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July 2, 2008

Law Offices of Stockwell, Harris, Widom, Woolverton & Muehl
1545 River Park Drive, #330, Sacramento, California 95815-4616
Attention: Eric G. Helphrey, Esquire

Law Offices of Frailing, Rockwell, Kelly & Duarte
P.O. Box 0142, Modesto, California 95353
Attention: David N. Rockwell, Esquire

Patient	:	Tom Beard
Employer	:	San Joaquin County MCVD
D/Injury	:	1/9/2007; CT 1/7/2007
Claim #	:	VE0700048; V6201500
WCAB #	:	STK 0231242146; STK 0211962 3; STK 0211961 4; STK 212117
I.D.#	:	35834
Date of Exam	:	7/2/2008

Dear Mr. Rockwell & Mr. Helphrey:

I evaluated Mr. Tom Beard in orthopedic consultation for an injury to his spine and right lower extremity as an **Agreed Medical Examiner** in my Fremont office. I spent a minimum of thirty minutes with the patient and performed the history-taking, physical examination, record review and report preparation.

IDENTIFYING DATA

Mr. Beard is a 58 year-old English speaking right-handed male. According to L.C. 5703 (a)(1), I declare under penalty of perjury the attached bill accurately reflects the services performed and physician time expended to complete this ML104.94 evaluation. I reviewed more than 2100 pages of medical records and spent 20 hours reviewing the records; one hour and 15 minutes was spent interviewing the patient; three hours were spent preparing this report.

JOB DESCRIPTION

Mr. Beard states he has been employed for the San Joaquin Mosquito Abatement District from 1972 through February 2008.

His job duties required mixing and loading pesticides, driving trucks and inspecting various sites.

He relates requirements for standing, walking, gripping, grasping, pushing, pulling, lifting and carrying up to 35 pounds.

He denies any concurrent employment; he denies any employment since leaving the San Joaquin Mosquito Abatement District.

He states he lives in a condominium that has two floors; he is required to walk up and down stairs.

He has been a member of In-Shape Health Club for more than five years; he discontinued working out in 2007. He used to go three times per week and he would walk on a treadmill for 25 minutes; he would lift light weights and do some abdominal strengthening.

He volunteers for his church choir. He does not belong to any sports teams or clubs. He is not performing any home restoration projects or car remodeling projects.

HISTORY OF INJURY

It is my understanding that I am evaluating Mr. Beard's right knee and lower back. It is clear from the medical records that this patient sustained a prior injury to his left knee.

It is also apparent from the medical records that Mr. Beard sustained a prior injury to his lumbar spine in August 1979 while employed for the San Joaquin Mosquito Abatement District when someone ran into the back of his truck. He related complaints to J.H. Buckingham M.D. and Dr. Latham M.D. of discomfort in his neck and low back. No permanent disability was ever assigned.

In Mr. Beard's deposition of February 2008, he did not recall this event.

Referable to his left knee, Mr. Beard sustained an injury in December 1988 when he was descending an embankment, he slipped and fell onto his buttocks, he slid down and injured his left knee.

He went on to receive treatment provided by G. Murata M.D. His knee remained symptomatic most notable with kneeling, squatting, crawling and negotiating uneven surfaces.

Mr. Beard continued performing his usual and customary duties. On June 22, 1995, while walking along a bar ditch to inspect the water in it, the ground gave-way and he further injured his left knee. There is no indication that he injured his right knee at this time.

He went on to receive treatment through Dameron Hospital. He eventually came to the care of E. Cahill M.D.

By January 18, 1996, he underwent left knee surgery with a medial meniscectomy and chondral shaving of the medial femoral condyle and the lateral tibial plateau.

The patient continued to follow-up with Dr. Cahill. The medical records indicate that prior to the 1995 injury, Mr. Beard received a 9.3% award for the October 27, 1988 injury. Subsequent to the left knee surgery, Mr. Beard was evaluated in December 1996 by B. Kornblatt M.D.

