STOCKWELL HARRIS WOOLVERTON MUEHL

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September 26, 2013

Ms. Tiffany Anderson
2 N. Avena Ave
Lodi, CA 95240

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

WCAB NO.: 1) ADJ7004221; 2) ADJ7004227; 3) ADJ7010682; 4) ADJ7976768
CLAIM NO.: VE0700184
OUR FILE NO.: 300141-040
DATE OF LOSS: 1) 6/19/08 2) 7/2/09 3) 3/26/09; 4) 6/29/11

Dear Ms. Anderson:

I am in receipt of your correspondence dated August 16, 2013. I am also in receipt of your Application alleging a new cumulative trauma injury through November, 2011.

In contrast to your email I have recommended that my client deny your claim based upon a lack of medical evidence. I also of the opinion that we can deny the claim on a Statute Of Limitations Defense.

Regarding your request for documents please find enclosed certain documents that I have been able to obtain from the employer.

I do have some questions before I request that SJCM & VCD begin the arduous task of compiling additional records.

I will refer to them as Item Numbers.

1. Please explain to me the relevance of your pre-employment physical results.

2. Please advise why you were seen at Dameron Occupational Health on the dates listed. Please advise if you filed claims alleging a work place injury for those dates.

3. I will ask for MSDS sheets in the District's possession for the locations that you serviced . If you worked at the White Slough Facility in Lodi I will ask for those records. It is of no relevance to your workers' compensation case what other employees were provided.

4. Please explain how this is relevant to your case.

5. Please explain how this is relevant to your case.

6. Please explain how this is relevant to your case.

7. Please explain how this is relevant to your case.

8. Please explain how this is relevant to your case.

As I discussed with you on the phone the issue for Dr. Allems to address is whether or not you sustained an industrial injury due to chemical exposure on June 29, 2011. As we have discussed on the phone it would be my preference and I believe consistent with the law to have Dr. Allems also address the issue of whether or not you sustained exposure on a cumulative trauma basis through November of 2011. It is my opinion that the only material that is relevant for such a determination is the following:

1. Information of the locations that you worked.

2. MSDS Sheets noting the chemicals and pesticides that you have worked with.

3. Medical Reports showing that you had sustained some type of injury (reaction) due to the exposure of those chemicals or pesticides.

Dr. Allems is not going to address anything related to your knee injury. I understand your disappointment with Dr. Tabaddor's findings but it is my opinion that he is the Panel QME and should remain as such to address any other issues related to know knees.

The examination with Dr. Allems is scheduled for October 24, 2013. If there are issues concerning his examination and documentation to be provided I recommend that we reschedule the evaluation. We can always request a Conference at the Stockton WCAB to address the issues.

Please do not hesitate to contact me should you wish to discuss this matter further.

Very truly yours,

STOCKWELL, HARRIS, WOOLVERTON & MUEHL
A Professional Corporation

KYLE R. HANSEN
KRH:krh

Enclosures

# Guidance for Controlling Potential Risks to Workers Exposed to Class B Biosolids

*This guidance is intended only for controlling health risks to workers from Class B biosolids during handling and land application. This guidance is not intended to address nonoccupational exposure.*

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
Centers for Disease Control and Prevention
National Institute for Occupational Safety and Health

July 2002

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**Publication Number 2002–149**

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## Introduction

Biosolids are the organic residues resulting from the treatment of commercial, industrial, and municipal wastewater (sewage). One purpose of the treatment is to significantly reduce the concentration of disease-causing organisms (also known as pathogens). Treatment also reduces the attractiveness of the residues to insects, birds, and rodents. The product is a material that can be recycled for uses such as adding organic material to the soil.

The U.S. Environmental Protection Agency (EPA) has established two categories of biosolids:

- Class A biosolids have undergone treatment to the point where the concentration of pathogens is reduced to levels low enough that no additional restrictions or special handling precautions are required by Federal regulations [40 CFR* Part 503]. If the Class A biosolids meet *exceptional quality* requirements for metals content, they may be sold in bags and applied in the same way as other soil conditioners such as peat moss.
- Class B biosolids have undergone treatment that has reduced but not eliminated pathogens. By definition, Class B biosolids may contain pathogens. As a result, Federal regulations for use of Class B biosolids require additional measures to restrict public access and to limit livestock grazing for specified time periods after land application [40 CFR Part 503]. This allows time for the natural die-off of pathogens in the soil.

Whereas EPA rules [40 CFR Part 503] restrict public access to lands treated with Class B biosolids in order to protect public health, these rules do not apply to workers involved with Class B biosolids handling and land application.

*Code of Federal Regulations.*

Workers may come in contact with Class B biosolids during the course of their work. Workers and employers may be well aware of the need for precautions when contacting untreated sewage but less aware of the need for basic precautions when using Class B biosolids. This document provides information, guidance, and recommendations to employers and employees working with Class B biosolids to minimize occupational risks from pathogens. It does not address other potential safety and health issues such as injuries or exposures to chemicals.

