RESPONSE #2

State of California
Department of Industrial Relations
DIVISION OF WORKERS COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

If you are injured or become ill because of your job, you may be entitled to workers' compensation benefits.

Complete the "Employee" section and give the form to your employer. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from your employer. You may contact the Division of Workers' Compensation at **1-800-736-7401** if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the reverse of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

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.

RECLAMO DEL EMPLEADO PARA BENEFICIOS DE COMPENSACIÓN DEL TRABAJADOR

Si Ud. se ha lesionado o se ha enfermado en/o a causa de su trabajo, Ud. tiene derecho a recibir beneficios de compensación al trabajador. Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia fechada de su empleador. Si Ud. necesita ayuda para completar esta forma o para obtener sus beneficios, póngase en contacto con la Division de Compensación al Trabajador al ***1-800-736-7401****. Al dorso de esta forma se encuentra una explicación de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que con conocimiento haga o cause que se produzca cualquier declaracion o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee: ***Empleado:***

1. Name. *Nombre.* Tiffany Anderson — Today's Date. *Fecha de Hoy.* 6-8-04
2. Home Address. *Dirección Residencial.* 1830 S. Hutchins #304
3. City. *Ciudad.* Lodi — State. *Estado.* CA — Zip. *Código Postal.* 95240
4. Date of Injury. *Fecha de la lesión(accidente).* 6-7-04 — Time of Injury. *Hora en que ocurrió.* 10 a.m. ____ p.m.
5. Address and description of where injury happened. *Dirección y descripción del lugar dónde occurió el accidente.* Mc Guck property Hwy 26 Calaveras River
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* poison oak legs and ankles
7. Social Security Number. *Numero de Seguro Social del Empleado.* 549-23-5133
8. Signature of employee. *Firma del empleado.* [signature]

Employer—complete this section and give the employee a copy immediately as a receipt.
Empleador—complete esta sección y déle inmediatamente una copia al empleado como recibo.

9. Name of employer. *Nombre del empleador.* San Joaquin Co. Mosquito & Vector Control Dist
10. Address. *Dirección.* 7759 S. Airport Way Stockton CA 95206
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* 6-8-04
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la forma del reclamo.* 6-8-04
13. Date employer received completed claim form. *Fecha en que el empleador recibió la forma del reclamo completado.* 6-8-04
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañia de seguros o agencia administradora de seguros.* Bragg & Assoc
15. Insurance Policy Number. *El numero de la poliza del Seguro.*
16. Signature of employer representative. *Firma del representante del empleador.* Carl Abstad
17. Title. *Título.* Secretary — 18. Telephone. *Teléfono.* 209 982-4675

Employer: You are required to date this form and provide copies to your insurer and to the employee, dependent or representative who filed the claim within one working day of receipt of completed form from employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros y empleado, dependiente o representante que haya presentado este reclamo dentro del plazo de un día hábil desde el momento de haber sido recibida la forma completa del empleado.

FIRMAR EN ESTA FORMA NO SIGNIFICA ADMISION DE ORIGINAL RESPONSABILIDAD

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State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type, if possible). Mail two copies to:

- ☐ P.O. Box 5372, Walnut Creek, CA 94596 — Tel (925) 933-2992 FAX (925) 933-2994
- ☐ P.O. Box 1406, Roseville, CA 95678 — Tel (916) 783-0100 FAX (916) 783-0335
- ☐ P.O. Box 491749, Redding, CA 96049-1749 — Tel (530) 223-2574 FAX (530) 223-2679

OSHA Case No. _____

☐ Fatality

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.