Dr. Kornblatt stated that the patient could not squat without pain; he had a slight limp; he lacked 25 degrees of his ability to squat. He declared him permanent and stationary precluding him from running, prolonged negotiation of uneven surfaces, broken terrain, prolonged squatting, full squatting, kneeling and prolonged climbing. He felt the patient had lost 15% - 20% of his lifting capacity and he did not feel the patient was a qualified injured worker. Mr. Beard received a 15% settlement after the 9.3% was taken out as a result of the prior settlement for the 1988 injury.

There was no indication in this report from Dr. Kornblatt that there was any discomfort in the right knee.

The first mention of the right knee appears was in June 1997 when Mr. Beard was seen by Dr. Broderick M.D. with complaints of right knee pain that was felt to be a compensable consequence of his left knee.

Dr. Cahill assumed further care, who initially performed left knee surgery. There are further notations throughout 1997 indicating treatment for the left knee with the recommendation the patient use a gym.

Mr. Beard sustained an additional industrial injury with toxic exposure. He was evaluated by M. Duncan M.D. in June 1998 for toxic exposure.

By June 1998, Dr. Cahill comments the patient has bilateral knee pain. He comments the patient underwent right knee surgery. Mr. Beard states that at the age of 18, he underwent right knee surgery. There are confusing notations in that Mr. Beard states it was performed due to a bony growth; however, on several occasions, Dr. Cahill comments that the patient underwent a prior medial meniscectomy. Mr. Beard was noted to have essentially normal range of motion in March 1999. Dr. Cahill recommended a weight loss program.

Mr. Beard continued to follow-up. On September 13, 1999, Dr. Cahill comments the patient may have had an osteochondroma resected at the age of 18.

Mr. Beard was continued on anti-inflammatory medications with notations of bilateral knee discomfort. In April 2000, Dr. Cahill records the patient's weight at 293 pounds. By July 2000, Mr. Beard weighed 339 pounds. Dr. Cahill states that the patient's right knee has not been accepted as yet.

There are notations in the latter part of 2000 indicating that the patient's knee is doing all right. He does have an effusion. X-rays of the right knee dated November 6, 2000 revealed 3.0 mm. of joint space left along the medial aspect of the right knee. Dr. Cahill comments that Mr. Beard may ultimately require a high tibial osteotomy of the right knee. He again comments that the patient's right knee is secondary to compensating for the left knee.

Dr. Cahill continues to recommend a weight reduction program. By March 2001, there is documentation indicating 0 - 120 degrees of motion, down five degrees from the documented range of motion of March 1999.

In August 2001, Dr. Cahill comments Mr. Beard is still very heavy. He has been favoring his knees; he believes the right knee condition is secondary to overuse phenomena. The patient weighs in at 280 pounds in September 2001. Dr. Cahill continues to recommend a gym program and continued treatment with anti-inflammatory medications throughout 2002.

By January 2003, Dr. Cahill comments the patient's right knee has a medial joint line incision. He is not sure if the meniscus or bone was removed secondary to trauma at the age of 16 due to a football injury. Dr. Cahill reviewed the patient's right knee MRI scan and states that it looks like there has been a prior meniscectomy performed on the right knee. He feels the patient should undergo another arthroscopy. Apparently, the patient's MRI scan revealed a medial meniscus tear.

Dr. Cahill cautions the patient that he may not obtain full relief as it appears that the tear is degenerative in nature.

By January 17, 2003, the patient was evaluated by R. Baker M.D. Dr. Baker comments that the patient never recovered from the October 1988 slip on the left knee with episodic giving-way. He notes the patient is complaining of left greater than right knee pain. For the left knee, he notes complaints of 5/10 pain with episodic popping, clicking and periodic giving-way. He says the patient has fallen on several occasions. For the right knee, Dr. Baker states the patient demonstrates 4/10 pain with three to four flare-ups per year noting the pain can increase to 8/10. Sitting too long, carrying heavy loads, walking, running and negotiating uneven surfaces aggravate the right knee.

