STATE OF CALIFORNIA
WORKERS' COMPENSATION APPEALS BOARD

STC
14246
21961.2
21217

Thomas Beard

Applicant,

v.

San Joaquin County Mosquito Vector Control District, and AIMS Ins.

Defendant.

Case No.: ADJ 2342648
ADJ 1900614
ADJ 4409104
ADJ 1634890

ORDER APPROVING JOINT COMPROMISE AND RELEASE

(a) Based upon review of the record, including medical reports, recitations and offers of proof contained in the submitted settlement document(s), and/or discussions with or representations of the parties/lien claimants, the Compromise and Release is deemed adequate and should be approved. In determining the adequacy of the agreement, the following has been considered and approved (if checked):

[X] Release of potential death benefits per Sumner v. WCAB(1983), 48 CCC 369 and Johnson v. WCAB(1970), 35 CCC 362.

[ ] Release of benefits for any injuries which might occur during the course of any vocational rehabilitation plan or program, per Rodgers v. WCAB(1985), 50 CCC 299 and Carter v. County of L.A.(1986), 51 CCC 255.

(b) The following specific findings of fact are hereby made:

[X] Release of rehabilitation benefits, per Thomas v. Sports Chalet, Inc.,(1977), 42 CCC 625/ Labor Code §.4646, given the serious and good-faith issue as to injury AOE/COE (or affirmative defense) proffered, which if decided adverse to applicant/claimant would defeat the entitlement therein to any and all benefits. The detailed offer of proof contained in the C&R is adopted and incorporated herein as a finding of fact.

[X] Other: Thomas finding is [illegible] of CT 1/9/07 limited to denied parts of body (left knee), 1/9/07 (back, rt. knee, ribcase), and CT 1/9/07 (sleep disorder)

→ Applicant retains Award of open future medical care for rt. knee, Left knee, and low back

An attorney's fee of $ 2,250.00 is found to be reasonable and is therefore allowed.

IT IS ORDERED THAT THE COMPROMISE AND RELEASE BE, AND IS, APPROVED.

(c) AWARD is made in favor of: Thomas Beard (applicant), and against

AIMS Ins. (defendant), in the sum of: $ 15,000.00

less approved attorney fee of: $ 2,250.00

less PDA's $ 4,140.00

less _____ $ —

Balance payable to applicant: $ 8,610.00

~~Less credit for permanent disability advanced, as set forth in the Compromise and Release.~~

The WCAB retains jurisdiction over liens filed and perfected to date, penalty and interest, as well as any benefit not resolved.

Date: 6/2/09

NOTICE: J. Duarte *is hereby designated under Rule 10500; is ORDERED to serve a copy of this order on all parties/lien claimants on the Official Address Record. SERVED on designee by* e *on* 6/2/09

DAVID D. BOVETT
Workers' Compensation Judge

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
COMPROMISE AND RELEASE

RECEIVED
JUN 02 2009
DIVISION OF WORKERS COMPENSATION STOCKTON OFFICE

ADJ2342648
Case Number 1

ADJ1034890
Case Number 4

ADJ1900614
Case Number 2

Case Number 5

ADJ4409104
Case Number 3

558-76-6159
SSN (Numbers Only)

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 Document Cover Sheet)

Employee(Completion of this section is required)

THOMAS
First Name

MI

BEARD
Last Name

2937 TOYON DRIVE APT 2
Address/PO Box (Please leave blank spaces between numbers, names or words)

STOCKTON
City

CA
State

95201
Zip Code

Employer Information (Completion of this section is required)

☐ Insured ☑ Self-Insured ☐ Legally Uninsured ☐ Uninsured

SAN JOAQUIN COUNTY MOSQUITO 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

Applicant's Attorney or Authorized Representative:

☑ Law Firm/Attorney ☐ Non Attorney Representative

DAVID
First Name

ROCKWELL
Last Name

5053458
Law Firm Number

FRAILING ROCKWELL MODESTO
Law Firm Name

PO BOX 0142
Address/PO Box (Please leave blank spaces between numbers, names or words)

MODESTO
City

CA
State

95353
Zip Code

Defendant's Attorney or Authorized Representative:

☑ Law Firm/Attorney ☐ Non Attorney Representative

ERIC
First Name

HELPHREY
Last Name

5185268
Law 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

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

AIMS INSURANCE
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

IT IS CLAIMED THAT:

1. The injured employee, born 09/24/1949 (DATE OF BIRTH: MM/DD/YYYY), alleges that while employed as a(n)

CONTROL TECH I (OCCUPATION AT THE TIME OF INJURY), sustained injury arising out of and in the course of employment at the locations and during the dates listed below:

(State with specificity the date(s) of injury(ies) and what part(s) of body, conditions or systems are being settled.)