NOTICE: California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident *OR* requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury/illness, or death must be reported **immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME: Tiffany Anderson
1A. POLICY NUMBER:
2. MAILING ADDRESS (Number and Street, City, ZIP): 1830 S Hutchins #304 Lodi CA 95240
2A. PHONE NUMBER: 333-9249
3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP):
3A. LOCATION CODE:
4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.:
5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.:
6. TYPE OF EMPLOYER: ☐ PRIVATE ☐ STATE ☐ CITY ☒ COUNTY ☐ SCHOOL DIST. ☐ OTHER GOVERNMENT - SPECIFY _____

EMPLOYEE

7. EMPLOYEE NAME: Tiffany Anderson
8. SOCIAL SECURITY NUMBER: 549-23-5133
9. DATE OF BIRTH (mm/dd/yy): 8-22-70
10. HOME ADDRESS (Number and Street, City, ZIP): 1830 S. Hutchins #304 Lodi CA 95240
10A. PHONE NUMBER: 333-9249
11. SEX: ☐ MALE ☒ FEMALE
12. OCCUPATION (Regular job title - NO initials, abbreviations or numbers):
13. DATE OF HIRE (mm/dd/yy):
14. EMPLOYEE USUALLY WORKS ____ hours per day ____ days per week ____ total weekly hours
14A. EMPLOYMENT STATUS (check applicable status at time of injury): ____ regular full-time ____ part-time ____ temporary ____ seasonal
14B. Under what class code of your policy were wages assigned?
15. GROSS WAGES/SALARY: $ _____ per _____
16. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? ☐ YES, $ _____ per _____ ☐ NO

INJURY OR ILLNESS

17. DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy):
18. TIME INJURY/ILLNESS OCCURRED: ____ A.M. 1 P.M.
19. TIME EMPLOYEE BEGAN WORK: 7 A.M. ____ P.M.
20. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy):
21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☒ NO
22. DATE LAST WORKED (mm/dd/yy):
23. DATE RETURNED TO WORK (mm/dd/yy):
24. IF STILL OFF WORK CHECK THIS BOX ☐
25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO
26. SALARY BEING CONTINUED? ☐ YES ☐ NO
27. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy):
28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm/dd/yy):
29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendonitis of left elbow, lead poisoning.: rash over all body
30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City): McGurk Property
30A. COUNTY: SJ
30B. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.:
32. OTHER WORKERS INJURED/ILL IN THIS EVENT? ☐ YES ☐ NO
33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.: weeds
34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck.: checking sources.
35. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.

walking through brush
looking for mosquito source
came in contact with poison oak

36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP):
36A. PHONE NUMBER:
37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP):
37A. PHONE NUMBER:

DO NOT USE THIS COLUMN: Case No. / Ownership / Industry / Occupation / Sex / Age / Daily hours / Days per week / Weekly hours / Weekly wage / County / Nature of injury / Part of body / Source / Event / Sec. Source / Extent of Injury

Completed by (type or print)	Signature	Title	Date

FORM 5020 (REV. 6)

Dameron Hospital Occupational Health Services
525 W. Acacia St., Stockton, CA 95203

WORK STATUS REPORT

Employee Name: Anderson, Tiffany K
Social Security No.: 549-23-5133
Employer: SJ Mosquito and Vector Control
Date of Injury: 06/07/2004
Clinic Case Number: 56808

Date of Visit: 06/09/2004
Time In: 07:55 am **Time Out:** 08:45 am
Guarantor: Gregory B Bragg and
Claim Number: Pending

CLINICAL STATUS

Diagnosis: Dermatitis, Contact Irritant

Since the last visit, this patient's condition has:

EVALUATION AND TREATMENT PLAN

Physical / Occupational Therapy:

Recommended Evaluation / Diagnostic Studies:

WORK STATUS

Work Status: Full work duties **From:** 06/09/2004 **To:** 06/18/2004

Work Restrictions:

Estimated return to full duty:

DISPOSITION

Disposition:

Next Scheduled Appointment: 07:40 am 06/18/2004

Note: Missed appointments without 24 hours advance notice will be charged a $25 fee.

"I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury."