## How are biosolids used?

Biosolids are typically treated to Class B or Class A standards at the wastewater (sewage) treatment plant, where a liquid or semi-solid material is produced. In a liquid state, biosolids can be transported by truck to a land application site where they are applied directly to the land using tractors, tank wagons, irrigation systems, or special application vehicles. Alternatively, biosolids may undergo mechanical dewatering that may include the use of polymers. Dewatered and liquid biosolids are often temporarily stored at the treatment plant or application site. Dewatered biosolids are transported and applied to land using front-end loaders, trucks, tractors, or biosolids-spreading equipment. Most biosolids are applied with spreaders in semisolid form and then incorporated into the soil using a disc plow. Workers may come into either direct or indirect contact with biosolids during any phase of the treatment, transport, or application process, or after they are land applied. Currently, more than 50% of the biosolids generated in the United States is recycled as soil conditioners to improve and maintain productive soils and stimulate plant growth rather than being sent to landfills or incinerated. Biosolids are applied on agricultural land, forestlands, and surface mine reclamation sites. Class A biosolids are also used in horticultural applications. EPA estimates that 7.1 million tons of biosolids were generated for use or disposal in 2000.

## What is in biosolids that requires control of worker exposures?

There are four major types of human disease-causing organisms (pathogens) that can be found in sewage: (1) bacteria, (2) viruses, (3) protozoa, and (4) helminths (parasitic worms). Class B biosolids may contain the same types of pathogens as the source sewage, but at reduced concentrations. Both Class A and Class B biosolids may also contain chemicals (including metals) and allergens.

To protect public health, the EPA's 40 CFR Part 503 rule prescribes a *restricted period* of up to 1 year to limit public access to lands where Class B biosolids have been applied. These EPA restrictions do not apply to occupational access. EPA does recognize that occupational exposure can occur and states that workers exposed to Class B biosolids might benefit from several additional precautions such as use of dust masks when spreading dry materials, the use of gloves when touching biosolids, and routine hand washing before eating, drinking, smoking, or using the bathroom.

The risk of worker exposure to infectious agents in Class B biosolids is likely greatest prior to, during, and immediately after land application of the biosolids. Because the concentration of pathogens declines through natural processes, the potential for pathogen exposure decreases over time.

## Do we know these pathogens can cause disease?

Yes, the association between poor hygiene, raw sewage, and infectious disease is well established. Most of the pathogenic bacteria, viruses, and parasites in biosolids are enteric, which means they are present in the intestinal tracts of humans and animals. Enteric organisms that may be found in biosolids include, but are not limited to, *Escherichia coli*, *Salmonella*, *Shigella*, *Campylobacter*, *Cryptosporidium*, *Giardia*, Norwalk virus, and enteroviruses. Exposure may potentially result in disease (e.g., gastroenteritis) or in a carrier state in which an infection does not clinically manifest itself in the individual but can be spread to others. These enteric organisms are usually associated with self-limited gastrointestinal illness but can develop into more serious diseases in sensitive populations such as immune-compromised individuals, infants, young children, and especially the elderly.

The disease risk is a function of the number and types of pathogens in the Class B biosolids relative to the exposure levels and infective dose. Because data are sparse on what constitutes an infective dose, it is prudent public health practice to minimize workers' contact with Class B biosolids and soil or dusts containing Class B biosolids during production and application, and at land application sites during the period when public access is restricted. Class A biosolids may also present some health risk to workers, since some chemicals and biologic constituents in Class A biosolids are not regulated by the EPA.

## Can workers be exposed to pathogens from biosolids?

Workers could be exposed to pathogens and irritants when working with Class B biosolids during the period when public access is restricted. During a NIOSH field investigation at one biosolids land application and storage site that did not comply with EPA requirements, the following was observed:

- NIOSH interviewed employees who worked in all phases of the biosolids operation. Some

employees reported repeated episodes of gastrointestinal illness after working with the biosolids, either at the treatment plant or during land application.

- NIOSH observed among workers an inconsistent awareness, provision, and use of protective equipment and hygiene practices appropriate for handling Class B biosolids (or biosolids that do not comply with EPA standards).
- NIOSH collected bulk samples from different locations within the biosolids storage site and found measurable concentrations of fecal coliforms. Fecal coliforms are used as an indicator for the presence of other enteric microorganisms. Enteric bacteria were detected in air samples collected at the land application site.
- The local department of environmental services recently informed NIOSH that biosolids applied at this site intermittently exceeded (by up to 4.5 times) the EPA fecal coliform upper limit for Class B biosolids prior to the NIOSH survey.
- The substandard biosolids were applied at the agricultural site before the monitoring results were received from the laboratory.

EPA reports that high-pressure spray applications may result in some aerosolization of pathogens and that application or incorporation of dewatered biosolids may cause very localized fine particulate/dusty conditions. Also, farm workers may be exposed to biosolids after application and during the restricted period. Ancillary workers (for example, laborers hired to clean trucks that were used to haul biosolids) can be exposed to biosolids. Exposures to substandard biosolids can occur when these materials are loaded and hauled to approved landfills or incinerators for disposal.