☑ Specific Injury

ADJ2342648 — Case Number 1

☐ Cumulative Injury

05/22/1995 (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: _____

The injury occurred at JOBSITE
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

THORNTON (City), CA (State) _____ (Zip Code).

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ Specific Injury

ADJ1900614
Case Number 2

☑ Cumulative Injury

// (Start Date: MM/DD/YYYY) 01/09/2007 (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: 420 BACK Body Part 3: 880 BODY SMS

Body Part 4: _____ Other Body Parts: RIBS, SLEEP DISORDER

The injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

RIPON (City), CA (State) _____ (Zip Code).

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☑ Specific Injury

ADJ4409104
Case Number 3

☐ Cumulative Injury

01/09/2007 (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: 420 BACK Body Part 3: 880 BODY SMS

Body Part 4: _____ Other Body Parts: RIB CAGE

The injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

RIPON (City), CA (State) _____ (Zip Code).

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ Specific Injury

ADJ1034890
Case Number 4

☑ Cumulative Injury

// (Start Date: MM/DD/YYYY) 01/09/2007 (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 513 KNEE (LEFT) Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

RIPON (City), CA (State) _____ (Zip Code).

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ Specific Injury

Case Number 5 ☐ 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: _____

The injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

_____ , _____ _____ .
City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

2. Upon approval of this compromise agreement by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge and payment in accordance with the provisions hereof, the employee releases and forever discharges the above-named employer(s) and insurance carrier(s) from all claims and causes of action, whether now known or ascertained or which may hereafter arise or develop as a result of the above-referenced injury(ies), including any and all liability of the employer(s) and the insurance carrier(s) and each of them to the dependents, heirs, executors, representatives, administrators or assigns of the employee. Execution of this form has no effect on claims that are not within the scope of the workers' compensation law or claims that are not subject to the exclusivity provisions of the workers' compensation law, unless otherwise expressly stated.

3. This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury set forth in Paragraph No. 1 and further explained in Paragraph No. 9 despite any language to the contrary elsewhere in this document or any addendum.

4. Unless otherwise expressly stated, approval of this agreement RELEASES ANY AND ALL CLAIMS OF APPLICANT'S DEPENDENTS TO DEATH BENEFITS RELATING TO THE INJURY OR INJURIES COVERED BY THIS COMPROMISE AGREEMENT. The parties have considered the release of these benefits in arriving at the sum in Paragraph 7. Any addendum duplicating this language pursuant to Sumner v WCAB (1983) 48 CCC 369 is unnecessary and shall not be attached.

5. Unless otherwise expressly ordered by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge, approval of this agreement does not release any claim applicant may have for vocational rehabilitation benefits or supplemental job displacement benefits.

6. The parties represent that the following facts are true: (If facts are disputed, state what each party contends under Paragraph No. 9.)

ALL SUBJECT TO PROOF

EARNINGS AT TIME OF INJURY $ 1,049.64

TEMPORARY DISABILITY INDEMNITY PAID 53,279.95 Weekly Rate $ 699.76

Period(s) Paid 01/10/2007 (Start Date: MM/DD/YYYY) 07/11/2008 (End Date: MM/DD/YYYY)

PERMANENT DISABILITY INDEMNITY PAID 4,140.00 Weekly Rate $ 230.00

Period(s) Paid 07/12/2008 (Start Date: MM/DD/YYYY) End date 11/14/2008 (End Date: MM/DD/YYYY)

TOTAL MEDICAL BILLS PAID $ 21,749.66 Total Unpaid Medical Expense to be Paid By: None by Defendant after date of Order Approving C&R.

