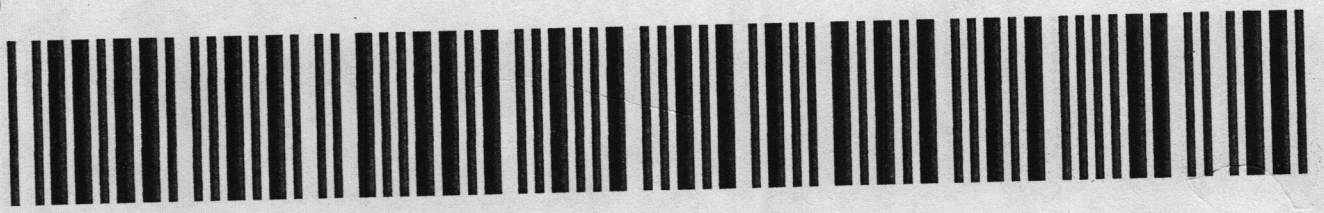
8-22-11

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

AIMS

DOCUMENT COVER SHEET



Is this a new case? Yes ☑ No ☐ Companion Cases Exist ☐ Walkthrough Yes ☐ No

More than 15 Companion Cases ☐

08/22/1970 MISTAKE
Date:(MM/DD/YYYY)

SSN: 549[redacted]

☑ Specific Injury

Case Number 1

☐ Cumulative Injury 06/29/2011 (Start Date: MM/DD/YYYY) NA (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 513

Body Part 2: 518

Body Part 3: 880

Body Part 4:

Other Body Parts:

Please check unit to be filed on (check only one box)

☑ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ INT ☐ RSU

Companion Cases

☐ Specific Injury

Case Number 2

☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

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

☐ Amended Application

Case No.

549235133
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

K
MI

Anderson
Last Name

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

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

NA
International Address (Please leave blank spaces between numbers, names or words)

Lodi
City

CA
State

95240
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

San Joaquin County Mosquito & Vector Control District
Employer Name (Please leave blank spaces between numbers, names or words)

7759 S Airport Way
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

Stockton (City) CA (State) _____ (Zip Code)

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

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

P.O. Box 269120
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

Sacramento (City) CA (State) 95826 (Zip Code)

Claims Administrator Information (If known and if applicable)

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

P.O. 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) Pesticide Applicator (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

☑ specific injury 06/29/2011 (Date of injury: MM/DD/YYYY)

suffered a :

☐ cumulative injury which began on _____ (Start Date: MM/DD/YYYY) and ended on _____ (End Date: MM/DD/YYYY)

The injury occurred at 30138 E HWY 120 , Van Vleit Dairy
Street Address/PO Box - Please leave blank spaces between numbers, names or words

Escalon (City), CA (State) 95320 (Zip Code).

(State which parts of the body were injured)

Body Part 1: 513 KNEE

Body Part 2: 518 LEG

Body Part 3: 880 BODY SMS

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)

The injured worker was walking the perimeter of the dairy pond with her hand can spraying oil to kill mosquito larva. The water level to the pond was low and the weeds surounding the pond were higher than knee level. While walking through the weeded pond the injured worker walked into a metal T-bar hidden in the grass. The

3. Actual earnings at the time of injury:

Rate of Pay $ 1020.55 ☐ Monthly ☑ Weekly ☐ Hourly

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

Number of hours worked per week 45

4. The injury caused disability as follows:

Last day off work due to injury: 08/18/2011 (MM/DD/YYYY)

First Period of Disability: Start Date 07/19/2011 (MM/DD/YYYY) End Date 7/26/2011 (MM/DD/YYYY)

Second Period of Disability: Start Date _____ (MM/DD/YYYY) End Date _____ (MM/DD/YYYY)

5. Compensation:

Compensation was paid: ☐ Yes ☑ No

Total paid: 0

Weekly rate(s): 0

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: 08/29/2011
MM/DD/YYYY

Other treatment was provided/paid by: Kaiser Permanente Stockton Facility
(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:

Kaiser Permanente Stockton Facility

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:

Case Number 1

Case Number 2

Case Number 3

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 Lodi, California
City

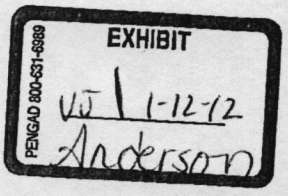
Date 08/31/2011
MM/DD/YYYY

NAME
STREET
CITY, STATE, ZIP CODE

TELEPHONE #:

STATE OF CALIFORNIA
WORKERS' COMPENSATION APPEALS BOARD

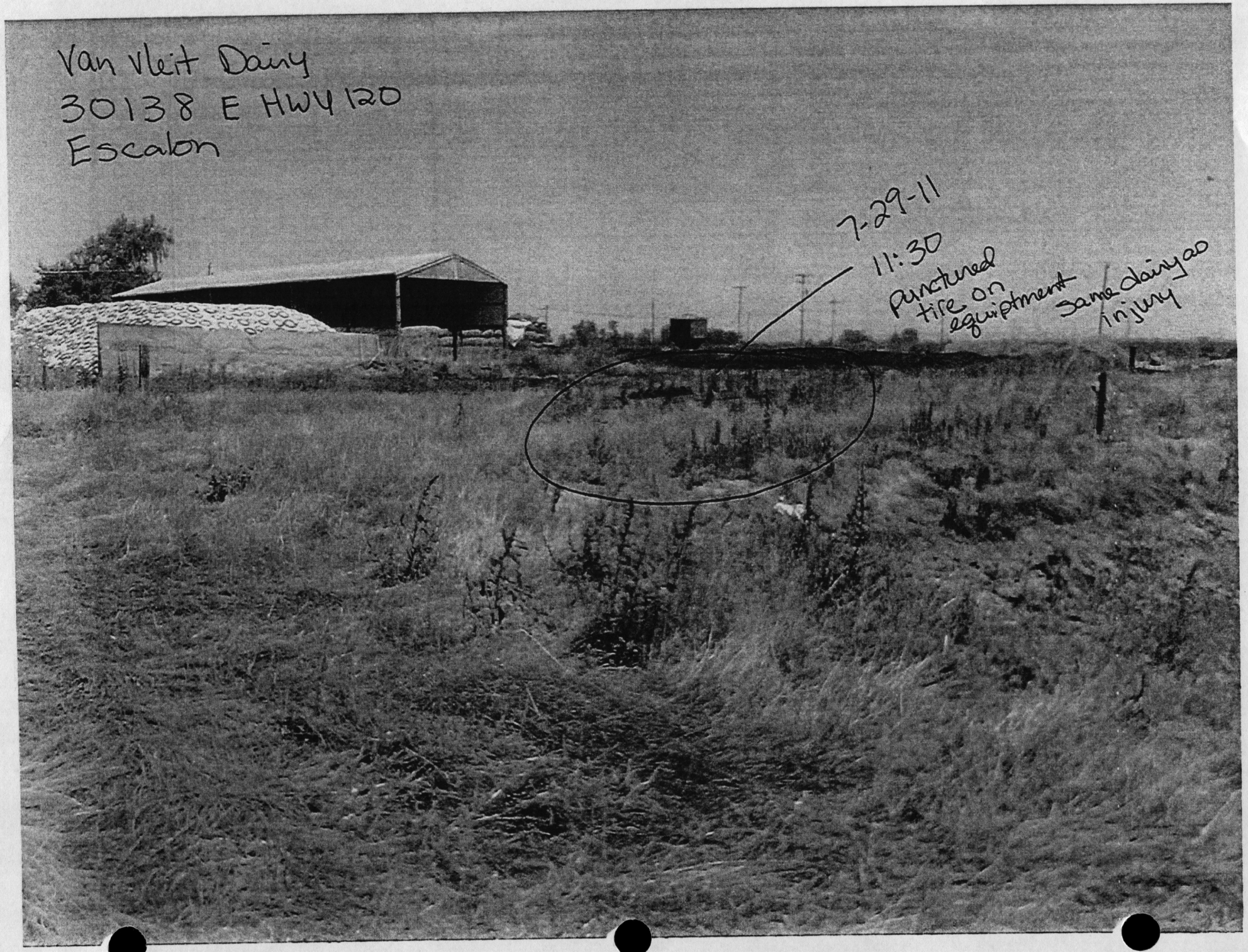
Tiffany Anderson Applicant, vs. San Joaquin County Mosquito & Vector Control District Defendants.	WCAB#: APPLICATION FOR DISCRIMINATION BENEFITS PURSUANT TO LABOR CODE SECTION 132(A)