Dr. Baker comments the patient had a prior right knee surgery. He questions that the patient may have had an osteochondroma resected. He states the patient's right knee reflects the medial meniscus tear and he was advised that arthroscopy is indicated. He feels the right knee condition is secondary to cumulative trauma ending in April 1997, not due to over compensating for the left knee, but still industrially related.

Mr. Beard continues to receive treatment provided by Dr. Cahill. He goes on to receive a series of Synvisc injections into both knees, which provided symptomatic improvement. Dr. Cahill continues the patient at his usual and customary duties.

In September 2003, Mr. Beard was offered arthroscopy, which he declined. A self supervised gym program continues to be recommended. By January 21, 2004, x-rays of both knees were performed that revealed medial compartment narrowing with marginal osteophytes. Dr. Baker issued another report dated January 30, 2004 commenting that the patient has had no further trauma since he was last seen in January 2003.

He has continued working; he has had prior knee surgery and he is not currently interested in undergoing right knee surgery. Dr. Baker notes the patient is complaining of right knee pain on a daily basis aggravated with standing, walking and climbing stairs. The knee continues to swell; he states the left knee is more symptomatic. He states the patient can carry greater than 50 pounds or walk more than one to one and one-half miles. Dr. Baker states the patient demonstrated range of motion of 0 - 110 degrees bilaterally on examination. He states that Dr. Cahill previously advised the patient to avoid lifting greater than 50 pounds and to avoid kneeling, squatting, crawling or crouching. He states there has been no change in the left knee; he states the right knee has worsened over time and that the patient has gained 150 pounds since 1988. The patient weighed 190 pounds in high school. Dr. Baker states the patient should avoid any prolonged weight-bearing, repetitive climbing, repetitive squatting, kneeling, running and jumping. Dr. Baker feels that apportionment is indicated. He states the patient may have undergone a medial meniscectomy as a teenager that would pre-dispose him to osteoarthritis of the medial compartment regarding the right knee. He did not think the right knee was a compensable consequence of the left knee, but as a result of cumulative trauma ending in 1997. He feels there is a partial overlap between the permanent disability applied to the left knee by Dr. Kornblatt in 1996, i.e. the preclusion from running, prolonged or full squatting, kneeling and prolonged climbing.

Dr. Cahill continues to monitor the patient. The patient was also being monitored for hypertension throughout 2004 and 2005.

By September 2, 2005, Dr. Cahill noted the patient weighed 364 pounds and he continued the patient on narcotic pain and anti-inflammatory medications.

Mr. Beard continued performing his usual and customary duties. In his deposition, Mr. Beard states that since 2006, his knees were okay, but he was careful with walking on uneven ground, he would lift whatever he wanted to, but he attempted to avoid lifting greater than 50 pounds.

By January 9, 2007, the patient was on his truck, reaching up to a top tier and somehow he slipped, falling down and striking his chest on the truck. He sustained an abrasion to the left knee and swelling of the right knee.

Mr. Beard was seen by H. Rossman M.D., who noted a contusion and an abrasion. Dr. Rossman comments the patient has some chest pain with complaints of lower back discomfort with numbness and tingling extending down the left lower extremity.

An MRI scan of the lumbar spine was performed in January 2007 revealing spinal stenosis at L5, mild and degenerative disc changes at L4-5 and L5-S1.

Mr. Beard continued to follow-up with Dr. Rossman with ongoing complaints of knee discomfort. This prompted an MRI scan of the left knee performed on February 21, 2007 that revealed a posterior horn medial meniscus tear and a partial tear of the anterior cruciate ligament.

Mr. Beard was also seen by C. Hull M.D. On March 23, 2007, Dr. Hull documents 5/10 low back pain. In April 2006, Dr. Hull comments that the patient should undergo an MRI scan of the right knee.

By May 2, 2007, an MRI scan of the right knee was performed that revealed a tear of the anterior horn of the lateral meniscus, the posterior horn of the medial meniscus, a 7.2 mm. Baker's cyst, a Grade I MCL strain and the presence of an os chondral defect in the right proximal lateral tibial plateau. Dr. Hull continued to monitor the patient noting ongoing complaints of aching and throbbing discomfort.

