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September 12, 2011

Mr. Ronald M. Stein
Ronald M. Stein Law Offices
4521 Quail Lakes Drive
Stockton, CA 95207

**RE: ANDERSON, TIFFANY VS. SAN JOAQUIN COUNTY MOSQUITO
& VECTOR CONTROL**

WCAB NO.: 1) ADJ7004221; 2) ADJ7004227; 3) ADJ7010682
CLAIM NO.: VE0700184
OUR FILE NO.: 300141-040
DATE OF LOSS: 1) 6/19/08 2) 7/2/09 3) 3/26/09

Dear Mr. Stein:

Pursuant to the Rules of the Division of Workers' Compensation, enclosed please find the following for your file, which appears to have only been served on my client and my office. It is our understanding that you still represent Ms. Anderson. If not, please advise.

- 1. Application for Adjudication of Claim dated August 31, 2011**
- 2. Declaration of Readiness to Proceed to Expedited Hearing dated August 31, 2011**
- 3. Medical Reports 7/6/11 to 8/26/11**

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(909) 381-5553

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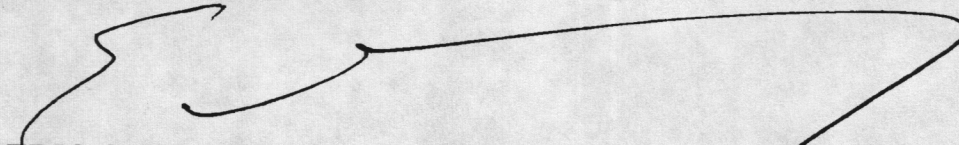
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Fresno, California 93710
(559) 226-9030

ANDERSON, TIFFANY VS. SAN JOAQUIN COUNTY MOSQUITO & VECTOR CONTROL
Page 2
September 12, 2011

Thank you for your attention to this matter.

Very truly yours,

STOCKWELL, HARRIS, WOOLVERTON & MUEHL
A Professional Corporation

A large, stylized handwritten signature in black ink, appearing to read 'Eric G. Helpfrey'. The signature is written in a cursive, flowing style with a long horizontal stroke extending to the right.

ERIC G. HELPHREY

EGH:ks

Enclosures: As noted above.

cc: Ms. Mackenzie Dawson, AIMS Insurance (Sacramento)

STATE OF CALIFORNIA
WC DISTRICT OFFICE

DOCUMENT COVER SHEET



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

More than 15 Companion Cases

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

SSN: 549235133

Specific Injury

Case Number 1 _____

Cumulative Injury 06/29/2011 NA
(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: 513

Body Part 3: 880

Body Part 2: 518

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 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____

DOCUMENT SEPARATOR SHEET



Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title Application FOR AdJUCATION

Document Date 08/22/1970
MM/DD/YYYY

Author Tiffany Anderson

Office Use Only

Received Date _____
MM/DD/YYYY



STATE OF CALIFORNIA
 DIV. 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 CA _____
City 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 CA 95826
City State 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 CA 95826
City State Zip Code

IT IS CLAIMED THAT (Complete all relevant information):

Pesticide Applicator

1. The injured worker, born 08/22/1970, while employed as a(n) _____
(DATE OF BIRTH: MM/DD/YYYY) (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 _____ and ended on _____
(Start Date: MM/DD/YYYY) (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 CA 95320
City State 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 surrounding 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 End Date 7/26/2011
MM/DD/YYYY MM/DD/YYYY

Second Period of Disability: Start Date _____ End Date _____
MM/DD/YYYY 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 3

Case Number 2

Case Number 4

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

- | | |
|--|---|
| <input checked="" type="checkbox"/> Temporary disability indemnity | <input type="checkbox"/> Permanent disability indemnity |
| <input type="checkbox"/> Reimbursement for medical expense | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Medical treatment | <input type="checkbox"/> Supplemental Job Displacement/Return to Work |
| <input type="checkbox"/> Compensation at proper rate | <input type="checkbox"/> 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 MI State Zip Code

Applicant Attorney/Representative Signature 
Applicant Signature

Dated at Lodi, California
City

Date 08/31/2011
MM/DD/YYYY

DOCUMENT SEPARATOR SHEET



Product Delivery Unit ADJ

Document Type LEGAL DOCUMENTS

Document Title Application for adjudication of claim

Document Date 08/31/2011
MM/DD/YYYY

Author Tiffany Anderson

Office Use Only

Received Date _____
MM/DD/YYYY

Proof Of Service By Mail

I declare that:

I am (resident of/employed in) the county of San Joaquin California. I am over the age of eighteen years, my (business/residence) address is:

2 N. Avena Avenue Lodi CA 95240

On 8/31/2011, I served the attached Application for Adjudication on the parties in said case, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United State mail at

Stockton CA

addressed as follows

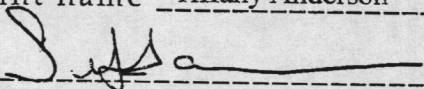
AIMS MacKenzie Dawson P.O. Box 269120 Sacramento CA 95826-9120
WCAB 31 E Chanel Street #344 Stockton CA 95202
stockwell, Harris, Woolreton & Muzhl 1545 River Park Drive suite 330
Sacramento CA 95815-4616

I declare under penalty of perjury under the laws of the State of California that the

foregoing is true and correct, and that this declaration was executed on

(date) 8/31/2011, at Stockton California.

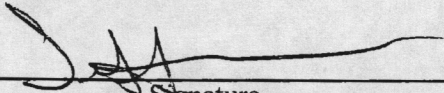
Type or print name Tiffany Anderson

Signature 

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: 8/31/2011



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."