Ventura, California 93003-7417
(805) 654-8994

FRESNO OFFICE
1550 East Shaw Avenue, Suite 103
Fresno, California 93710
(559) 226-9030

Copies of these documents are being served on the parties listed in the attached Proof of Service at this time.

Very truly yours,

STOCKWELL, HARRIS, WOOLVERTON & MUEHL
A Professional Corporation



ERIC G. HELPHREY
EGH:ks

Applicant/Employee: TIFFANY ANDERSON WCAB No(s). ADJ 7010682

AWARD

AWARD IS MADE in favor of TIFFANY ANDERSON against SAN JOAQUIN COUNTY MOSQUITO AND VECTOR CONTROL DISTRICT of:
(entity legally obligated to pay the award)

(A) Additional temporary disability indemnity in accordance with paragraph 2(a) above,

(B) Permanent disability indemnity in accordance with paragraph 3 above,

Less the sum of $ 207.00, payable to applicant's attorney as the reasonable value of services rendered.
☐ Fees are to be commuted pursuant to Paragraph 6.

(C) Liens in accordance with Paragraph 7 above,

(D) Further medical treatment in accordance with Paragraph 4 above,

(E) Reimbursement for medical-legal expenses in accordance with Paragraph 5 above,

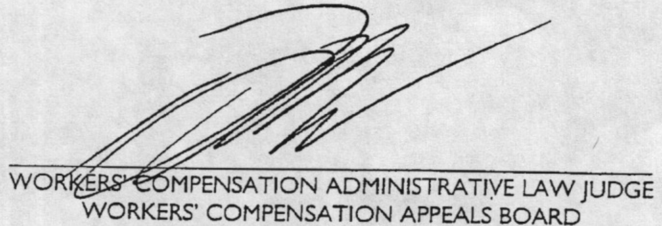
(F) Stipulations in Paragraph 8 and 9 are approved.

(G) The matter is ordered off calendar / set for status/lien conference.

(H) ADDENDUM TO STIPULATIONS PARAGRAPH 9 is Approved.

ADJ 7004227 is DISMISSED

3/8/11
(Dated)



WORKERS' COMPENSATION ADMINISTRATIVE LAW JUDGE
WORKERS' COMPENSATION APPEALS BOARD

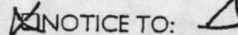
On 3/8/11, this document ☐ was personally served on all persons appearing at the hearing on said date, as set forth in the minutes of that hearing ☒ was personally served on

S. Vidim

☐ was served by mail on all persons listed on the Official Address Record ☐ was served by mail on following party or parties:

By

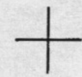
☒ NOTICE TO: Δ



Pursuant to Rule 10500, you are designated to serve this document on all parties shown on the Official Address Record, together with a proof of service. You shall maintain this proof of service, which shall not be filed with the WCAB unless a dispute arises regarding service. A copy of the current Official Address Record accompanies this notice.

PRINT CLEAR

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



ADJ7010682
Case No.

Date of Injury 03/26/2009
MM/DD/YYYY

549-23-5133
SSN (Numbers Only)

RECEIVED

MAR 08 2011

DIVISION OF
WORKERS COMPENSATION
STOCKTON OFFICE

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).)
- [x] 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
- [x] Self-Insured
- [ ] Legally Uninsured
- [ ] Uninsured

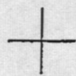
SAN JOAQUIN COUNTY MOSQUITO AND VECTOR CONTROL DISTRICT
Employer Name (Please leave blank spaces between numbers, names or words)

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 know[illegible] and if applicable - include even if carrier [illegible]djusted 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	CA	95826
City	State	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	CA	95826
City	State	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)

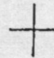
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

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)

Case ID: ADJ7010682
{A1D663CB-85E9-4395-A94A-0F6C53E1FCCC}



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)

{A1D563CE-85E9-4396-A94A-0F6C53E1FCCC}

☐ 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

Case ID:ADJ7070682 {A1D[illegible]-3595-4944-0F6C58E1FCCC}

☑ Specific Injury

ADJ7070682
Case Number 1

☐ Cumulative Injury

03/26/2009
(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 RIGHT   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)

Case ID: ADJ7041082

2. The injury (ies) caused temporary disability for the period ______ (MM/DD/YYYY) through ______ (MM/DD/YYYY) for which indemnity has been paid at $ ______ (Indemnity Paid) per week.

2(a). The injury(ies) caused additional temporary disability for the period ______ (MM/DD/YYYY) through ______ (MM/DD/YYYY) at the rate of $ ______ (Rate) in the amount of $ ______ (Indemnity Paid)

3. The injury(ies) caused permanent disability of 2 % for which indemnity is payable at $ 230.00 (Indemnity Rate) per week beginning 09/08/2010 (MM/DD/YYYY) in the sum of $ 1,380.00 , less credit for such payments 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 09/08/2010 (MM/DD/YYYY)

☐ Not Applicable

or, $1,173.00, less credit of $2,225.42, ~~leaving defendant a total indemnity credit of $1,052.42~~. sd

TA

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

TA

6. Applicant's attorney requests a fee of $ 207.00

☐ Fees to be commuted as follows:

7. Liens Against compensation are payable as follows:

NONE KNOWN.