By May 2007, Mr. Beard returned to the care of Dr. Cahill, who comments that the patient was complaining of catching in his knee and back. Dr. Hull continued to concurrently monitor the patient.

In June 2007, Dr. Cahill comments the patient was complaining of bilateral knee pain since his fall. The patient sustained an abrasion to the left knee with right knee swelling. Dr. Cahill comments that the old MRI scan revealed a posterior horn medial meniscus tear. The new MRI scan revealed an anterior horn lateral meniscus tear. Dr. Cahill states that the patient's biggest problem is obesity and he does not want surgery. Dr. Cahill recommends the patient proceed with the Synvisc injections.

By July 2007, Dr. Cahill comments the patient has done well losing weight and he has reduced his weight by 25 pounds. Dr. Cahill continues to recommend Synvisc injections, which were subsequently performed in the summer of 2007.

By September 18, 2007, Dr. Cahill comments that the patient may require total knee arthroplasties in the future. He now weighs 300 pounds.

Dr. Cahill issued a PR4 report dated December 19, 2007 indicating that the left knee remaining joint space places the patient with an 18% whole person impairment with the recommendation to avoid any lifting greater than 50 pounds, no frequent lifting greater than 25 pounds and occasionally 35 pounds. He states the patient should avoid uneven terrain due to his heavy weight. He states there has been no real change with the Synvisc injections. He states the patient would need to reduce his weight in order to undergo bilateral knee total arthroplasties. He states he apportioned 40% of the patient's impairment to his exogenous obesity and 60% to the multiple injuries from 1986 through 2007.

Mr. Beard continued to follow-up with Dr. Cahill. By March 11, 2008, Dr. Cahill comments the patient has attempted to lose some weight; he weighs 336 pounds. He uses a cane when he goes out. Dr. Cahill recommends the patient use Cosminds.

Mr. Beard has continued to follow-up with Dr. Cahill. He is seen today for an Agreed Medical Examination.

His deposition was taken in February 2008.

It is my understanding from the information that I received that I am evaluating the patient's right knee and back; his left knee has been denied.

PRIOR HISTORY

Mr. Beard states that in 2007, he was involved in a motor vehicle accident and hit another car while traveling at a speed of 20 miles per hour; he sustained no injuries.

PATIENT COMPLAINTS

Low Back

Mr. Beard continues to complain of low back pain at waist level with radiating pain extending into the posterior aspect of both calves.

The patient presented today without any assistive walking devices.

He states he can sit and walk between one to two hours. The symptoms prevent him from walking more than one mile. He can lift and carry heavy objects with extra discomfort. He can look after himself normally without extra discomfort. He states that he can perform moderate activities strenuously for two minutes.

He has some difficulty climbing a flight of stairs. He can push or pull light objects. He has a lot of difficulty reaching above shoulder level; he has some to a lot of difficulty reaching over shoulder level.

His sleep is moderately disturbed. There has been a moderate change in his ability to have intimate relations.

He describes his low back pain as a six at its worst, averaging a four.

Right Knee

Mr. Beard describes the knee pain as a 5/10 after extended periods of sitting and 8/10 with standing and walking-type activities.

He states the symptoms prevent him from walking more than one mile. He can stand or walk between one to two hours. He can lift and carry heavy objects, but with extra discomfort. He can perform moderate activities strenuously for up to two minutes.

He has some difficulty climbing one flight of stairs.

He can sit between one to two hours.

He has a lot of difficulty with kneeling, bending and squatting.

Overall, he states that some of the time, the pain interferes with his ability to travel, engage in social activities, concentrate and think and causes emotional distress, anxiety and depression. He states that a lot of the time, the pain interferes with his ability to engage in recreational activities.

Left Knee

Mr. Beard complains of pain described as 3/10 at rest, 8/10 with standing, walking, squatting and kneeling-type activities.