Signed,

Corky Hull, MD (Original signature on file)

Doctor's Phone: (209) 461-3196 opt. 3
Doctor's Fax: (209) 461-7529
Case Coordinator Phone: (209) 461-3196 opt.1

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the "Employee" section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

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.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabjador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* Tiffany Anderson Today's Date. *Fecha de Hoy.* 1-26-05
2. Home Address. *Dirección Residencial.* 1859 S. Hutchins #204
3. City. *Ciudad.* Lodi State. *Estado.* CA Zip. *Código Postal.* 95240
4. Date of Injury. *Fecha de la lesión (accidente).* 1-21-05 Time of Injury. *Hora en que ocurrió.* _____ a.m. 12 p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* 7151 S. Harney way / unloading truck
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* hurt to the arch of both feet
7. Social Security Number. *Número de Seguro Social del Empleado.* 549-23-5133
8. Signature of employee. *Firma del empleado.* [signature]

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* S.S. Contingent Director Central
10. Address. *Dirección.* 7151 S. Harney way, Stockton
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* 1-25-05 3:00
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* 1-26-05
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* 1-26-05
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* Contingent Services PO Box 28100 Fresno CA 93729
15. Insurance Policy Number. *El número de la póliza de Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* [signature]
17. Title. *Título.* Secretary 18. Telephone. *Teléfono.* 209 982-4675

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/ *Copia del Empleado* ☒ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

7/1/04 Rev.

State of California
EMPLOYER'S REPORT OF
OCCUPATIONAL INJURY OR ILLNESS

ACCLAMATION INSURANCE MANAGEMENT SERVICES
209-227-0801
P.O. Box 28100
FRESNO, CA 93729

OSHA CASE NO.

FATALITY ☐

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.

California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

Please do not use this column

CASE NUMBER

OWNERSHIP

INDUSTRY

OCCUPATION

SEX

AGE

DAILY HOURS

DAYS PER WEEK

WEEKLY HOURS

WEEKLY WAGE

COUNTY

NATURE OF INJURY

PART OF BODY

SOURCE

EVENT

SECONDARY SOURCE

EXTENT OF INJURY

Date (mm/dd/yy)

EMPLOYER

1. FIRM NAME: SAN JOAQUIN CO. MOSQUITO & VECTOR CONTROL DISTRICT

1a. Policy Number:

2. MAILING ADDRESS: (Number, Street, City, Zip): 7759 SOUTH AIRPORT WAY STOCKTON CA 95206

2a. Phone Number: 209 982-4675

3. LOCATION if different from Mailing Address (Number, Street, City and Zip):

3a. Location Code:

4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.: MOSQUITO CONTROL

5. State unemployment insurance acct.no:

6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District [XX] Other Gov't, Specify: Special Dist.

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy): 1/21/05

8. TIME INJURY/ILLNESS OCCURRED: ____ AM 12:__ PM

9. TIME EMPLOYEE BEGAN WORK: 7:30 AM ____ PM

10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy):

11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? [X] Yes ☐ No

12. DATE LAST WORKED (mm/dd/yy): 1/25/05

13. DATE RETURNED TO WORK (mm/dd/yy):

14. IF STILL OFF WORK, CHECK THIS BOX: [X]

15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? [X] Yes ☐ No

16. SALARY BEING CONTINUED? [X] Yes ☐ No

17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy): 1/25/05

18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy): 1/26/05

19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning: Rash all over body

20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip): District yard

20a. COUNTY: San Joaquin

21. ON EMPLOYER'S PREMISES? [XX] Yes ☐ No

22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.: yard area

23. Other Workers injured or ill in this event? ☐ Yes [X] No

24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold: weeds

25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.: XXXXXXXXXXXXXXXX Standing and jumping on the weeds to pack them down in garbage dumpster.

26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY: same as above

27. Name and address of physician (number, street, city, zip): Dr. Rossman Dameron Occupational Health Services 525 W Acacia St Stockton CA 95203

27a. Phone Number: 209 461-3196 #3

28. Hospitalized as an inpatient overnight? [XX] No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)

28a. Phone Number:

29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.

Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME: Tiffany Anderson

31. SOCIAL SECURITY NUMBER: 549-23-5133

32. DATE OF BIRTH (mm/dd/yy): 08/22/70

33. HOME ADDRESS (Number, Street, City, Zip): 1830 S Hutchins #304 Lodi CA 95240

33a. PHONE NUMBER: 209 333-1037

34. SEX: ☐ Male [XX] Female

35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers): Mosquito Technician I

36. DATE OF HIRE (mm/dd/yy): 4/19/04

37. EMPLOYEE USUALLY WORKS: 8 hours per day, 5 days per week, 40 total weekly hours

37a. EMPLOYMENT STATUS: [X] regular, full-time ☐ part-time ☐ temporary ☐ seasonal

37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED: salaries/wages

38. GROSS WAGES/SALARY: $ 1421. per bi-weekly

39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes [XX] No

Completed By (type or print): Carol Aksland

Signature & Title: Carol Aksland 1-26-05

* Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

FORM 5020 (Rev7) June 2002

DISTRIBUTION: WHITE=WORKERS' COMPENSATION • CANARY=WORKERS' COMPENSATION • PINK=PERSONNEL DEPT

EXAMINATION AND/OR TREATMENT AUTHORIZATION

Employer: SAN JOAQUIN CO. MOSQUITO & VECTOR CONTROL
7759 S Airport Way
STOCKTON CA 95206

TO DOCTOR: DAMERON OCCUPATIONAL HEALTH
420 W. Acacia St #12
STOCKTON CA 95203

DATE: 1/26/05

EMPLOYEE TIFFANY ANDERSON

DATE OF INJURY 1/21/05

Our employee, Tiffany Anderson is reported to have been injured on the above date. This person is being referred to you pursuant and subject to applicable workers' compensation laws. Please complete this entire form and return it to the injured worker.

AUTHORIZED SIGNATURE Carol Richard DEPT OFFICE

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* **TO THE TREATING PHYSICIAN:** The Employer provides, whenever possible, modified work (light duty), for employees who are unable to perform their regular duties due to illness or injury. Because of varied activities, work can usually be found within the employee's limitations while he/she is recuperating.

THE FOLLOWING PORTION TO BE COMPLETED BY THE PHYSICIAN

A. ☐ Patient may return to work with no work restrictions

Date of next doctor's appointment_____

B. ☐ Patient may be capable of performing a light duty work assignment. The following work restrictions

apply until____/____/____ .

C. ☒ Patient is not capable of returning to regular work or modified work because Allergic reaction

Expected period of disability (use specific dates)_____

Date of next doctor's appointment 1/27/05

SIGNATURE [illegible]
TREATING PHYSICIAN

THIS FORM MUST BE COMPLETED AND RETURNED IMMEDIATELY BY THE EMPLOYEE TO THE PERSONNEL DEPARTMENT FOR VALIDATION.

PLEASE FORWARD YOUR DOCTOR'S FIRST REPORT OF INJURY OR ILLNESS TO OUR ADMINISTRATOR:
ACCLAMATION INSURANCE MANAGEMENT SERVICES
P.O. Box 28100
Fresno, CA 93729

SIGNATURE & TITLE

DISTRIBUTION AFTER COMPLETION: White - AIMS, Yellow - Personnel Office, Pink - Doctor

A 3012 (9-94)

Dameron Hospital Occupational Health Services
525 W. Acacia St., Stockton, CA 95203

WORK STATUS REPORT

Employee Name: Anderson, Tiffany
Social Security No.: 549-23-5133
Employer: SJ Mosquito and Vector Control
Date of Injury: 01/21/2005
Clinic Case Number: 66402

Date of Visit: 01/26/2005
Time In: 08:25 am **Time Out:** 09:57 am
Guarantor: AIMS - Fresno 8046
Claim Number: Pending

CLINICAL STATUS

Diagnosis: Allergic Reaction

Since the last visit, this patient's condition has:

EVALUATION AND TREATMENT PLAN

Physical / Occupational Therapy:

Recommended Evaluation / Diagnostic Studies:

WORK STATUS

Work Status: Off balance of shift; return to full w **From:** 01/26/2005 **To:** 01/27/2005

FTN - 1-27-05

Work Restrictions:

Estimated return to full duty:

DISPOSITION

Disposition:

Next Scheduled Appointment: 08:00 am 1/27/2005

"I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury."