See attached

8/31/2011


Van Vleit Dairy
30138 E HWY 120
Escalon
site of injury 6-29-11


Van Vleit Dairy
30138 E HWY 120
Escalon
7-29-11
11:30
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Same dairy as
injury


Van Vleit Dairy injury Site
Example
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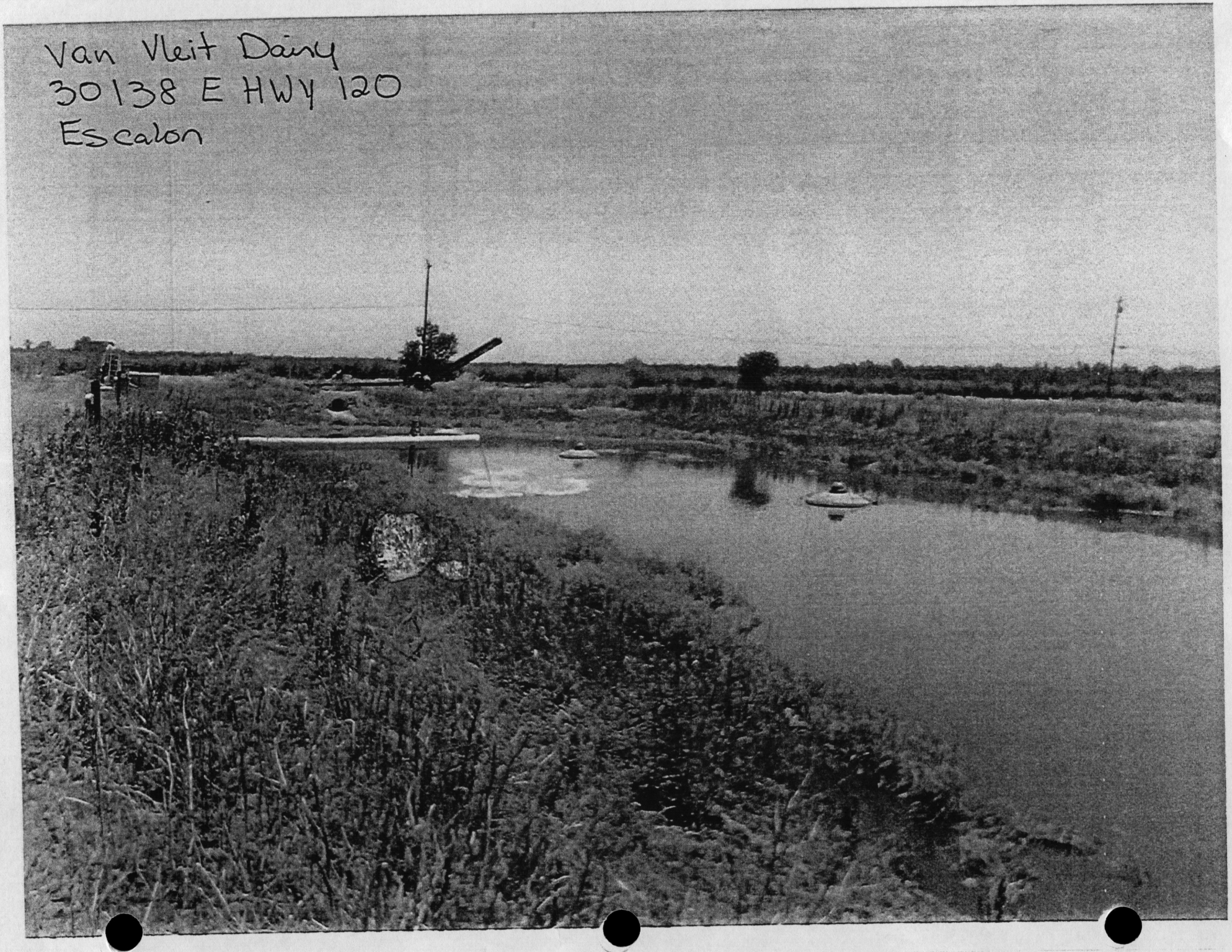
Van Vleit Dairy
30138 E HWY 120
Escalon


Van Vleit Dairy
30138 E HWY 120 Escalon site of injury 6-29-11