He relates a sensation of numbness around the knee posteriorly and anteriorly. As previously noted, he was complaining of some numbness and tingling emanating from the lumbar spine.

He has some difficulty climbing a flight of stairs. He has a lot of difficulty with squatting, kneeling and bending.

He states that the same activities that aggravate his back and right knee also aggravate his left knee condition.

When discussing the symptoms with Mr. Beard, when questioned specifically if he feels that his left knee is worse now than at the time he was evaluated by Dr. Baker, he feels that his symptoms are about the same.

MEDICAL HISTORY:

MEDICATIONS:	Vicodin; Ibuprofen; High blood pressure medications; aspirin; Aupro; Triamit/HCTZ; Afeditab; Clonidine Klor-Con; Metoprolol; Benazepril.
ALLERGIES:	None known.
PRIOR SURGERIES:	Denied.
FAMILY PHYSICIAN:	None.

PHYSICAL EXAMINATION

GENERAL APPEARANCE: Physical examination revealed a 58 year-old male who appeared comfortable during the history taking and arose without support.

The examination was performed in an attempt to avoid placing any of the patient's extremities through range of motion that would exacerbate or further complicate their injury. Care was taken to allow the patient to move through range of motion and to perform manual motor testing skills that would not further exacerbate their discomfort.

Height: 5'9"

LOW BACK EXAMINATION

General Examination:

The patient had a normal gait and was able to walk on his toes and heels. Upon examination of the lumbar spine, sacroiliac joints and sciatic notches, there was tenderness in the paraspinous muscles with spasms.

RANGE OF MOTION - BACK	Degrees of Motion	
Flexion	60 degrees	
Extension	30 degrees	
	Right	Left
Lateral bending	30 degrees	35 degrees
Hip/pelvic - 40 degrees		

Neurological Testing:
Straight leg raising test was to 80 degrees bilaterally with sciatica. Deep tendon reflexes were 1 at the patellae and 1 at the Achilles. Sensation to pinprick was intact in both lower extremities.

Vascular/Pulses:
There was no skin/color change, abnormal hair/nail growth, or varicosities noted in either extremity. Dorsalis pedis, posterior tibial, popliteal & femoral pulses are normal bilaterally.

MEASUREMENTS	Right	Left
ASIS to medial malleolus	93.0	93.0 cm.
Thighs - 15.0 cm. from superior pole of patella	66.0	66.0 cm.
Mid-patella	45.0	45.0 cm.
Maximum calves	50.0	50.0 cm.
Ankles	30.0	30.0 cm.

CREDIBILITY TESTS	
Axial loading	Appropriate.
Passive rotation	Appropriate.
Distraction test	Appropriate.
Diffuse tenderness	Appropriate.
Nonanatomic nerve dysfunction	Appropriate.
Histrionic movements	Appropriate.
Hypersensitivity	Appropriate.

LOWER EXTREMITY

KNEE EXAMINATION

General Inspection:
Examination revealed bilateral knee pain.

Range of Motion - Knees:
Range of motion of both knees was normal at 180 degrees extension and 135 degrees flexion.

Muscle Strength - Knees:
Testing of the extensor and flexor muscles of both knees was normal.

Special Tests/observations:

Varus/Valgus	Normal.
Patellofemoral Compression	Normal.
Apprehension	Normal.
McMurray's Test	Normal.
Lachman's Test	Normal.
Apley Test	Normal.
Pivot Shift Test	Normal.

Measurements:

	Right	Left
A.S.I.S. to medial malleolus	90.0	90.0 cm.
Thighs (10.0 cm. from sup. pole of patella)	48.0	48.0 cm.
Midpatellae	38.0	38.0 cm.
Maximum calves	37.0	37.0 cm.
Ankles	22.0	22.0 cm.

Credibility Tests:

Distraction test	Appropriate.
Diffuse tenderness	Appropriate.
Nonanatomic Nerve Dysfunction	Appropriate.
Histrionic Movements	Appropriate.
Hypersensitivity	Appropriate.

