

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

05009073-F581-3CA0-9E13-1F6F-A072E29

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) 151517104227
(35008076-F591-7CAU-0E13-1FBFA072E2A)

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)

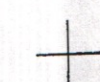
City _____ State _____ Zip Code _____

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

Case ID: ADJ7004221
(500007) FRI-7040-0613-1FBFA072E224

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

08/13/2010
MM/DD/YYYY

for which indemnity has been paid at \$ 602.59 per week.
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

3. The injury(ies) caused permanent disability of 4 % for which indemnity is payable at \$ 230.00
Indemnity Rate

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 9/8/10 MM/DD/YYYY

Not Applicable

All due and payable \$2,346.00 less
temporary disability credit of \$4,571.42,
less permanent disability payout for TR
ADJ7010682 (DOI: 3/26/09) of \$1,173.00,
leaving a total indemnity credit of \$1,052.42. S

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.

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9. Other stipulations:

SEE ATTACHED ADDENDUM INCORPORATED HEREIN

+

Dated

12-23-10

MM/DD/YYYY

3-8-11

[Signature]

Applicant

TR

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

[Signature]

Applicant Attorney Signature

+

Defendant's Attorney or Authorized Representative: IL-AD-0114227
 Law Firm/Attorney (504) 577-1613 Non-Attorney Representative 1FBFA072E204

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 11/16/11
MM/DD/YYYY

[Signature]
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. STE 330
Address/PO Box (Please leave blank spaces between numbers, names or words)

SACRAMENTO
City

CA
State

95858
Zip Code

Dated 3/8/2011
MM/DD/YYYY

[Signature]
Defense Attorney Signature

Defendant's Attorney or Authorized Representative: ID:AD70427

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

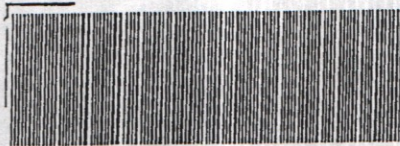
Permanent disability is based on Panel QME Dr. Tabaddor dated June 8, 2010, August 20, 2010 and September 7, 2010 at 2% permanent disability. This settlement resolves any and all claims for temporary disability (medical, TPD, TTD, wage loss, or any other form of TD) through the date of the award. This 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 (ADJ7004227). 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.~~

TR

Defendants waive all claims of overpayments against future indemnity in ADJ 7010682 or ADJ 7004227
Applicant waives all claims of additional periods of disability, incorrect rate for disability paid or underpayment of benefits

TR



STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

MINUTES OF HEARING

Case No. ADJ 7004221 ; ADJ 7004227 ; ADJ 7010682

Date of Hearing (MM/DD/YYYY) 03/08/2011

Hearing Information

Before AT Trial Conf MSC EXP. HEARING Lien

Request Date (MM/DD/YYYY) _____

Applicant

TIFFANY
First Name

MI

ANDERSON
Last Name

VS

Defendants

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

Appearances

Applicant Present Not Present

Attorney Hearing Rep

Applicant Represented By _____

Defendant Represented By STOCKWELL HARRIS SACRAMENTO by *Shawn Dick*

Others Appearing _____

Interpreter _____ Cert. No. _____

Party Making Request

Joint Applicant Defendant Other _____

Request For: Continuance OTOC Request By: Letter Telephone

Position of Opposing Party

Agree Oppose Unreachable Unknown

PROOF OF SERVICE

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STATE OF CALIFORNIA
COUNTY OF SACRAMENTO

I am in the County of Sacramento, State of California. I am over the age of 18 years and not a party to the within action. My business address is 1545 River Park Drive, Suite 330, Sacramento, California 95815-4616.

I served the foregoing document described as: **Minutes of Hearing, Award and Stipulations with Request for Award dated March 8, 2011** on all interested parties in this action by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid in the United States mailed at Sacramento, California, addressed as follows:

Ms. Tiffany Anderson
2 N. Avena Ave
Lodi, CA 95242

Ms. Mackenzie Dawson
AIMS Insurance (Sacramento)
Post Office Box 269120
Sacramento, California 95826-9120
(SEND ALL CORRESPONDENCE AND ENCLOSURES VIA E-MAIL ONLY)

Mr. John Stroh
San Joaquin County Mosquito & Vector Control District
7759 S. Airport Way
Stockton, CA 95206

Mr. Ronald M. Stein
Ronald M. Stein Law Offices
4521 Quail Lakes Drive
Stockton, CA 95207

I certify, under penalty of perjury, that the foregoing is true and correct.

Executed on March 14, 2011, at Sacramento, California.

By: Kathi Stokes
Kathi Stokes