STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. INSURER NAME AND ADDRESS
AIMS-SACTO 8049 PO BOX 269120 Sacramento, CA 95826

PLEASE DO NOT USE THIS COLUMN
Case No.

2. EMPLOYER NAME
SJ Mosquito & Vector Control

3. Address No. and Street: 7759 S Airport Way
City: Stockton
Zip: 95206
Industry

4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes.)
County

5. PATIENT NAME (first name, middle initial, last name)
Tiffany Anderson

6. Sex ☐ Male ☒ Female

7. Date of Birth Mo. Day Yr. 08/22/1970
Age

8. Address: No. and Street: 1416 Iris Dr #7
City: Lodi
Zip: 95242
Hazard

9. Telephone number (209) 333-1037

10. Occupation (Specific job title)
Pesticide Applicator
Disease

11. Social Security Number 549-23-5133

12. Injured at: No. and Street City County
Hospitalization

13. Date and hour of injury or onset of illness: Mo. Day Yr. 06/19/2008 Hour _____ a.m. _____ p.m.
Occupation

14. Date last worked Mo. Day Yr.

15. Date and hour of first examination or treatment: Mo. Day Yr. 06/20/2008 Hour 8:10 a.m. _____ p.m.
Return Date/Code

16. Have you (or your office) previously treated patient? ☐ Yes ☐ No

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. **DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED.** (Give specific object, machinery or chemical. Use reverse side if more space is required.) **See Attached**

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use reverse side if more space is required.) **See Attached**

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)
A. Physical examination **See Attached**
B. X-ray and laboratory results (State if none or pending.)

20. **DIAGNOSIS** (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? ☐ Yes ☒ No
Knee effusion, Right
ICD-9 Code 719.06

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? ☒ Yes ☐ No If "no", please explain.

22. Is there any other current condition that will impede or delay patient's recovery? ☐ Yes ☐ No If "yes", please explain.

23. **TREATMENT RENDERED** (Use reverse side if more space is required.) **See Attached**

24. If further treatment required, specify treatment plan/estimated duration.

25. If hospitalized as inpatient, give hospital name and location
Date admitted Mo. Day Yr.
Estimated stay

26. WORK STATUS -- Is patient able to perform usual work? ☐ Yes ☒ No
If "no", date when patient can return to: Regular work _____
Modified work 06/20/2008 Specify restrictions **See Attached**

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JUL 17 2008
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Doctor's Signature _____ CA License Number C35074

Doctor Name and Degree (please type) Donald Rossman, M.D. IRS Number 68-0361204

Address 420 W. Acacia Street, Ste#2 Stockton, CA 95203 Telephone Number (209) 461-3116
Fax: (209) 461-3123

FORM 5021 (Rev. 4) 1992

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

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