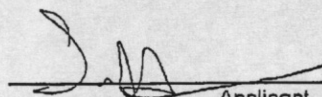
8.Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

{A1D663CB-85E9-4596-A94A-0F6C53E1FC0C}

9.Other stipulations:

SEE ATTACHED ADDENDUM INCORPORATED HEREIN.

Dated 12-23-10
MM/DD/YYYY



Applicant

3-8-11 TA

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

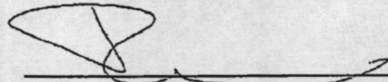
4521 QUAIL LAKES DRIVE
Address/PO Box (Please leave blank spaces between numbers, names or words)

STOCKTON
City

CA
State

95207
Zip Code

Dated 12/23/10
MM/DD/YYYY



Applicant Attorney Signature

Defendant's Attorney or Authorized Representative: ILCALJA010952

☑ Law Firm/Attorney {A1D...} ☐ Non Attorney Representative ...94A-0F6C53E1F02C}

ERIC
First Name

HELPHREY
Last Name

5185268
Firm Number

STOCKWELL HARRIS SACRAMENTO
Law Firm Name

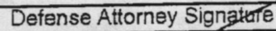
1545 RIVER PARK DRIVE SUITE 330
Address/PO Box (Please leave blank spaces between numbers, names or words)

SACRAMENTO
City

CA
State

95815
Zip Code

Dated 1/11/11
MM/DD/YYYY



Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

☑ Law Firm/Attorney ☐ Non Attorney Representative

Sharon
First Name

Didion
Last Name

5185268
Firm Number

STOCKWELL HARRIS SACRAMENTO
Law Firm Name

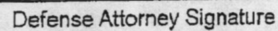
1545 RIVER PARK DR SUITE 330
Address/PO Box (Please leave blank spaces between numbers, names or words)

SACRAMENTO
City

Ca
State

95815
Zip Code

Dated 3/8/2011
MM/DD/YYYY



Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

{41DE60?B-85E9-4245-494A-0F6C58E1FCCC}

☐ 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: ADJ7004227; ADJ7004221 ADJ 7010682

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 4% 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.

D.
~~Defendant entitled to a future indemnity credit of $4,571.42, less permanent disability payout of $1,173.00 (ADJ7010682, date of injury: 3/26/09), leaving a total indemnity credit of $1,052.42 against the case cited herein, as well as ADJ7010682 (date of injury: March 26, 2009).~~ 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. TA TA

Defendants waive all claims of credit against future indemnity in ADJ 7004221 and ADJ 7010682 TA

Applicant waive all claims of increased rates, additional periods of disability or underpayment of benefits TA

Applicant/Employee: TIFFANY ANDERSON WCAB No(s). ADJ 7004221

AWARD

AWARD IS MADE in favor of TIFFANY ANDERSON against SAN JOAQUIN COUNTY MOSQUITO AND VECTOR CONTROL DISTRICT of:
(entity legally obligated to pay the award)

(A) Additional temporary disability indemnity in accordance with paragraph 2(a) above,

(B) Permanent disability indemnity in accordance with paragraph 3 above,

Less the sum of $ 414.00, payable to applicant's attorney as the reasonable value of services rendered.
☐ Fees are to be commuted pursuant to Paragraph 6.

(C) Liens in accordance with Paragraph 7 above,

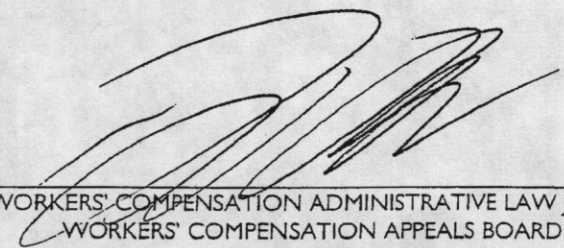
(D) Further medical treatment in accordance with Paragraph 4 above,

(E) Reimbursement for medical-legal expenses in accordance with Paragraph 5 above,

(F) Stipulations in Paragraph 8 and 9 are approved.

(G) The matter is ordered off calendar / set for status/lien conference.

(H)

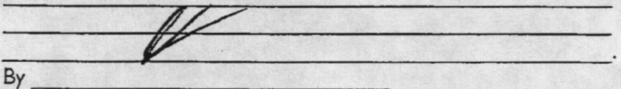


3/8/11
(Dated)

WORKERS' COMPENSATION ADMINISTRATIVE LAW JUDGE
WORKERS' COMPENSATION APPEALS BOARD

On 3/8/11, this document ☐ was personally served on all persons appearing at the hearing on said date, as set forth in the minutes of that hearing ☒ was personally served on S. Didion

☐ was served by mail on all persons listed on the Official Address Record ☐ was served by mail on following party or parties:



By

☒ NOTICE TO: S. Didion
Pursuant to Rule 10500, you are designated to serve this document on all parties shown on the Official Address Record, together with a proof of service. You shall maintain this proof of service, which shall not be filed with the WCAB unless a dispute arises regarding service. A copy of the current Official Address Record accompanies this notice.

PRINT CLEAR

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

ADJ7004221
Case No.

Date of Injury 06/19/2008
MM/DD/YYYY

549-23-5133
SSN (Numbers Only)

RECEIVED
MAR 08 2011
DIVISION OF WORKERS COMPENSATION STOCKTON OFFICE

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