State of California
Division of Workers' Compensation
Disability Evaluation Unit

DEU Use Only

EMPLOYEE'S DISABILITY QUESTIONNAIRE

This form will aid the doctor in determining your permanent impairment or disability. Please complete this form and give it to the physician who will be performing the evaluation. The doctor will include this form with his or her report and submit it to the Disability Evaluation Unit, with a copy to you and your claims administrator.

Employee

Tiffany V
First Name MI

Anderson
Last Name

549-23-5133
SSN (Numbers Only)

2 N Avena Ave
Street Address1/PO Box (Please leave blank spaces between numbers, names or words)

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

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

Lodi **CA** **95240**
City State Zip Code

Date of Birth **8/22/1970**
MM/DD/YYYY

Date of Injury **6/29/2011**
MM/DD/YYYY

San Joaquin County MVCK
Employer

Nature of Employers Business

Claim Number 1 **VE0700184**

Claim Number 2 _____

Claim Number 3 _____

Claim Number 4 _____

Claim Number 5 _____

PLEASE ANSWER THE FOLLOWING QUESTIONS FULLY:
How was your evaluating doctor selected? (check one)

☒ From a list of doctors provided by the Sate of California, Division of Workers' Compensation

☐ Other (explain) QME Insurance Choice

What is the name of the doctore who will be doing the evaluation? **Khosrow Tabaddor, M.D.**

When is your examination scheduled? **3/27/2012**

What were your job duties at the time of your injury?

applied pesticides to pastures, dairy ponds ditches

What is the disability resulting from your injury?

right knee

How does this injury affect you in your work?

I cant work right now.

Have you ever had a disability as a result of another injury or illness? yes

If so, when? 2004, 2005, ~~2005~~, ~~2008~~ 2008, 2009, 2011

Please describe the disibility.

4 ~~5~~ exposures to unknown & 3 right knee surgies

Date 3-27-12
MM/DD/YYYY

Signature _____

STATE OF CALIFORNIA

Division of Workers' Compensation - Medical Unit
P.O. Box 71010, Oakland, CA 94612
(510) 286-3700 or (800) 794-6900

QUALIFIED MEDICAL EVALUATOR'S FINDINGS SUMMARY FORM
UNREPRESENTED INJURED EMPLOYEE CASES ONLY

EMPLOYEE

Tiffany Anderson	549-23-5133	6/29/2011
1. Employee Name (First, Middle, Last)	2. Social Sec No (Optional)	3. Date of Injury (Mo/ Dy /Yr)

2 N Avena Ave	Lodi, CA	95240	(209) 625-8575
4. Street Address	City	Zip	5. Phone

CLAIMS ADMINISTRATOR *(if none, enter Employer information)*

AIMS ACCLAMATION INSURANCE MANAGEMENT SERVICES

6. Name

P.O. Box 269120	Sacramento, CA	95826-9120	(916) 563-1900
7. Street Address	City	Zip	8. Phone

EVENT DATES

12/29/2011	3/27/2012	
9. Date of Appointment Call	10. Date of initial Examination	11. Date of Referral for Medical Testing/Consultation

12. Date AME/QME's Report Served on all Parties

12b. Date(s) of all prior report(s) served by this QME?

DISPUTED MEDICAL ISSUES AND CONCLUSIONS

13. The following medical issues will be used to determine the injured employee's eligibility for workers' compensation benefits.

(Check the appropriate box)

	Yes	No	Pending or Info. Not Sent
a. Has the condition reached permanent and stationary status or maximum medical improvement?	☒	☐	☐
b. Is there permanent impairment/disability?	☐	☒	☐
c. Did work cause or contribute to the injury or illness?	☒	☐	☐
d. If permanent disability exists, is apportionment warrented?	☐	☒	☐
e. Is there a need for current or future medical care?	☒	☐	☐
f. Can this employee now return to his/her usual job?	☒ Yes	☐ No	

If yes:

i. Without restrictions	☐ Yes	☐ No	If YES, Date: _____
ii. With restrictions	☒ Yes	☐ No	If YES, Date: _____

BASIS FOR CONCLUSIONS

(Check the appropriate box)

	Yes	No	Pending or Info. Not Sent
14. Are there subjective complaints.	☒	☐	☐
15. Are there any abnormal physical or psychological examination findings?	☒	☐	☐
16. Are impairments described and measured using:			
(For non-psyche injuries) the AMA Guides?	☒	☐	☐
(For psyche injuries) the GAF and 2005 PD Schedule?	☐	☐	☒