Additional study of worker exposures to pathogens and other toxics possibly present in Class B biosolids is needed. This will reduce scientific uncertainty about these issues and allow further refinement of worker precautions.

## What should employers do to prevent work-related illness?

To protect workers who have direct contact with Class B biosolids and thus are likely to have an exposure to pathogens, employers should provide a basic level of protection, including appropriate measures from those listed below. While the measures are worded to refer to Class B biosolids, most also apply to tasks involving contact with sewage, untreated or partially treated sludge, or substandard biosolids.

### Provide basic hygiene recommendations for workers.

Basic hygiene precautions are important for workers handling biosolids. The following list, originally developed by EPA, provides a good set of hygiene recommendations.

1. Wash hands thoroughly with soap and water after contact with biosolids.
2. Avoid touching face, mouth, eyes, nose, genitalia, or open sores and cuts while working with biosolids.
3. Wash your hands *before* you eat, drink, or smoke and before and after using the bathroom.
4. Eat in designated areas away from biosolids-handling activities.
5. Do not smoke or chew tobacco or gum while working with biosolids.

6. Use barriers between skin and surfaces exposed to biosolids.

7. Remove excess biosolids from footgear prior to entering a vehicle or a building.

8. Keep wounds covered with clean, dry bandages.

9. Thoroughly but gently flush eyes with water if biosolids contact eyes.

10. Change into clean work clothing on a daily basis and reserve footgear for use at worksite or during biosolids transport.

11. Do not wear work clothes home or outside the work environment.

12. Use gloves to prevent skin abrasion.

In addition, NIOSH recommends the following steps to provide a more comprehensive set of precautions for use by employers and employees:

## Provide appropriate protective equipment, hygiene stations, and training.

*Personal Protective Equipment (PPE).*—Appropriate PPE should be provided for all workers likely to have exposure to biosolids. The choices of PPE include goggles, splash-proof face shields, respirators, liquid-repellent coveralls, and gloves. Face shields should be made available for all jobs in which there is a potential for exposure to spray or high-pressure leaks, or aerosolized biosolids during land application. Management and employee representatives should work together to determine which job duties are likely to result in this type of exposure, to conduct appropriate on-site monitoring, and to determine which type of PPE is needed in conjunction with a qualified safety and health professional. If respirators are needed, a comprehensive program would include respirator fit-testing and training or retraining.

*Hygiene and Sanitation.*—Hand-washing stations with clean water and mild soap should be readily available whenever contact with biosolids occurs. In the case of workers in the field, portable sanitation equipment, including clean water and soap, should be provided. Cabs should be wiped down and cleaned of residual mud (or settled dust) frequently to reduce potential for exposure to biosolids.

*Training.*—Periodic training on standard hygiene practices for biosolids workers should be conducted by qualified safety and health professionals to cover issues such as the following:

- Frequent and routine hand washing (the most valuable safeguard in preventing infection by agents present in biosolids), especially before eating or smoking
- The proper use of appropriate PPE, such as coveralls, boots, gloves, goggles, respirators, and face shields
- The removal of contaminated PPE and the use of available on-site showers, lockers, and laundry services
- Proper storage, cleaning, or disposal of contaminated PPE
- Instructions that work clothes and boots should not be worn home or outside the immediate work environment
- Prohibition of eating, drinking, or smoking while working in or around biosolids
- Procedures for controlling exposures to chemical agents that may be in biosolids

*Reporting.*—Workers should be trained to report potentially work-related illnesses or symptoms to the appropriate supervisory or health care staff. This may aid in the early detection of work-relat ed health effects.

*Immunizations.*—Ensure that all employees are up-to-date on tetanus-diphtheria immunizations, since employees are at risk of soil-contaminated injuries. Current CDC recommendations do not support hepatitis A vaccination for sewage workers.

## Extend good environmental practices to prevent and minimize occupational exposures.

- Where feasible, substituting Class A biosolids could reduce the pathogen exposure risks during land application compared to applying Class B biosolids. Feasibility may be affected by local customer preferences, since the two types of biosolids vary in the nutrient value they provide to end-users.

- Monitor the source material coming from the wastewater treatment facility. Check monitoring results to assure they meet specified Class B or Class A standards prior to land application operations.

- Monitor stored biosolids prior to application to assure that the biosolids are properly stabilized and that unacceptable regrowth or cross-contamination from substandard material has not occurred.

- Where local conditions permit, inject biosolids below the soil or incorporate (thoroughly mix) into tilled soil. This will minimize post-application worker contact with applied biosolids and prevent resuspension into the air during periods of dryness.

- On windy days, avoid spreading or disturbing dry biosolids (e.g., compost) that would create dust.

- On windy days, avoid spreading biosolids by high-pressure spray.

- Avoid unnecessary mechanical disturbance and contact with land-applied Class B biosolids during the period when public access is restricted.