Unless otherwise specified herein, the employer will pay no medical expenses incurred after approval of this agreement.

7. The parties agree to settle the above n(s) on account of the injury(ies) by the pay it of the SUM OF

$ 15,000.00
Settlement Amount

The following amounts are to be deducted from the settlement amount:

$ 4,140.00 for permanent disability advances through date of Order Approving C&R

$ _____ for temporary disability indemnity overpayment, if any.

$ _____ payable to _____

$ _____ payable to _____

$ _____ payable to _____

$ _____ payable to _____

$ 2,250 - requested as applicant's attorney's fee.

LEAVING A BALANCE OF $ 8,610 , after deducting the amounts set forth above and less further permanent disability advances made after the date set forth above. Interest under Labor Code section 5800 is included if the sums set forth herein are paid within 30 days after the date of approval of this agreement.

8. Liens not mentioned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary):

NONE KNOWN.

9. The parties wish to settle these matte[illegible] avoid the costs, hazards and delays of fur[illegible] itigation, and agree that a serious dispute exists as to the following issues (initial only those that apply). ONLY ISSUES INITIALED BY THE APPLICANT OR HIS/HER REPRESENTATIVE AND DEFENDANTS OR THEIR REPRESENTATIVES ARE INCLUDED WITHIN THIS SETTLEMENT.

Applicant	Defendant	
DR	EOA	earnings
DR	EOT	temporary disability
DR	EOJ	jurisdiction
DR	EOA	apportionment
DR	EOE	employment
DR	EOI	injury AOE/COE
DR	EOW	serious and willful misconduct
DR	EOD	discrimination (Labor Code §132a)
DR	EOS	statute of limitations
DR	EOF	future medical treatment save future medical treatment Award to applicant's right knee, left knee and low back only.
		other _____
DR	EOP	permanent disability _____
DR	EOS	self-procured medical treatment, except as provided in Paragraph 7
DR	EOV	vocational rehabilitation benefits/supplemental job displacement benefits

COMMENTS:

FUTURE MEDICAL TREATMENT TO APPLICANT'S RIGHT KNEE, LEFT KNEE AND LOW BACK ONLY. THIS SETTLEMENT RESOLVES EACH AND EVERY DATE OF CLAIMED INJURY BY THE APPLICANT DURING EMPLOYMENT WITH SAN JOAQUIN COUNTY MOSQUITO VECTOR CONTROL DISTRICT INCLUDING BUT NOT LIMITED TO: STK0144653 - DOI: 3/23/98; STK0156894 - DOI: 11/19/95; STK0181022 - DOI: CT-4/97; STK0124214 - DOI: CT-1/18/96; STK0124216 - DOI: 5/22/95; STK0098489 - DOI: 10/26/88; STK0144654 - DOI: 7/18/77; AND STK0140774 - DOI: 5/18/78.
Defendant is still to provide medical treatment to right knee, left knee and low back only.

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

10. It is agreed by all parties hereto that the filing of this document is the filing of an application, and that the workers' compensation administrative law judge may in its discretion set the matter for hearing as a regular application, reserving to the parties the right to put in issue any of the facts admitted herein and that if hearing is held with this document used as an application, the defendants shall have available to them all defenses that were available as of the date of filing of this document, and that the workers' compensation administrative law judge may thereafter either approve this Compromise and Release or disapprove it and issue Findings and Award after hearing has been held and the matter regularly submitted for decision.

11. WARNING TO EMPLOYEE: SETTLEMENT OF YOUR WORKERS' COMPENSATION CLAIM BY COMPROMISE AND RELEASE MAY AFFECT OTHER BENEFITS YOU ARE RECEIVING TO WHICH YOU BECOME ENTITLED TO RECEIVE IN THE FUTURE FROM SOURCES OTHER THAN WORKERS' COMPENSATION, INCLUDING BUT NOT LIMITED TO SOCIAL SECURITY, MEDICARE AND LONG-TERM DISABILITY BENEFITS.

