

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 <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female		7. Date of Birth Mo. Day Yr. 08/22/1970	
8. Address: No. and Street 1416 Iris Dr #7		City Lodi		Zip 95242		9. Telephone number (209) 333-1037
10. Occupation (Specific job title) Pesticide Applicator			11. Social Security Number 549-23-5133			Disease
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.		14. Date last worked Mo. Day Yr.		Occupation
15. Date and hour of first examination or treatment Mo. Day Yr. 06/20/2008		Hour 8:10 a.m. p.m.		16. Have you (or your office) previously treated patient? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Return Date/Code
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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Knee effusion, Right						ICD-9 Code <u>719.06</u>
21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "no", please explain.						
22. Is there any other current condition that will impede or delay patient's recovery? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "no", date when patient can return to: Regular work _____ Modified work <u>06/20/2008</u> Specify restrictions See Attached						

Doctor's Signature _____

CA License Number C35074JUL 17 2008Doctor Name and Degree (please type) Donald Rossman, M.D.IRS Number 68-0361204Address 420 W. Acacia Street, Ste#2

Stockton, CA 95203

Telephone Number (209) 461-3125AIMS-FRESNO
Fax: (209) 461-3125

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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