- Equip heavy equipment used at storage and application facilities with sealed, positive-pressure, air-conditioned cabs that contain filtered air-recirculation units.

- Monitor worker exposures when adjusting precautions to address site-specific issues.

## For More Information

Additional information about biosolids and preventive measures can be obtained from the following government Web sites:

- Environmental Protection Agency (EPA). *Biosolids.*
  www.epa.gov/owm/bio.htm
  (This site includes links to professional associations that address biosolids.)

- National Center for Infectious Diseases (NCID). *Viral Hepatitis Resource Center.*
  www.cdc.gov/ncidod/diseases/hepatitis

- National Institute for Occupational Safety and Health (NIOSH).
  www.cdc.gov/niosh

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# Formaldehyde

**Overexposure to formaldehyde irritates the eyes, nose, throat, and skin.** Formaldehyde can cause allergic reactions of the skin (dermatitis) and the lungs (asthma). Formaldehyde is a known cause of cancer in humans.

## How to find out if you are working with formaldehyde

Your employer must tell you if you are working with formaldehyde, and must train you to use it safely, under California's Formaldehyde Standard and the Hazard Communication Standard (see page 8). If you think you may be exposed to formaldehyde on the job, ask to see the Material Safety Data Sheets (MSDSs) for the products you are using. The MSDS must identify formaldehyde in Section 2, by the Chemical Abstract Service (CAS) number 50-00-0.

Formaldehyde is commonly used as formalin, a mixture of 30-50% formaldehyde and 10-20% methyl alcohol in water. Formalin readily gives off irritating vapors with a strong odor.

## Some synonyms and trade names of formaldehyde products

| | |
|---|---|
| formalin | BFV |
| methaldehyde | Fannoform |
| methanal | Formalith |
| methyl aldehyde | Formol |
| methylene glycol | Fyde |
| methylene oxide | Ivalon |
| oxomethane | Karsan |
| oxymethylene | Lysoform |
| paraform | Morbicid |
| paraformaldehyde | |

## How formaldehyde is used and where it's found

Formaldehyde is used as a...

- disinfectant and sterilant,*
- fumigant,
- preservative, and in...
- embalming fluid,
- some keratin-based hair smoothing treatments.

* *(other aldehydes used include glutaraldehyde and ortho-phthalaldehyde)*

FACT SHEET

HESIS

**HAZARD EVALUATION SYSTEM & INFORMATION SERVICE**
California Department of Public Health
Occupational Health Branch
850 Marina Bay Parkway, Building P, 3rd Floor, Richmond, CA 94804
510-620-5757 • www.cdph.ca.gov/programs/ohb

FEBRUARY 2011 (revised) **California Department of Public Health • California Department of Industrial Relations**

It is used in making...

- chemical resins • wrinkle-proof fabrics
- rubber products • latex paints • dyes
- plastics • paper products, and • cosmetics.

It is found in...

- insulation materials • plywood • particle board
- adhesives • glues • paint primers, and
- fingernail products.

Any of these materials may give off formaldehyde vapors.

Formaldehyde is also present in combustion products, such as vehicle exhaust and tobacco smoke.

## Some workers who may have substantial exposure to formaldehyde

chemical and rubber workers
embalmers
laboratory workers
health care workers
clothing and textile workers
furniture or wood product makers
foundry workers
insulation workers

# How formaldehyde affects your body

Formaldehyde can affect you when you breathe its vapors or touch the liquid. Because formaldehyde reacts quickly with body tissues, it mainly affects the place of direct contact, such as the eyes, nose, and skin. The most common effect of overexposure is irritation of the eyes, nose, and throat.

**Eyes, Nose, and Throat.** The eyes, nose, and throat are irritated by formaldehyde vapors at levels as low as about 0.3 part formaldehyde per million parts of air (0.3 part per million, or 0.3 "ppm" – see "Legal Exposure Limits"). This exposure can cause red, teary, burning eyes, sneezing and coughing, and sore throat. Some people have irritant symptoms at these very low exposure levels, while others can tolerate levels as high as a few ppm with little or no reaction.

Liquid formaldehyde solutions contacting the eyes can damage the cornea, possibly causing blindness.

**Lungs.** High levels (5-30 ppm and higher) can severely irritate the lungs, causing chest pain and shortness of breath.

Repeated exposure to formaldehyde can cause allergic asthma. Symptoms of asthma include chest tightness, shortness of breath, wheezing, and coughing. Formaldehyde's long-term effects on the lungs are not fully understood.

**Skin.** Formaldehyde solutions can destroy your skin's natural protective oils, causing dryness, flaking, cracking, and dermatitis (skin rash). Skin contact can also cause an allergic reaction (redness, itching, hives, and blisters). As many as one in twenty workers who are regularly exposed to formaldehyde develop an allergic skin reaction.

**Cancer.** Formaldehyde exposure can cause cancer of the nose and sinuses in humans, as well as some types of leukemia and lymphoma. Formaldehyde is regulated as a carcinogen by Cal/OSHA and Cal/EPA.