IMPRESSION

1. Transient flare-up of left knee pain from direct trauma.
2. Right knee posterior horn medial meniscus tear, anterior horn lateral meniscus tear.
3. Lumbar spine spinal stenosis at L5 with mild degenerative disc changes at L4-5 and L5-S1.

Maximum Medical Improvement
In my opinion, Mr. Beard has reached maximum medical improvement.

Using the AMA Guides, Mr. Beard does not fit into the range of motion guidelines as his pelvic/hip range of motion when compared to straight leg raising test is greater than 15 degrees and as such, contraindicates the use of the range of motion in this particular case.

I would place Mr. Beard in DRE Category II with non-verifiable radicular symptoms, asymmetric motion of the lumbar spine and spasms in the paraspinous musculature. I would assign Mr. Beard a 7% whole person impairment.

Referable to the right knee, taking into consideration Mr. Beard has not undergone formal arthroscopy of the right knee, but, but by analogy, utilizing table 17-33, Mr. Beard has a medial and lateral meniscus tear. I would assign him a 4% whole person impairment. By x-rays performed in my office today, Mr. Beard demonstrated narrowing along the medial joint line to 3.0 mm. Therefore, utilizing Table 17-31, Mr. Beard has a 3% whole person impairment for the total of a 7% whole person impairment for his right lower extremity.

For the left knee, Mr. Beard demonstrated joint space narrowing to 1.0 mm. according to Dr. Cahill, which is a 10% whole person impairment. In addition, Mr. Beard has an MRI scan of the left knee revealing a posterior horn medial meniscus tear. It is unclear whether or not this is a post surgical change or a new tear; however, if this is a new tear, assigning an impairment by analogy, utilizing Table 17-33, Mr. Beard would have a 1% whole person impairment for the total of an 11% whole person impairment for the left knee.

Referable to the patient's chest, he has no complaints at this time.

Referable to his sleep disorder, I would defer that issue entirely to a sleep specialist, as this is beyond my purview as an orthopedic surgeon.

CAUSATION

Based on Mr. Beard's history and review of the medical records, it is my opinion he sustained specific trauma to the right knee and the lumbar spine and a contusion to the left knee.

APPORTIONMENT

I feel apportionment is applicable.

Referable to the patient's knees, it is apparent that Mr. Beard sustained prior injuries to both knees. However, it appears that the left knee condition has returned to its baseline condition.

Thereby, while I have assigned this patient an impairment, based upon reasonable medical probability, from an orthopedic standpoint, taking into consideration Labor Code 4663 and 4664 and the Escobedo case, it appears that this impairment was pre-existing predating the specific injury of 2007.

To reiterate, I would apportion Mr. Beard's left knee condition entirely to pre-existing trauma predating the 2007 event. The 2007 event appears to have been a temporary lighting-up phenomena only.

Referable to the right knee, it is apparent that Mr. Beard has experienced right knee symptomatology predating the specific event of 2007. Dr. Baker previously listed the patient's complaints in 2003 as pain in the right knee, 4/10, increasing to 8/10 with sitting too long, carrying heavy loads, walking and running, noting he cannot walk on uneven ground. In January 2004, Dr. Baker noted complaints of daily pain in the right knee aggravated with standing, walking, climbing stairs and swelling, but that the left knee was worse. The patient could not lift greater than 50 pounds and he could not walk more than one and one-half miles. At that time, Dr. Baker stated that the right knee worsened over time. He recommended no prolonged weight-bearing, repetitive climbing, repetitive squatting, kneeling, running or jumping-type activities. At this time, I was asked to rate the patient using the AMA Guides. Thereby, while Labor Code 4664 would be applicable, it appears to be difficult to institute this labor code when rating between the two proposed guidelines.

Therefore, in my opinion, the joint space narrowing and the medial meniscus tear of the right knee pre-existed January 2007; the new right knee injury appears to be the lateral meniscus tear. Therefore, it appears that 1% of the patient's right knee impairment is apportionable to the new injury, as utilizing Table 17-33, a lateral meniscectomy would equal a 1% whole person impairment. The additional add-on would be for the patient's medial meniscectomy or analogy thereof.