THE APPLICANT'S (EMPLOYEE'S) SIGNATURE MUST BE ATTESTED TO BY TWO DISINTERESTED PERSONS OR ACKNOWLEDGED BEFORE A NOTARY PUBLIC

By signing this agreement, applicant (employee) acknowledges that he/she has read and understands this agreement and has had any questions he/she may have had about this agreement answered to his/her satisfaction.

Witness the signature hereof this 10 day of MAY, 2009 at 2:30 PM

Witness 1 (Date) 5/10/09

Witness 2 (Date) 5/10/09

Interpreter (Date)

X Applicant (Employee) (Date) 5/10/09

Attorney for Applicant (Date) 5/13/09

Attorney for Defendant (Date) 5/20/09

Attorney for Defendant (Date)

Attorney for Defendant (Date)

Attorney for Defendant (Date)

RE: Beard, Tom vs. San Joaquin County MVCD
WCAB #: ADJ2342648; ADJ1900614; ADJ4409104; ADJ1034890
CLAIM #: VE0700048

ADDENDUM TO COMPROMISE & RELEASE

Future Medical Treatment Award: This settlement includes a future medical treatment award to applicant's right knee, left knee and low back only. All other aspects of any/all other claims are settled herein.

Thomas Finding: There is a genuine good-faith dispute of injury AOE/COE on which a finding adverse to the applicant would entirely defeat applicant's right to workers' compensation benefits regarding the denied body parts (CT-1/9/07, left knee; 1/9/07, back, right knee, ribcage; CT-1/9/07, sleep disorder). The parties expressly settle applicant's rights, if any, to vocational rehabilitation benefits and request a finding of a good-faith issue under *Thomas vs. Sports Chalet, Inc.* 42 CCC 625 (1977). This finding is based in part on the opinion of Agreed Medical Examiner Donald Pang, M.D. and affirmative defenses including post-termination defense. Applicant stipulates to no injury AOE/COE as to the specific dates of injury and body parts listed above only.

General Release Of Workers' Compensation Claims: The 1/9/07 admitted back and knee disability is 9% adjusted after apportionment of 25%. Any right knee disability is subject to apportionment under Labor Code §4663 based on the Award of 11/4/04 of 25%. The left knee disability is subject to apportionment under Labor Code §4663 based on the Award of 6/26/97 at 15-1/4%. The parties stipulate there are no additional claims for any workers' compensation benefits during any period of employment with San Joaquin County Mosquito Vector Control District, permissibly self-insured regarding the body parts identified above. The intent of this settlement is to resolve any and all aspects of all workers' compensation claims, whether filed or not, as a result of all periods of employment with San Joaquin County Mosquito Vector Control District, permissibly self-insured regarding the body parts identified above. This settlement specifically resolves any claims for self-procured expenses, mileage, out-of-pocket expenses, or any other claimed workers' compensation benefits. This release is limited to workers' compensation issues only. Future medical treatment to the right knee, left knee and low back is not resolved herein.

Labor Code Section 5800 Interest: The parties stipulate that Labor Code Section 5800 Interest is waived in consideration if payment is made within 25 days. The defendants shall make payment of the Order Approving Compromise and Release no later than 25 days after defendant's receipt of the duly issued Order Approving Compromise and Release. It is agreed that if there is any untimely payment of the Order Approving Compromise and Release, any penalty owed shall be owed on the Compromise and Release settlement amount listed in the Compromise and Release and shall not attach to any species of benefits previously paid or allegedly owed by the defendant prior to the date of the Order Approving Compromise and Release.

Dated: 5-10-09 X Tom Beard
Thomas Beard, Applicant

Dated: 5-13-09 David Rockwell
David Rockwell, Applicant's Attorney

Dated: 5/26/09
Eric G. Helphrey, Defense Attorney

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

MINUTES OF HEARING

ADJ2342648 ADJ1034890
ADJ1900614
ADJ4409104
Case No.