**Reproductive System.** Formaldehyde's effect on pregnancy and the reproductive system has been studied in both humans and in laboratory animals. Formaldehyde has been shown to decrease fertility and increase the risk of spontaneous abortion (miscarriage) in humans. In laboratory animals, formaldehyde can harm the developing fetus and damage sperm. In order to avoid risk to pregnancy and the reproductive system, HESIS recommends minimizing workplace exposures to formaldehyde prior to and during pregnancy.

# Legal exposure limits

**Permissible Exposure Limits.** The Occupational Safety and Health Standards Board sets Permissible Exposure Limits (PELs) for the amounts of chemicals in workplace air. PELs are intended to protect the health of most workers who are exposed every day over a working lifetime.

The **PEL** for formaldehyde is 0.75 part of formaldehyde per million parts of air (0.75 part per million, or **0.75 ppm**). Legally, your exposure may be above the PEL at times, but only if it is below the PEL at other times, so that your average exposure for any 8-hour workshift is no more than 0.75 ppm.

The **Short-Term Exposure Limit (STEL)** for formaldehyde is **2 ppm**. Your average exposure during any 15-minute period must not exceed 2 ppm. Exposure at or above the STEL triggers special requirements.

The **Action Level** for formaldehyde is **0.5 ppm** averaged over an 8-hour period. Air monitoring, medical surveillance, and other special requirements are triggered at or above this level.

Cal/OSHA's formaldehyde standard, California Code of Regulations, Title 8, Section 5217, contains many other specific requirements (see information on page 8).

# Monitoring your exposure

To reduce your risk of developing health problems from exposure to formaldehyde, your employer must...

- Identify employees who may be exposed at or above the action level or STEL.
- Test the air to accurately determine how much formaldehyde each identified employee is breathing.
- Test the air periodically if the first tests show that exposures are at or above the action level or STEL.
- Re-test the air for formaldehyde each time there is a change that may result in new or additional exposure.
- Determine exposures promptly, if employees are having formaldehyde-related respiratory or skin symptoms.
- Allow employees or their designated representatives to observe any required exposure monitoring.
- Notify employees in writing within 15 days after receiving the exposure monitoring results.

See the formaldehyde standard (information on page 8) for additional exposure monitoring requirements.

# Tests for exposure and medical effects

**Blood or urine tests.** Formaldehyde does not stay in your body. No medical or laboratory test can accurately measure the amount of formaldehyde to which you have previously been exposed. There is no medical reason to do blood or urine tests for formaldehyde.

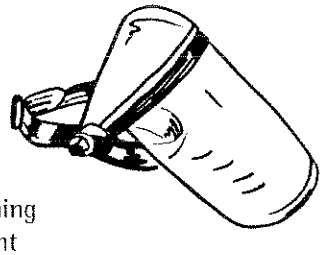
**Medical Surveillance.** If you are exposed to formaldehyde at or above the action level or above the STEL, your employer must have a *medical surveillance program* to monitor effects on your health.

Your employer also must...

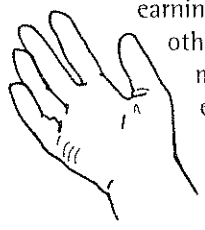
- Provide the *medical surveillance program* if you develop signs and symptoms of overexposure to formaldehyde, or if you are exposed to formaldehyde during an emergency.
- Provide a *medical disease questionnaire* before assignment to jobs where exposures are at or above the action level or above the STEL, and promptly when you experience signs and symptoms that indicate overexposure to formaldehyde.

- Ensure a *medical examination*
  - if evaluation of the questionnaire indicates that you may be at increased risk for health effects;
  - at the time you first start using a respirator (if you are required to wear one) and then once a year;
  - as soon as possible if you are exposed to formaldehyde in an emergency.
- Provide the medical exam at a reasonable time and place, at no cost to you, and without loss of pay.
- Have a *licensed physician* or someone under the physician's supervision perform all medical procedures, including administration of the medical disease questionnaire.
- Provide specific information about your job, and a copy of the formaldehyde standard and the appendices, to the health care provider.
- Provide you with a copy of the *physician's written opinion* within 15 days after receiving it.

**Medical Removal.** If you experience significant *irritation of the eyes, throat, or lungs, or asthma-like symptoms* such as chest tightness, shortness of breath, coughing, or wheezing, a physician must determine whether you need to be removed from exposure to formaldehyde. A physician must also evaluate *skin irritation or skin allergies* caused by products that contain at least 0.1% formaldehyde.



See the Cal/OSHA formaldehyde regulation for other specific medical removal requirements including job transfer or job training with retention of current earnings, seniority and other benefits, and provisions for multiple physician review of evaluation results.