Signed,

Donald Rossman, (Original signature on file)

Doctor's Phone: (209) 461-3196 opt. 3
Doctor's Fax: (209) 461-7529
Case Coordinator Phone: (209) 461-3196 opt.1

Dameron Hospital Occupational Health Services
525 W. Acacia St., Stockton, CA 95203

WORK STATUS REPORT

Employee Name: Anderson, Tiffany
Social Security No.: 549-23-5133
Employer: SJ Mosquito and Vector Control
Date of Injury: 01/21/2005
Clinic Case Number: 66402

Date of Visit: 01/27/2005
Time In: 07:46 am **Time Out:** 08:27 am
Guarantor: AIMS - Fresno 8046
Claim Number: Pending

CLINICAL STATUS

Diagnosis: Allergic Reaction

Since the last visit, this patient's condition has:

EVALUATION AND TREATMENT PLAN

Physical / Occupational Therapy:

Recommended Evaluation / Diagnostic Studies:

WORK STATUS

Work Status: Full work duties **From:** 01/27/2005 **To:** 01/31/2005

Work Restrictions:

Estimated return to full duty:

DISPOSITION

Disposition:

Next Scheduled Appointment: 08:00 am 1/31/2005

"I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury."

Signed,

Donald Rossman, (Original signature on file)

Doctor's Phone: (209) 461-3196 opt. 3
Doctor's Fax: (209) 461-7529
Case Coordinator Phone: (209) 461-3196 opt.1

Dameron Hospital Occupational Health Services
525 W. Acacia St., Stockton, CA 95203

WORK STATUS REPORT

Employee Name: Anderson, Tiffany K
Social Security No.: 549-23-5133
Employer: SJ Mosquito and Vector Control
Date of Injury: 01/21/2005
Clinic Case Number: 66402

Date of Visit: 01/31/2005
Time In: 08:00 am **Time Out:** 08:47 am
Guarantor: AIMS - Fresno 8046
Claim Number: Pending

CLINICAL STATUS

Diagnosis: Allergic Reaction

Since the last visit, this patient's condition has:

EVALUATION AND TREATMENT PLAN

Physical / Occupational Therapy:

Recommended Evaluation / Diagnostic Studies:

WORK STATUS

Work Status: Full work duties **From:** 01/31/2005 **To:** 02/03/2005

Work Restrictions:

Estimated return to full duty:

DISPOSITION

Disposition:

Next Scheduled Appointment: 08:00 am 2/ 7/2005

"I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury."

Signed,

Donald Rossman, (Original signature on file)

Doctor's Phone: (209) 461-3196 opt. 3
Doctor's Fax: (209) 461-7529
Case Coordinator Phone: (209) 461-3196 opt.1

Dameron Hospital Occupational Health Services
525 W. Acacia St., Stockton, CA 95203

WORK STATUS REPORT

Employee Name:	Anderson, Tiffany K	**Date of Visit:**	02/07/2005
Social Security No.:	549-23-5133	**Time In:** 09:04 am	**Time Out:** 09:32 am
Employer:	SJ Mosquito and Vector Control		
Date of Injury:	01/21/2005	**Guarantor:**	AIMS - Fresno 8046
Clinic Case Number:	66402	**Claim Number:**	Pending

CLINICAL STATUS

Diagnosis: Allergic Reaction

Since the last visit, this patient's condition has:

EVALUATION AND TREATMENT PLAN

Physical / Occupational Therapy:

Recommended Evaluation / Diagnostic Studies:

WORK STATUS

Work Status: Full work duties **From:** 02/07/2005 **To:** 02/14/2005

Work Restrictions:

Estimated return to full duty:

DISPOSITION

Disposition:

Next Scheduled Appointment: 09:40 am 2/28/2005 EC. 2/7/05

"I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury."

Signed,

Donald Rossman (Original signature on file)

Doctor's Phone: (209) 461-3196 opt. 3
Doctor's Fax: (209) 461-7529
Case Coordinator Phone: (209) 461-3196 opt.1

State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

*** AIMS WORKERS' COMPENSATION ***
P.O. Box 28904
Fresno, CA 93729-8904

OSHA CASE NO.

FATALITY ☐

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.