6-2-09
Date of Hearing (MM/DD/YYYY)

Hearing Information

☐ Before ☒ AT ☐ Trial ☐ Conf ☐ MSC ☐ EXP. HEARING ☐ Lien

Request Date (MM/DD/YYYY) _____

☒ Walk-through

Applicant

Thomas
First Name

MI

Beard
Last Name

VS

Defendants

San Joaquin County Mosquito Vector Control District
Employer Name (Please leave blank spaces between numbers, names or words)

Appearances

			Attorney	Hearing Rep
Applicant	☐ Present	☒ Not Present		
Applicant Represented By	Jeff Ovarte, FRK+D		☒	☐
Defendant Represented By			☐	☐
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

Decision

☐ OTOC ☑ C&R / STIPS Submitted for Approval ☑ C&R / STIPS Approved

☐ LIEN STIPS and ORDER Approved ☐ N.O.I. to Allow/Disallow Issued

☐ MSC ☐ CONF ☐ TRIAL ☐ LIEN TRIAL ☐ CONTD TESTIMONY

Set On _____ At _____
MM/DD/YYYY

Location _____

Before Judge _____

☐ Supplemental Pages Attached _____ Pages

6/2/09
Date - MM/DD/YYYY

WORKERS' COMPENSATION ADMINSTRATIVE LAW JUDGE

Notice To J. Duarte

Pursuant to Rule 10500 you are designated to serve this/these document(s) on all parties.

☒ Served on parties and lien claimants present

NOTICE TO PARTIES: **Disability accommodation is available upon request.** Any person with a disability requiring an accommodation, auxiliary aid or service, or a modification of policies or procedures to ensure effective communication and access to the programs of the Division of Workers' Compensation should contact the **Disability Accommodation Coordinator** at the local District Office of the WCAB, or the **state-wide Disability Accommodation Coordinator at 1-866-681-1459 (toll free). The state-wide Coordinator can also be reached through the California Relay Service, by dialing 711 or 1-800-735-2929 (TTY) or 1-800-855-3000 (TTY-Spanish).**
Accommodations can include modifications of policies or procedures or provision of auxiliary aids or services. Accommodations include, but are not limited to, an Assistive Listening System (ALS), a Computer-Aided Transcription System or Communication Access Realtime Translation (CART), a sign language interpreter, documents in Braille, large print or on computer disk, and audio cassette recording. Accommodation requests should be made as soon as possible. Requests for an ALS or CART should be made no later than five (5) days before the hearing

DIA WCAB FORM 10 (REV. 7/81)
STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS

WORKERS' COMPENSATION APPEALS BOARD

ANSWER OF DEFENDANT

Tom Beard
(INJURED EMPLOYEE)

VS.

San Joaquin County Mosquito Vector Control District
(CORRECT NAME OF EMPLOYER, INDICATE IF SELF-INSURED)

AIMS Insurance
(CORRECT NAME OF INSURANCE CARRIER OR IF SELF-INSURED, ADJUSTING AGENCY)

Case No. STK 0212117

Date of alleged injury: CT- 1/9/07

7759 South Airport Way
Stockton, CA 95206
(EMPLOYER'S ADDRESS AND ZIP CODE)

P.O. Box 269120
Sacramento, CA 95826
(INSURANCE CARRIER OR ADJUSTING AGENCY'S ADDRESS AND ZIP CODE)

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DIVISION OF WORKERS COMPENSATION STOCKTON OFFICE

ANSWERING DEFENDANTS deny the allegations of the application as indicated below with such explanations as expressly set forth and admit all other material allegations.

DENIALS (Mark X if allegation is denied)		EXPLAIN BELOW
	Employment	
	Occupation	
x	Injury	denied (IF DENIAL IS BASED ON DATE OR PART OF BODY INJURED, EXPLAIN FULLY)
	Insurance coverage	(CHECK IF EMPLOYER HAS BEEN NOTIFIED TO APPEAR AND DEFEND)
x	Liability for self-procured treatment	reasonable and necessary
x	Liability for future medical treatment	reasonable and necessary
x	Medical-legal costs	reasonable and necessary
	Earnings	
x	Periods of disability	(GIVE LAST DAY WORKED AND CORRECT DATE OF RETURN TO WORK)
x	Rehabilitation	denied pending appropriate evidence and/or demands
x	Permanent disability	apportionment (IF APPORTIONMENT IS CLAIMED, SO STATE)

IT IS FURTHER ALLEGED:

1. Defendants have paid disability indemnity in the total amount of $ Subject to Proof at the rate of $ _____ a week beginning _____ through _____

   plus _____

2. Affirmative defenses and other matters: All affirmative defenses permitted under California law, including the Labor Code, California Code of Regulations, and case law; post-termination defense and non-discriminatory good faith personnel action; contributions and credits and judicial notice of all other cases.