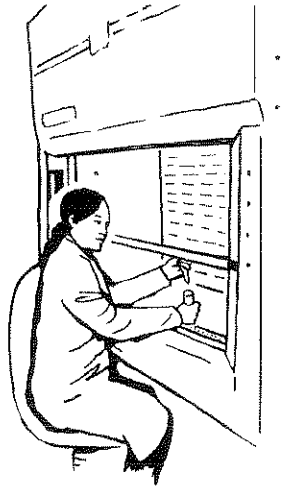
# Reducing exposure

By law, employers must provide a safe and healthy workplace. Here are some ways employers and workers can work together to reduce exposures to formaldehyde. See the formaldehyde regulation for specific Cal/OSHA requirements (information on page 8).

### Use safer substitutes whenever possible

- *Hydrogen peroxide-based solutions* often can be used as disinfectants.
- *Ethyl alcohol, polyethylene glycol,* or *phenoxyethanol* can be used as fixatives or preservatives.

### Ventilate the work area



- Install *professionally designed ventilation systems* to maintain formaldehyde exposures below legal exposure limits.
- Conduct *regular maintenance on ventilation systems* and ensure that they are functioning properly.
- Do not allow ventilation systems to recirculate formaldehyde vapors.

### Use personal protective equipment

- *Protective clothing and equipment* must be provided at no cost to prevent skin and eye contact with liquids containing 1% or more formaldehyde. Employers must ensure that employees use it.
- *Change rooms* as specified in Title 8, Section 3367 must be provided for employees who are required to change from work clothes to protective clothing.
- *Gloves made of nitrile, neoprene, butyl rubber or polyethylene laminate* protect against incidental hand or skin contact with formaldehyde. Gloves made of latex may not provide adequate protection and can cause allergic reactions.

- *Chemical resistant aprons* protect against splashes to the body.
- *Chemical safety goggles* protect eyes from splashes.
- *Face shields* with *chemical safety goggles* protect the entire face from splashes.
- *Respirators* should be used as specified in the formaldehyde regulation, *only if ventilation and other control methods are not effective or feasible*. Employers also must comply with the Cal/OSHA Respiratory Protection Standard (Title 8, Section 5144).

### Inform and train workers

- Explain and discuss the *formaldehyde regulation* and *MSDSs*.
- Educate employees about formaldehyde *health hazards* and *symptoms of overexposure*. Emphasize the importance of reporting symptoms early.
- Instruct employees on the use of *safe work procedures*.
- Demonstrate the proper *use and maintenance* of fume hoods and other *local exhaust ventilation systems*.
- Explain the *purpose and limitations of personal protective clothing and equipment* and demonstrate how to use them properly.
- Instruct employees on how to respond to *spills* and *emergencies*, and on safe *clean-up procedures*.
- Conduct drills on *emergency procedures* that include each employee's specific duties.
- Ensure that *employees understand* the *information* and *training*.

### Establish and use safe work procedures

- Identify *regulated areas* where formaldehyde concentrations exceed the PEL or the STEL. Post with signs required by the regulation, and limit access to persons trained on the hazards of formaldehyde.
- Provide eyewash facilities in areas where splashing may occur with solutions that contain 0.1% or more formaldehyde. Provide emergency showers in areas where solutions of 1% or more formaldehyde are used. Where both are required, locate them together within 10 seconds of the splash area (Title 8, Section 5162).
- Use *laboratory fume hoods* when working with open containers of formaldehyde and specimens preserved in formaldehyde.
- *Label all containers* as specified in the formaldehyde regulation.
- *Cap storage containers* immediately when formaldehyde is not in use.
- Do not use formaldehyde on surfaces like carpets that can't be cleaned easily.

### Minimize exposure from spills and contaminated material

- Perform *preventive maintenance on equipment* and *inspect frequently* to detect leaks and spills.
- Develop *procedures to contain spills, decontaminate work areas*, and dispose of waste in work areas where spills may occur.
- Use *formaldehyde neutralization pads* or sheets where small spills or drips may occur on work surfaces.
- *Repair all leaks* and *clean up spills* promptly. Ensure that employees are wearing suitable protective equipment and are trained.
- Use *formaldehyde neutralization products* that neutralize quickly and don't generate hazardous by-products.
- Promptly *remove contaminated material*, such as towels, clothing, and sponges from the work area.
- *Ventilate contaminated clothing and equipment* in properly labeled and established storage areas. Have only persons trained in formaldehyde hazards remove them.
- Place *contaminated waste* and debris for disposal in *sealed, labeled containers* that warn of formaldehyde hazards.

