

STATE OF CALIFORNIA
DWC DISTRICT OFFICE
E-COVER SHEET

Companion Cases Exist ☒

Location: CTL

More than 15 Companion Cases ☐

Walk Thru Yes ☐ No ☒

Date: (MM/DD/YYYY) 03/15/2010

Case Number*: ADJ7004221

SSN(Numbers Only) 549235133

☒ Specific Injury (If Specific Injury, use the start date as the specific date of injury)

☐ Cumulative Injury

06/19/2008

(START DATE: MM/DD/YYYY) *

(END DATE: MM/DD/YYYY)

Body Part 1 : 513 KNEE PATELLA

Body Part 2 :

Body Part 3 :

Body Part 4 :

Other Body Parts :

Please check unit to be filed on (check only one box)*

☒ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ VOC ☐ INT ☐ RSU

Companion Cases

Case 1: ADJ7010682

☒ Specific Injury (If Specific Injury, use the start date as the specific date of injury)

☐ Cumulative Injury

03/26/2009

(START DATE: MM/DD/YYYY)

(END DATE: MM/DD/YYYY)

Body Part 1 : 513 KNEE PATELLA

Body Part 2 :

Body Part 3 :

Body Part 4 :

Other Body Parts :

Case 2: ADJ7004227

☒ Specific Injury (If Specific Injury, use the start date as the specific date of injury)

☐ Cumulative Injury

07/02/2009

(START DATE: MM/DD/YYYY)

(END DATE: MM/DD/YYYY)

Body Part 1 : 513 KNEE PATELLA

Body Part 2 :

Body Part 3 :

Body Part 4 :

Other Body Parts :

**STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
NOTICE AND REQUEST FOR ALLOWANCE OF LIEN**

Date Of Original Lien (MM/DD/YYYY)*

☒ Original Lien ☐ Amended Lien

CASE No.

INFORMATION WILL BE OBTAINED FROM THE COVERSHEET

(Choose only one)

☐ a specific injury on

SPECIFIC AND CUMULATIVE TRAUMA INJURY INFORMATION WILL BE OBTAINED FROM THE COVERSHEET

(DATE OF INJURY: MM/DD/YYYY)

☐ a cumulative trauma injury beginning on

Thru

(START DATE: MM/DD/YYYY)

(END DATE: MM/DD/YYYY)

SSN (Numbers Only)

Information Will Be Obtained From The Coversheet

Date Of Birth (MM/DD/YYYY)

08/22/1970

Injured Worker

First Name

TIFFANY

MI

Last Name

ANDERSON

Address/PO Box

1516 SYLVAN WAY APT 205

City

LODI

State

CA

Zip Code (Numbers Only)

95242

Attorney/Representative for Injured Worker

Name

RONALD STEIN STOCKTON

Address/PO Box

4521 QUAIL LAKES DR

City

STOCKTON

State

CA

Zip Code (Numbers Only)

95207

Lien Claimant

Organization* ARS LEGAL

First Name*

Last Name*

Address/PO Box*

13925 WHITTIER BLVD

City*

WHITTIER

State*

CA

Zip Code* (Numbers Only)

90605

Phone (Numbers Only)

5626961181

Lien Claimant's Attorney / Representative, if any☐ Law Firm/Attorney ☐ Non Attorney Representative ☒ Lien Claimant Not RepresentedLien Claimant Law
Firm/Representative

First Name

Last Name

Address/PO Box

City

State

Zip Code (Numbers Only)

Phone (Numbers Only)

Employer

Name SAN JOAQUIN COUNTY MOSQUITO AND VECTOR C

Address/PO Box

44 N SAN JOAQUIN ST STE 550

City

STOCKTON

State

CA

Zip Code (Numbers Only)

95202

Insurance Carrier or Claims Administrator

Name ACCLAMATION SACRAMENTO

Address/PO Box PO BOX 269120

City SACRAMENTO

State CA

Zip Code (Numbers Only) 95826

Employer or Claims Administrator Attorney/Representative (if known)

Name STOCKWELL HARRIS SACRAMENTO

Address/PO Box 1545 RIVER PARK DR STE 330

City SACRAMENTO

State CA

Zip Code (Numbers Only) 95815

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow
as a lien the sum of \$ 401.20 against any amount now due or which may hereafter
Total Lien Amount*

become payable as compensation to the above-named employee on account of the above-claimed
injury.

This request and claim for lien is for (mark appropriate box):

- ☐ A reasonable attorney's fee for legal services pertaining to any claim for compensation either before the appeals board or before any of the appellate courts, and the reasonable disbursements in connection therewith. (Labor Code § 4903 (a).)
- ☐ The reasonable expense incurred by or on behalf of the injured employee, as provided by Labor Code § 4600. (Labor Code § 4903 (b).)
- ☐ Reasonable expense incurred by or on behalf of the injured employee for medical-legal expenses. (Labor Code § 4903 (b).)
- ☐ The reasonable value of the living expenses of an injured employee or of his or her dependents, subsequent to the injury. (Labor Code § 4903 (c).)
- ☐ The reasonable burial expenses of the deceased employee. (Labor Code § 4903 (d).)
- ☐ The reasonable living expenses of the spouse or minor children of the injured employee, or both, subsequent to the date of the injury, where the employee has deserted or is neglecting his or her family. (Labor Code § 4903 (e).)
- ☐ The reasonable fee for interpreter's services performed on
(Labor Code § 4600 (f).) (MM/DD/YYYY)
- ☐ The amount of indemnification granted by the California Victims of Crime Program. (Labor Code § 4903 (i).)
- ☐ The amount of compensation, including expenses of medical treatment, and recoverable costs that have been paid by the Asbestos Workers' Account. (Labor Code § 4903 (j).)
- ☒ Other Lien(s): Specify nature and statutory basis. Field size limited to 585 characters

LABOR CODE 4620 LEGAL PHOTOCOPY

NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

- ☒ A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

(Signature of Attorney/Representative for Lien Claimant)

S KLARA RUIZ

(Signature of Lien Claimant)

03/15/2010

(MM/DD/YYYY)