	Yes	No	Pending or Info. Not Sent
17. If the AMA Guides are used, are pernentages of impairment stated?	☒	☐	☐
18. Are there any relevant diagnostic test results (x-ray/laboratory)?	☐	☒	☐
19. What are the diagnoses? (List)			
20. Were medical records reviewed?	☒	☐	☐
21. Were other physicians consulted?	☐	☒	
22. Are there any unresolved disputed issues beyond the scope of your licensure or clinical competenct that should be addressed by an evaluator in a different specialty?	☐	☒	

23. If the answer to #22 is yes, what disputed issue(s)?

24. Based on the answer in #23, what specialty (or specialties)?

QME

22. Signature [signature] Date 4-10-12

23. Name **Khosrow Tabaddor, M.D.** Specialty **Orthopaedic Surgeon**

24. Street Address **8221 N. Fresno St** City **Fresno** Zip **93720**

25. Phone **(559) 222-2294** Cal. License No.: **A 0040537**

Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))

Dianna A , declare:
(Print Name)

1. I am over the age of 18 and I am not a party to this case.
2. My business address is: **8221 N. Fresno St, Fresno, CA 93720**

3. On the date shown below, I served this QME Findings Summary Form with the original, or a true and correct copy of the original, comprehensive medical-legal report, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

B placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.

Means of service: *(For each addressee, Enter A-F as appropriate)*	Date:	Addressee and Address:
B	4-30-12	Tiffany Anderson, 2 N Avena Ave Lodi CA 95240
B	4-30-12	Mackenzie Dawson, P.O. Box 269120 Sacramento CA 95826-9120
B	4-30-12	L/O Stockwell Harris Woolverton Muehl, 1545 River Park Dr Ste 330 Sacramento CA 9

When report addresses PD:

4-30-12 Disability Evaluation Unit, DWC, Stockton

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date Signed: 4-30-12

deep
(Signature of Declarant)

Dianne A.
(Print Name)

Claims Administrator

AIMS ACCLAMATION INSURANCE MANAGEMENT SERVICES

Company Name

PO. Box 269120

Street Address1/PO Box (Please leave blank spaces between numbers, names or words)

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

Sacramento City | **CA** State | **95826-9120** Zip Code

VE0700184

Claim Number 1

Claim Number 2

Claim Number 3

Claim Number 4

Claim Number 5

Phone No. **(916) 563-1900**

Adjuster **Mackenzie Dawson**

Employer **San Joaquin County MVCK**

Employee

Tiffany First Name | MI

Anderson

Last Name

2 N Avena Ave

Street Address1/PO Box (Please leave blank spaces between numbers, names or words)

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

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

12/16/13

State of California

DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT

AME or QME Declaration of Service of Medical - Legal Report (Lab, Code § 4062.3(i))

Case Name: Tiffany Anderson *(employee name)* v AIMS ACCLAMATION INSURANCE MANAGEMENT SE *(claims administrator name, or if none employer)*

Claim No.: VE0700184 **EAMS or WCAB Case No. (if any):**

I, Nicholas Dennie, declare:

1. I am over the age of 18 and I am not a party to this case.
2. My business address is: **8221 N. Fresno St, Fresno, CA 93720**
3. On the date shown below, I served this QME Findings Summary Form with the original, or a true and correct copy of the original, comprehensive medical-legal report, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

A depositing the sealed envelope with the U.S. Postal Service with the postage fully prepaid.

X placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.

C placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.

D placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*

E personally delivering the sealed envelope to the person or firm named below at the address shown below.

Means of service: *(For each addressee, Enter A-E as appropriate)*	Date Served:	Addressee and Address:
B	4/30/2012	Tiffany Anderson, 2 N Avena Ave Lodi CA 95240
B	4/30/2012	AIMS ACCLAMATION INSURANCE MANAGEMENT SERVICES, P.O. Box 269120
B	4/30/2012	L/O Stockwell Harris Woolverton Muehl, 1545 River Park Dr Ste 330 Sacramento CA 9

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: 4/30/2012

Nicholas Dennie

(Signature of Declarant)

Nicholas Dennie

(Print Name)

QME Form 122
(rev. February 2009)