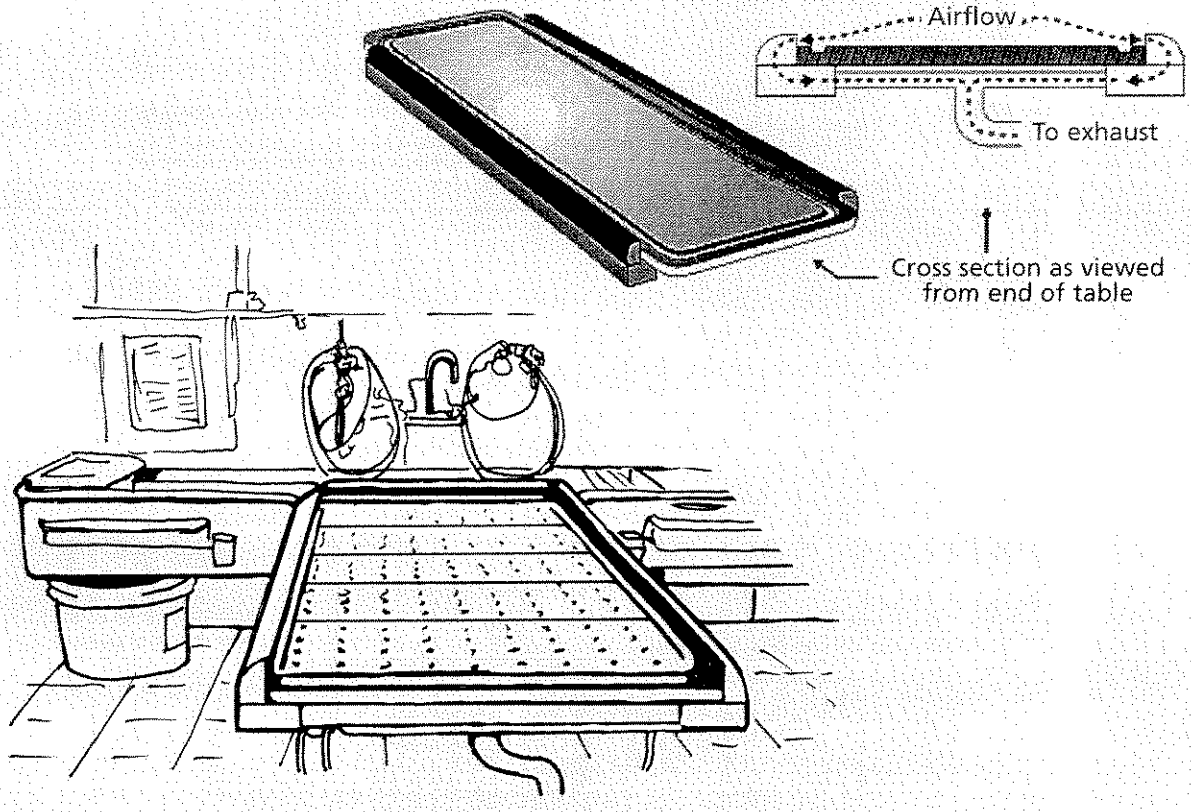
# SPECIFIC WAYS TO REDUCE EXPOSURES FOR VARIOUS INDUSTRIES

## FUNERAL

- Use *embalming fluid substitutes* that contain ethyl alcohol, polyethylene glycol, or phenoxyethanol. Be aware that embalming creams and drying and hardening powders may also contain formaldehyde.
- Use *embalming tables with local exhaust ventilation* that draws air down at the sides and carries it out of the room through ducts. These systems are sold for existing tables.
- Use *small quantities* for easy and safe handling.
- Use personal protective equipment such as gloves, chemical safety goggles, face shields, and aprons.

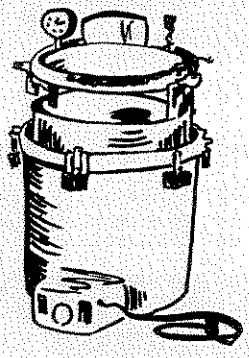
## APPAREL AND TEXTILE

- Use *low formaldehyde-containing cross-linking agents* in textile manufacturing processes, when possible.
- Use a *roof exhaust fan* or other ventilation systems to remove formaldehyde vapors from stored apparel and to provide *a continuous supply of fresh air.*

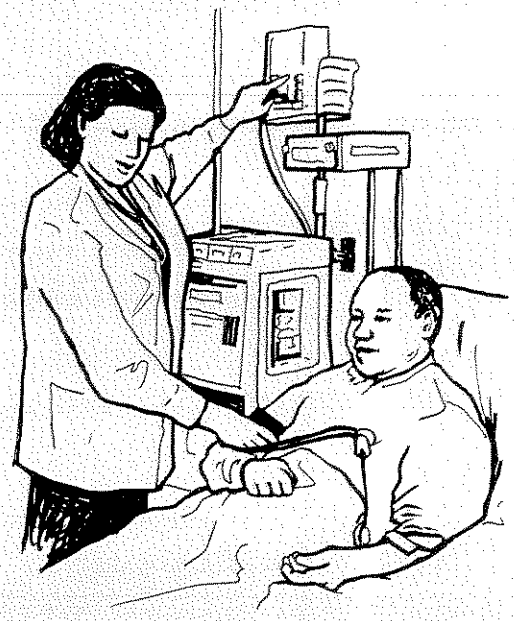


## MEDICAL AND HEALTH SERVICES

- Use other sterilization methods, such as *low temperature plasma* or *autoclaving*, instead of formaldehyde whenever possible.