Referable to the joint space narrowing, there have been notations that the patient has had medial compartmental narrowing dating all the way back to 2004.

Without the actual films for comparison between 2004 and 2007, in all likelihood, this patient has suffered from further industrially related cumulative trauma to the right knee resulting in further joint space narrowing.

I would state that the assignment of the 3% whole person impairment for the joint space narrowing, 50% of that would be apportioned to the patient's new injury and cumulative trauma extending up to 2007; and of the remaining 50%, I would apportion retrograde all the way to 2004 when the patient was declared permanent and stationary by Dr. Baker.

Referable to the lumbar spine, there are notations indicating low back pain dating back to 1979; however, it does not appear that he had any residuals from the 1979 injury. There were notations in 2004 indicating that he experienced some lower back discomfort.

It is apparent that Mr. Beard is over-weight and that the MRI scan of the lumbar spine revealed degenerative changes at L4-5 and L5-S1. It is medically improbable, from an orthopedic standpoint that the specific fall of 2007 led to the degenerative changes. In all likelihood, there would be underlying cumulative trauma and non-industrially related cumulative trauma to the lumbar spine based upon the patient's body habitués. In my opinion, 25% of the lumbar spine impairment is a direct result of his body habitués; of the remainder, I would apportion to the specific injury of January 2007 and cumulative trauma extending up to January 2007.

To reiterate, referable to his knees, I feel that the apportionment that I have assigned would be as follows: 50% of the joint space narrowing is due to the specific injury, cumulative trauma extending up to January 2007 and the remaining 50% would be apportioned to pre-existing trauma to the knee and his body habitués.

Referable to the patient's left knee, as I have commented, I do not feel the patient has suffered from any further industrially related cumulative trauma. I feel that the injury of January 2007 led to a lighting-up phenomena only.

MEDICAL TREATMENT

I recommend a provision for the patient to seek out medical attention with the possibility of undergoing repeat x-rays, possible arthroscopy of both knees as well as Synvisc injections.

Referable to the lumbar spine, he may require physician follow-up appointments, treatment with anti-inflammatory medications and physical therapy.

VOCATIONAL REHABILITATION

It is my understanding that Mr. Beard has retired; however, based upon the job analysis, it does not appear that this patient would be able to continue performing his job duties. I would preclude him from prolonged standing and walking, repetitive climbing, squatting, kneeling, running, jumping and heavy lifting-type activities.

In compliance with Labor Code Section 4628, I personally examined the patient. I reviewed the medical records as set forth in this report. The history was taken by me by direct questions on my part and through the use of a questionnaire completed by the examinee which I reviewed with the examinee. In addition to conduction of the examination, I personally composed and drafted the conclusions of this report. All conclusions are mine alone. Pursuant to 8 Cal Code Regs., Section 49.2-49.9., I have complied with the requirement for face to face time with the patient in his evaluation.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately described the information provided to me and, except as noted herein, that I believe it to be true.

In accordance with Labor Code Section 5703 (a) (1), there has not been a violation of Labor Code Section 139.3. This statement is made under penalty of perjury.

Thank you for referring Mr. Tom Beard to me for evaluation and report. If I may be of further assistance, please feel free to contact me.

Very truly yours,

Donald Pang, M.D.
Diplomate, American Board of Orthopedic Surgery
Fellow, American Academy of Orthopedic Surgeons

Signed this 2ND day of July, 2008, in Alameda county, in the State of California.

DP:lb

Patient : Tom Beard
Employer : San Joaquin County MCVD
D/Injury : 1/9/2007; CT 1/7/2007
Claim # : VE0700048; V6201500
WCAB # : STK 0231242146; STK 0211962 3; STK 0211961 4; STK 212117
I.D.# : 35834
Date of Exam : 7/2/2008

REVIEW OF MEDICAL RECORDS

1. Records from G. Murata M.D. dated October 14, 1988, November 15, 2008, November 16, 2008, December 14, 2008, December 29, 2008, October 3, 1989, January 20, 1990, July 18, 1991, August 31, 1991, September 20, 1991, November 22, 1992, December 23, 1992, April 7, 1992.