Defendants do not waive the right to raise additional issues in accordance with the provisions of law and the Rules of Practice if other issues develop.

see attached proof of service

Dated at Sacramento, California, December, 2007

(EMPLOYER OR INSURANCE CARRIER)

By: Eric G. Helphrey, Esq.

Stockwell, Harris, Widom, Woolverton & Muehl
(ADDRESS AND TELEPHONE NUMBER OF ATTORNEY)

1545 River Park Dr., Suite 330, Sacramento, CA 95815

WCAB-10

Beard, Tom

PROOF OF SERVICE

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.

On 12/14/2007, I served the foregoing document described as: **Answers of Defendant – STK 0211962, STK 0211961, STK 0212117** 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:

Workers' Compensation Appeals Board
31 E. Channel Street, Room 344
Stockton, CA 95202

Ms. Mackenzie Dawson
AIMS Insurance
Post Office Box 269120
Sacramento, California 95826-9120

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

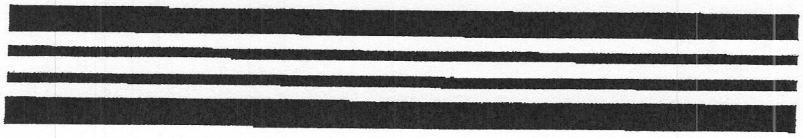
Mr. David N. Rockwell
Frailing, Rockwell & Kelly
Post Office Box 0142
Modesto, CA 95353-0142

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

Executed on 12/14/2007, at Sacramento, California.

By: Kathi Stokes

Kathi Stokes



STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS

WORKERS' COMPENSATION APPEALS BOARD

SEE REVERSE SIDE FOR INSTRUCTIONS

APPLICATION FOR ADJUDICATION OF CLAIM
(PRINT OR TYPE NAMES AND ADDRESSES)

CASE No. ~~Unassigned~~ STK 211217

M r. Tom Beard

Social Security No.: 558-76-6159

(APPLICANT, IF OTHER THAN INJURED EMPLOYEE)

VS.

San Joaquin County Mosquito & Vector Control

(EMPLOYER - STATE IF SELF-INSURED)

AIMS

(EMPLOYER'S INSURANCE CARRIER OR, IF SELF-INSURED, ADJUSTING AGENCY)

2937 Toyon Dr. #2
Stockton, CA 95201
(INJURED EMPLOYEE'S ADDRESS AND ZIP CODE)

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NOV 15 2007
DIVISION OF WORKERS' COMPENSATION STOCKTON OFFICE

(APPLICANT'S ADDRESS AND ZIP CODE)

7759 S. Airport Way
Stockton, CA 95206
(EMPLOYER'S ADDRESS AND ZIP CODE)

P.O. Box 269120
Sacramento, CA 95826
(INSURANCE CARRIER OR ADJUSTING AGENCY'S ADDRESS)

IT IS CLAIMED THAT:

1. The injured employee, born 09/24/1949 (DATE OF BIRTH), while employed as a Control Tech I (OCCUPATION AT TIME OF INJURY)
   on CT through 1/9/07 (DATE OF INJURY) at Ripon, Ca (ADDRESS) (CITY) (STATE) (ZIP CODE)
   By the employer sustained injury arising out of and in the course of employment to
   Left knee
   (STATE WHAT PARTS OF BODY WERE INJURED)
2. The injury ocurred as follows: cumulative trauma
   (EXPLAIN WHAT EMPLOYEE WAS DOING AT TIME OF INJURY AND HOW INJURY WAS RECEIVED)
3. Actual earnings at time of injury were: maximum
   (GIVE WEEKLY OR MONTHLY SALARY OF HOURLY RATE AND NUMBER OF HOURS WORKED PER WEEK)
   (SEPARATELY STATE VALUE PER WEEK OR MONTH OF TIPS, MEALS, LODGING OR OTHER ADVANTAGES REGULARLY RECEIVED)
4. The injury caused disability as follows: 1/9/07 to present and continuing
   (SPECIFY LAST DAY OFF WORK DUE TO THIS INJURY AND BEGINNING AND ENDING DATES OF ALL PERIODS OFF DUE TO THIS INJURY)
5. Compensation was paid ____ (YES) ____ (NO) $ ____ (TOTAL PAID) $ ____ (WEEKLY RATE) ____ (DATE OF LAST PAYMENT)
6. Unemployment insurance or unemployment compensation disability benefits have been received since the date of injury
   ____ (YES) ____ (NO)
7. Medical treatment was received ____ (YES) ____ (NO) ____ (DATE OF LAST TREATMENT) All treatment was furnished by the Employer or Insurance Company ____ (YES) ____ (NO) Other treatment was provided or paid for by ____
   (NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE) Did Medi-Cal pay for any health care related to this claim ____ (YES) ____ (NO) doctors not provided or paid for by employer or insurance company who treated or examined for this injury are ____
   (STATE NAMES AND ADDRESSES OF SUCH DOCTORS AND NAMES OF HOSPITALS TO WHICH SUCH DOCTORS ADMITTED INJURIES)
8. Other cases have been filed for industrial injuries by this employee as follows:
   STK 0211961; 0211962
   (SPECIFY CASE NUMBER AND CITY WHERE FILED)
9. This application is filed because of a disagreement regarding liability for: Temporary disability indemnity X
   Permanent disability indemnity X Reimbursement for medical expense X Medical Treatment X
   Compensation at proper rate X Rehabilitation X Other (Specify) ____
   All CA LCS Benefits
   AND APPLICANT REQUESTS A HEARING AND AWARD OF THE SAME, AND FOR ALL OTHER APPROPRIATE BENEFITS PROVIDED BY LAW.

Dated at Modesto (CITY) California, 11/13/2007 (DATE)

David N. Rockwell DV VE
(APPLICANT'S ATTORNEY)

David N. Rockwell
Frailing, Rockwell, Kelly & Duarte
P.O. Box 0142 1600 "G" Street, Suite 203
Modesto, CA 95353-0142, (209) 521-2552
(ADDRESS AND TELEPHONE NUMBER OF ATTORNEY)

David N. Rockwell DV VE
Tom Beard (APPLICANT'S SIGNATURE)

DIA WCAB FORM 1 (REV. 7/81)
AI-Law

84 32595

STR 0212117

LCS 4906(g) STATEMENT FOR APPLICATION OR ANSWER

The undersigned employee and attorney hereby declare under penalty of perjury that they have not violated Labor Code Section 139.3 and that they have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

Tom Beard

Employee

Attorney

(This section to be used only if employee cannot sign)

I, _____, attorney for applicant herein, declare under penalty of perjury, based upon my own knowledge or upon information and belief, that the employee herein cannot sign the above Statement, and cannot sign for the following reason(s): _____

_____

_____.

_____

Attorney

PROOF OF SERVICE BY MAIL
(1013a, 2015.5, C.C.P.)

I am a citizen of the United States and a resident of the County of Stanislaus. I am over the age of eighteen years and not a party to the within above-entitled action. My business address is FRAILING, ROCKWELL & KELLY, P.O. Box 0142, Modesto, CA, 95353-0142 (1601 I Street, Suite 150, Modesto, California 95354).

On November 14, 2007, I filed with the Workers' Compensation Appeals Board (by mailing) and served the within cover letter of this same date, Application for Adjudication of Claim and 4906(g) Statement regarding the injury (injuries) of:

Tom Beard

for the following date(s) of injury:

CT through 1/9/07.

on the parties listed below, by placing a true copy thereof enclosed in a sealed envelope with proper postage thereon fully prepaid, in the United States post office mail box at Modesto, California, addressed as follows:

Workers' Compensation Appeals Board
31 East Channel Street, Room 344
Stockton, CA 95202

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

AIMS
P.O. Box 269120
Sacramento, CA 95826

Mr. Tom Beard
2937 Toyon Dr. #2
Stockton, CA 95201

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

Executed on November 14, 2007 at Modesto, California.

Jacqui Espinoza