California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

Please do not use this column

CASE NUMBER

OWNERSHIP

INDUSTRY

OCCUPATION

SEX

AGE

DAILY HOURS

DAYS PER WEEK

WEEKLY HOURS

WEEKLY WAGE

COUNTY

NATURE OF INJURY

PART OF BODY

SOURCE

EVENT

SECONDARY SOURCE

EXTENT OF INJURY

EMPLOYER

1. FIRM NAME: San Joaquin Co. Mosquito & Vector Control
1a. Policy Number:
2. MAILING ADDRESS: (Number, Street, City, Zip): 7759 S. Airport WAY Stockton CA 95206
2a. Phone Number: 209 982-4675
3. LOCATION if different from Mailing Address (Number, Street, City and Zip):
3a. Location Code:
4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.: Mosquito Control
5. State unemployment insurance acct.no:
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☒ Other Govt. Specify: Spec. Dist

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy): 10-11-05
8. TIME INJURY/ILLNESS OCCURRED: 9:00 AM ____ PM
9. TIME EMPLOYEE BEGAN WORK: 7:00 AM ____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy): —
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy):
13. DATE RETURNED TO WORK (mm/dd/yy):
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy): 10-11-05
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy): 10-13-05
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning: Rash - legs - stomach area
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip): McDonald Island
20a. COUNTY: San Joaquin
21. ON EMPLOYER'S PREMISES? ☐ Yes ☒ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.: Field
23. Other Workers Injured or ill in this event? ☐ Yes ☒ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold: dipper for sampling water
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.: checking flooded area for larva breeding - slipped down into water - 4½ ft deep. bank gave away.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY: It was a 30 minute drive back to district yard with wet clothes, Something irritated my skin. Hugh rash This is spreading and a sore throat.
27. Name and address of physician (number, street, city, zip): Dameron Hospital 420 W. Acacia St Stockton
27a. Phone Number: 209 461-3196
28. Hospitalized as an inpatient overnight? ☒ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number:
29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME: Tiffany Anderson
31. SOCIAL SECURITY NUMBER: 549 23 5133
32. DATE OF BIRTH (mm/dd/yy): 8/22/70
33. HOME ADDRESS (Number, Street, City, Zip): 1416 Iris Dr Lodi CA 95242
33a. PHONE NUMBER: 209 333-1037
34. SEX: ☐ Male ☒ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers): Mosquito Control Technician I
36. DATE OF HIRE (mm/dd/yy): 4/19/04
37. EMPLOYEE USUALLY WORKS: 8 hours per day, 5 days per week, 40 total weekly hours
37a. EMPLOYMENT STATUS: ☒ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED: Salaries / Wages
38. GROSS WAGES/SALARY: $1492.54 per bi weekly
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☒ No

Completed By (type or print): Carol Aksland
Signature & Title: Carol Aksland - Secretary
Date (mm/dd/yy): 10/13/05

* Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the "Employee" section and give the form to your employer. Keep a copy and mark it "Employee's Temporary Receipt" until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at (800) 736-7401. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

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.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* Tiffany Anderson Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* 1416 Iris Dr. #7
3. City. *Ciudad.* Lodi State. *Estado.* CA Zip. *Código Postal.* 95242
4. Date of Injury. *Fecha de la lesión (accidente).* 10-11-05 Time of Injury. *Hora en que ocurrió.* 9:00 a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* Mc Donald Island
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* rash midsection of body spreading to head. Soar throat
7. Social Security Number. *Número de Seguro Social del Empleado.* 549-23-5133
8. Signature of employee. *Firma del empleado.* [signature]

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* San Joaquin Co. Mosquito & Vector Control District
10. Address. *Dirección.* 7759 S. Airport Way Stockton CA 95206
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* 10-11-05
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* 10-13-05
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* 10-13-05
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* AIMS 770 E. Shaw Ave Fresno CA 93710
15. Insurance Policy Number. *El número de la póliza de Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* Carol Ahsland
17. Title. *Título.* Secretary 18. Telephone. *Teléfono.* 209 982-4675

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☒ Employer copy/*Copia del Empleador* ☐ Employee copy/ *Copia del Empleado* ☒ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

7/1/04 Rev.