2. Record from J. Sepiol M.D. dated November 3, 1988.

3. Records from Dameron Hospital dated November 14, 1988, January 11, 1990.

4. Record from P. Baker M.D. dated June 28, 1989.

5. Records from G. Westin M.D. dated May 14, 1992, May 1, 1992,

6. Record from H. Kim M.D. dated January 19, 1990.

7. Record from F.X. Schwartz M.D. Jr., dated May 23, 1995.

8. Record from Stockton Orthopedic Medical Group dated June 22, 1995.

9. Records from R. Baker M.D. dated January 17, 2003, January 30, 2004.

10. X-rays of both knees dated January 21, 2004.

11. Records from H. Rossman M.D. dated January 9, 2007, January 12, 2007, January 16, 2007, January 24, 2007, February 9, 2007, May 31, 2007.

12. MRI scan of the left knee dated February 21, 2007.

13. MRI scan of the lumbar spine dated January 2007.

14. Records from E. Cahill M.D. dated November 22, 1995, December 13, 1995, January 18, 1996, April 15, 1996, May 6, 1996, May 29, 1996, June 12, 1996, July 3, 1996, April 3, 1996, May 15, 1996, May 21, 1996, May 24, 1996, October 29, 1996, November 18, 1996, January 29, 1997, April 29, 1997, June 26, 1997, October 27, 1997, January 9, 1998, February 9, 1998, March 9, 1998, April 6, 1998, May 4, 1998, June 1, 1998, June 29, 1998, September 21, 1998, November 16, 1998, February 21, 1999, March 31, 1999, April 5, 1999, April 26, 1999, May 24, 1999, September 13, 1999, October 18, 1999, November 1, 1999, December 8, 1999, January 10, 2000, April 10, 2000, July 24, 2000, October 16, 2000, December 16, 2000, December 11, 2000, March 5, 2001, May 30, 2001, August 9, 2001, September 5, 2001, September 26, 2001, October 10, 2001, December 26, 2001, January 9, 2002, April 10, 2002, July 20, 2002, December 6, 2002, January 6, 2003, February 14, 2003, March 5, 2003, March 17, 2003, March 24, 2003, March 31, 2003, April 7, 2003, April 30, 2003, May 6, 2003, May 27, 2003, June 2, 2003, September 5, 2003, December 3, 2003, March 3, 2004, June 9, 2004, August 11, 2004, November 10, 2004, February 14, 2005, April 11, 2005, July 6, 2005, September 2, 2005, November 4, 2005, May 10, 2007, June 4, 2007, June 19, 2007, July 18, 2007, August 15, 2007, August 22, 2007, August 28, 2007, September 17, 2007, September 18, 2007, December 19, 2007, December 11, 2007, December 26, 2007, March 11, 2008.

15. MRI scan of the left knee dated December 7, 1995.

16. Record from J.H. Buckingham M.D. dated October 23, 1979.

17. Record from B. Kornblatt M.D. dated December 12, 1996.

18. Record from Dr. Bielejeski M.D. dated January 18, 1996.

19. Record from Dr. Broderick M.D. dated June 30, 1997.

20. Record from M. Duncan M.D. dated June 19, 1998.

21. MRI scan of the right knee dated May 2, 2007.

22. Record from S. Raina M.D. dated August 10, 2007.

23. Records from C. Hull M.D. dated February 23, 2007, March 2, 2007, March 9, 2007, March 23, 2007, April 6, 2007, April 20, 2007, May 4, 2007, May 17, 2007, June 14, 2007, June 21, 2007.

24. Record from G. Alegre M.D. dated October 16, 2007.

25. Deposition of Mr. Beard dated February 29, 2008.