8-22-11 STATE OF CALIFORNIA DWC DISTRICT OFFICE

AIMS

DOCUMENT COVER SHEET

s this a new case?	Yes 🗸	No 🔘	Companion Cas	ses Exist	Walkthrough	Yes 🔘	No
More than 15 Comp 08/22/1970 Date:(MM/DD/YYY	MIST		ecific Injury	06/29/2011	SSN:	5492-11 NA	
Case Number 1		Cui	mulative Injury	(Start Date: MM	/DD/YYYY) Injury, use the start date	(End Date: MM	
Body Part 1:	513	0	_	+	Body Part 3:	880	0
Body Part 2:	518	0			Body Part 4:		0
Other Body Parts:					0		
ease check unit t	o be filed on (check only	ne box)				
✓ ADJ	DEU	SIF	O UE	F		INT C	RSU
ompanion Cases		O s	pecific Injury				
Case Number 2		O c	umulative Injury	(Start Date: MI	M/DD/YYYY) Injury, use the start date	(End Date: Mas the specific date	M/DD/YYYY) te of injury)
Body Part 1:		0			Body Part 3		•
Body Part 2:		•			Body Part 4	:	C
Other Body Parts	X				0		+
DWC-CA form 10)232.1 Rev. 7/2	2010 - Page 1	of 8				

NSATION ALS BOARD OF CLAIM

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STATE OF CALIFORNIA DIVISION OF WORKERS' COMPENSATION APPEA APPLICATION FOR ADJUDICATION
APPLICATION FOR ADSODIOATION

State No. 549235133 Stit (Numbers Only) enue 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 of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).) County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).) STIK County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).) STIK County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).) STIK County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).) STIK County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).) STIK County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).) STIK County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).) STIR of the place of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).) STIR of the place of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).) County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).) County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).) County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).) County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).) County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(a) County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(a) County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(a) County of principal place of business of employee's attorney			Amended Application	
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	City DWC/WCAB Form 1A (11/2008) - (Page 14/2008)		Oldio	WCAB1

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Joaquin County Mo	osquito & Vector Cor leave blank spaces bet	ntrol District	names or words)	
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toalston		Section 1997		CA O	
tockton ity).			State	Zip Code
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Acclamation Insurance	e Management Servic	es		18 May 18 18 18 18 18 18 18 18 18 18 18 18 18	
nsurance Carrier Name (Pl	lease leave blank spaces	between numbers	s, names or words)		
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<u> </u>		(State which	ch parts of the body were injured)		
Body Part 1:	513 KNEE				0
Body Part 2:	518 LEG				C
Body Part 3:	880 BODY SI	MS			C
					C
Body Part 4: Other Body Parts:	-				G
(EXPLAIN W) The injured	worker was wal	king the perimeter of the was low and the weeds	E TIME OF INJURY AND HOW THE IN the dairy pond with her hand can spreas surrounding the pond were higher the dinto a metal T-bar hidden in the g	han knee lev	
3. Actual ear	nings at the time	Monthly State v	value of tips, meals, lodging, or other tages, regularly received \$		Monthly Weekly Hourly
Number of he	ours worked per	week <u>45</u>			
4. The injury	caused disabili	ty as follows:			
Last day off	work due to injury	y: <u>08/18/2011</u> MM/DD/YYYY			
First Period o	of Disability:	Start Date	07/19/2011 MM/DD/YYYY	End Date	7/26/2011 MM/DD/YYYY
Second Perio	od of Disability:	Start Date	MM/DD/YYYY	End Date	MM/DD/YYYY
5. Compens	ation:				
Compensation	on was paid:	Yes No			
Total paid:	0				
Weekly rate	(s): <u>0</u>				
Date of last	payment:				
		DD/YYYY	Landler and unample	vment comr	pensation
6. Has the v	vorker received enefits (state dis	any unemployment ins sability) since the date (urance benefits and/or any unemplo of injury? Yes 🗸 No	yment comp	

