STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
APPLICATION FOR ADJUDICATION OF CLAIM

☐ Amended Application

RECEIVED
AUG 15 2013
DIVISION OF WORKERS COMPENSATION
STOCKTON OFFICE

Case No.

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 the Document Cover Sheet)

Injured Worker (Completion of this section is required)

TIFFANY
First Name

MI

ANDERSON
Last Name

2 N AVENA AVE
Street Address/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
City

CA
State

95242
Zip Code

Applicant (If other than Injured Worker)

☐ Insurance Carrier ☐ Employer ☐ Lien Claimant

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

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

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

City

State

Zip Code

Employer Information (Completion of this section is required)

☐ Insured ☑ Self-Insured ☐ Legally Uninsured ☐ Uninsured

AN JOAQUIN COUNTY MOSQUITO AND VECTOR CONTROL DISTRIC
Employer Name (Please leave blank spaces between numbers, names or words)

7759 SOUTH AIRPORT WAY
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

STOCKTON — City
CA — State
95206 — Zip Code

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

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

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

City
CA — State
Zip Code

Claims Administrator Information (If known and if applicable)

ACCLAMATION SACRAMENTO
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 (Complete all relevant information):

1. The injured worker, born 08/22/1970 (DATE OF BIRTH: MM/DD/YYYY), while employed as a(n) _____ (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

suffered a :

☐ specific injury _____ (Date of injury: MM/DD/YYYY)

☑ cumulative injury which began on 6-2004 (Start Date: MM/DD/YYYY) and ended on 11-2011 (End Date: MM/DD/YYYY)

The injury occurred at 7759 S. Airport Way / ~~Stockton~~ White Slough facility
Street Address/PO Box - Please leave blank spaces between numbers, names or words

Stockton / Lodi — City, CA — State, _____ Zip Code

(State which parts of the body were injured)

Body Part 1: 800 BODY SYS

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

2. The injury occurred as follows:

(EXPLAIN WHAT THE WORKER WAS DOING AT THE TIME OF INJURY AND HOW THE INJURY OCCURED)

work requirements allow for entering into areas that carry human & animal excriment. Chemicals sprayed without knowledge or consent. Required to inspect water of all varieties and treat with chemicals while unknown environmental conditions were hazardous.

3. Actual earnings at the time of injury:

Rate of Pay $ 4,000. ☒ Monthly ☐ Weekly ☐ Hourly

State value of tips, meals, lodging, or other advantages, regularly received $ _____ ☐ Monthly ☐ Weekly ☐ Hourly

Number of hours worked per week _____

4. The injury caused disability as follows:

Last day off work due to injury: _____ MM/DD/YYYY

First Period of Disability: Start Date 6-09-04 MM/DD/YYYY End Date 6-30-04 MM/DD/YYYY

Second Period of Disability: Start Date 1-26-05 MM/DD/YYYY End Date 1-31-05 MM/DD/YYYY

11-1-05 11-30-05

5. Compensation:

Compensation was paid: ☐ Yes ☒ No

Total paid: _____

Weekly rate(s): _____

Date of last payment: _____ MM/DD/YYYY

6. Has the worker received any unemployment insurance benefits and/or any unemployment compensation disability benefits (state disability) since the date of injury? ☐ Yes ☒ No

7. Medical treatment:

Medical treatment was received: ☒ Yes ☐ No

All treatment was furnished by the Employer or Insurance Carrier: ☐ Yes ☒ No

Date of last treatment: 2012
MM/DD/YYYY

Other treatment was provided/paid by: Karen Stockton
(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

Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or examined for this injury, but that were not provided or paid for by the employer or insurance carrier:

Name of Doctor/Hospital/Clinic 1 (Please leave blank spaces between numbers, names or words)

Name of Doctor/Hospital/Clinic 2 (Please leave blank spaces between numbers, names or words)

8. Other cases have been filed for industrial injuries by this worker as follows:

ADJ 7976768
Case Number 1

ADJ 7010682
Case Number 3

ADJ 7004227
Case Number 2

ADJ 7004221
Case Number 4

9. This application is filed because of a disagreement regarding liability for:

- ☑ Temporary disability indemnity
- ☐ Reimbursement for medical expense
- ☑ Medical treatment
- ☐ Compensation at proper rate
- ☑ Permanent disability indemnity
- ☐ Rehabilitation
- ☑ Supplemental Job Displacement/Return to Work
- ☐ Other (Specify) _____

Is the Applicant Represented? ☐ Yes ☑ No **If "No", applicant is to sign and date below.**

If "Yes", applicant's representative is to complete the following and is to sign and date below.

☐ Law Firm/Attorney ☐ Non-Attorney Representative

Law Firm or Company Name (If Applicable)

Law Firm Number (If Applicable)

Attorney/Representative First Name MI

Attorney/Representative Last Name

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

City State Zip Code

Applicant Attorney/Representative Signature Applicant Signature

Dated at STOCKTON CA 95240, California
City

Date 8-15-13
MM/DD/YYYY

DECLARATION PURSUANT TO LABOR CODE SECTION 4906(g)

Pursuant to Labor Code Section 4906(g), I declare under penalty of perjury that I have not violated Section 139.3 and I 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.

Dated: 8-15-13

Signature

Before signing this form, you should be aware that: "Any person who makes or causes to be made any knowingly false or fraudulent material statement or representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony."

PROOF OF SERVICE BY MAIL

I, Tiffany Anderson certify that the following is true and correct:

I am employed in the City of Stockton and County of San Joaquin, California am over the age of eighteen years, and am not a party to the within entitled cause.

2 N Avena Ave, Lodi, CA 95242

On 8-15-13 served **Application for Adjudication,** by causing true copies thereof, enclosed in sealed envelopes with postage thereon fully prepaid, to be placed in the United States Post Office mail box at Stockton, CA, addressed to the following parties:

Stockwell Harris 1545 River Park Dr., Sacramento, CA 95815;

San Joaquin County Mosquito and Vector Control District, 7759 South Airport Way, Stockton, CA 95206

WCAB 31 E Channel St. Room 344, Stockton, CA 95202

Acclamation, PO Box 269120, Sacramento, CA 95826

I am readily familiar with the business practice at my place of business for collection and processing of correspondence for delivery by mail. Correspondence so collected and processed is deposited with the United States Postal Service on the same day in the ordinary course of business. On the above date the said envelopes were collected for the United States Postal Service following ordinary business practices.

I declare under penalty of perjury that the foregoing is true and correct, and that this declaration was executed on 8-15-13 at Stockton, CA

Tiffany Anderson