ss di- li - li fue etmonti				
. Medical treatment: Nedical treatment was received:		✓ Yes	No No	
	Comminu	Yes	₩ No	
Il treatment was furnished by the Employer or Insu	rance Carner:	O res	• 110	
te of last treatment: $\frac{08/29/2011}{\text{MM/DD/YYYY}}$				
Other treatment was provided/paid by: Kaiser Per	manente Stockton AME OF PERSON OR A	Facility GENCY PROVIDING	OR PAYING FOR MEDIC	AL CARE)
old Medi-Cal pay for any health care related to t	his claim?	Yes	No	
Names and addresses of doctor(s)/hospital(s)/corovided or paid for by the employer or insuran	linic(s) that treated ce carrier:	or examined fo	or this injury, but tha	t were not
Kaiser Permanente Stockton Facility				The Charmen
. Other cases have been filed for industrial inju	uries by this worke			
		l as lonows.		
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Case Number 1 Case Number 2 9. This application is filed because of a disagree Temporary disability indemnity	Case Num Case Num eement regarding li Perma	nber 3 ability for: anent disability in	ndemnity placement/Return to \	·
Case Number 1 Case Number 2 9. This application is filed because of a disagree Temporary disability indemnity Reimbursement for medical expense	Case Num Case Num ement regarding li Perma Rehab	nber 3 ability for: anent disability in		Vork

The Whenever	eant is to sign and date below.
Yes", applicant's representative is to complete the following a	ind is to sign and date below.
Law Firm/Attorney Non-Attorney Representative	
w Firm or Company Name (If Applicable)	
w Firm Number (If Applicable)	
torney/Representative First Name	MI -
ttorney/Representative Last Name	
treet Address/PO Box (Please leave blank spaces between number	ers, names or words)
	•
iity	State Zip Code
Applicant Attorney/Representative Signature	Applicant Signature
Dated at Lodi City	, California
Date 0813112011	

NAME STREET CITY, STATE, ZIP CODE

TELEPHONE #:

STATE OF CALIFORNIA WORKERS' COMPENSATION APPEALS BOARD

Tiffany anderson

WCAB#:

VS.

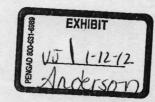
San Joaquin County mosquito & Vector Control District

Defendants.

Applicant,

APPLICATION FOR DISCRIMINATION BENEFITS PURSUANT TO LABOR CODE SECTION 132(A)

See attached



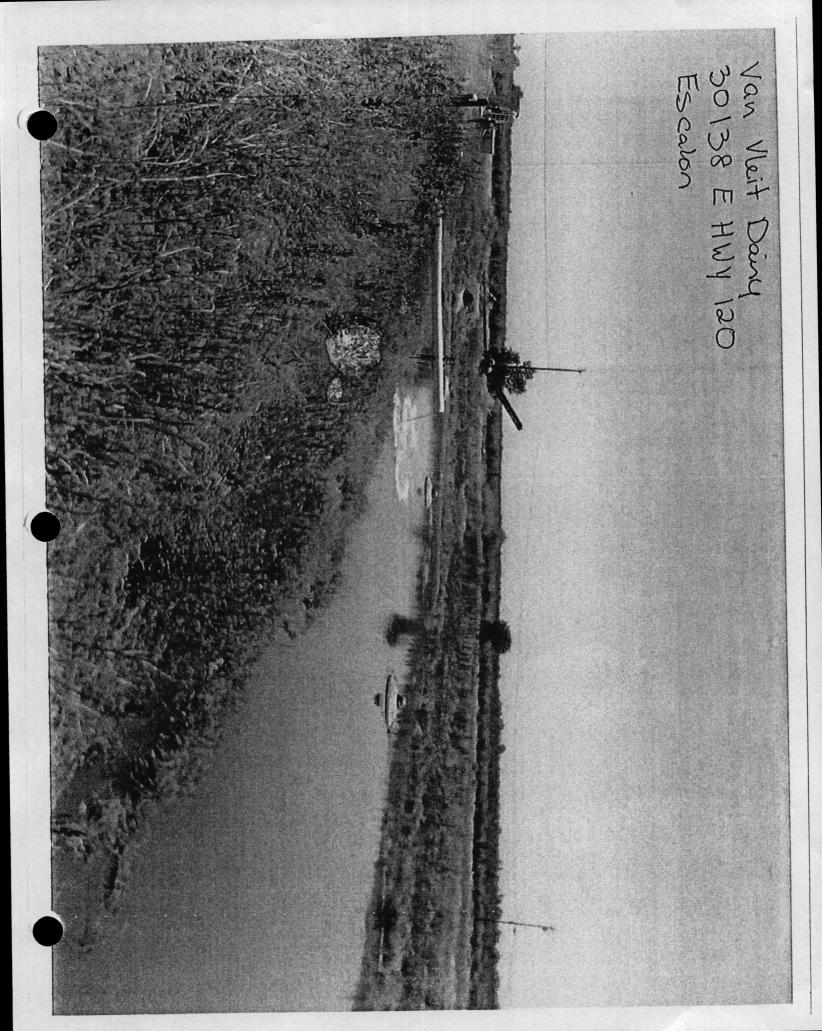
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