- Use non-formaldehyde disinfectants. *Hydrogen peroxide-based solutions* may be suitable.
- Use formaldehyde-free fixatives for histopathological procedures, when possible.
- Use formaldehyde-based fixatives with the lowest concentration of formaldehyde possible.
- Incorporate *automatic dispensing systems* to replace manual formaldehyde handling procedures, such as washing, disinfecting, or dispensing.
- Conduct work with open containers in laboratory fume hoods or using other local exhaust ventilation systems.



- Ensure that *hemodialysis* drain line connections are airtight to prevent formaldehyde vapors from escaping into treatment rooms.
- Spend as little time as possible in areas where *hemodialyzers are reprocessed.*

## FOUNDRY AND FURNITURE

- Convert to *low-emitting formaldehyde resins*, when possible.
- Use *formaldehyde-free wood products.*
- Provide a *continuous supply of fresh air* where furniture is stored.

## ELECTRONICS

- Consider switching to *formaldehyde-free alternatives* in printed circuit boards. Carbon, graphite, organic-palladium, tin-palladium, sodium hypophosphite electroless copper, and conductive polymer technology are examples.

# RESOURCES

## REGULATIONS THAT HELP TO PROTECT WORKERS

- **Formaldehyde Standard.** This comprehensive standard, California Code of Regulations (CCR), (Title 8, Section 5217) requires employers to take specific actions to protect workers from allergic reactions, irritation, and cancer that can result from exposure to formaldehyde.
  See www.dir.ca.gov/title8/5217.html.

- **Hazard Communication Standard.** Under this standard (Title 8, Section 5194), your employer must tell you if you are working with any hazardous substances, must train you to use them safely, and must make Material Safety Data Sheets available.
  See www.dir.ca.gov/title8/5194.html.

- **Injury and Illness Prevention Program.** Every employer must have an effective, written Injury and Illness Prevention Program (IIPP) that identifies a person with the authority and responsibility to run the program (Title 8, Section 3203). The IIPP must include methods for identifying workplace hazards, methods for correcting hazards quickly, health and safety training at specified times, a system for communicating clearly with all employees about health and safety matters (including safe ways for employees to tell the employer about hazards), and recordkeeping to document the steps taken to comply with the IIPP.
  See www.dir.ca.gov/title8/3203.html.

- **Access to Medical and Exposure Records.** You have the right to see and copy your own medical records, and any records of toxic substance exposure monitoring (Title 8, Section 3204). These records are important in determining whether your health has been affected by your work. Employers who have such records must keep them and make them available to you for at least 30 years after the end of your employment.
  See www.dir.ca.gov/title8/3204.html.

## WHERE TO GET HELP

- **HESIS.** Answers questions about formaldehyde and other workplace hazards for California workers, employers, and health care professionals. Call **1-866-282-5516**. HESIS also has many free publications available. To request publications, leave a message at **(866) 627-1586**, visit our website at **www.cdph.ca.gov/programs/ohb**, or write to HESIS at 850 Marina Bay Parkway, Building P, 3rd Floor, Richmond, CA 94804.

- **National Institute for Occupational Safety and Health (NIOSH).** Hazard Control 26 / *Controlling Formaldehyde Exposures During Embalming*: www.cdc.gov/niosh/hc26.html.

- **California Division of Occupational Safety and Health (Cal/OSHA).** Investigates workers' complaints and answers questions about workplace health and safety regulations. Complainants' identities are kept confidential. Contact the nearest Cal/OSHA Enforcement District Office. They are listed in the blue government section near the front of the phone book, under "State Government / Industrial Relations /Occupational Safety and Health /Enforcement" or visit their website at www.dir.ca.gov/DOSH.

- **Other resources for employees** may include your supervisor, your union, your company health and safety officer, your doctor, or your company doctor.

- **Cal/OSHA Consultation Service.** Helps employers who want free non-enforcement assistance to improve health and safety conditions. Employers can call **1-800-963-9424.**

To obtain a copy of this document in an alternate format, please contact: (510) 620-5757. (CA Relay Service: 800-735-2929 or 711). Please allow at least ten (10) working days to coordinate alternate format services.


Edmund G. Brown Jr., Governor
State of California

Diana S. Dooley, Secretary
Health and Human Services Agency

Mark B Horton, MD, MSPH, Director
Department of Public Health

Marty Morgenstern, Secretary
Labor and Workforce Development Agency

John C. Duncan, Director
Department of Industrial Relations

JANE NORLING DESIGN

ACCLAMATION INSURANCE
MANAGEMENT SERVICES

February 28 2005

Tiffany Anderson
1830 S. Hutchins, #304
Lodi, CA 95240

Employee: Tiffany Anderson
Employer: San Joaquin Co. Mosquito/Vector Control District
Claim No: VE050054
D/Injury: 01-21-05

Dear Ms. Tiffany Anderson:

Based on a review of your file it appears you have recovered from your injury without any permanent disability. For this reason, we assume that you are not in need of further medical treatment and are having no further problems from your injury.

If you feel that you are in need of further medical care or that you are having some residual disability resulting from head to toe rash, then please contact me in order that we might make arrangements for necessary medical care. If we do not hear from you within 30 days from the date of this letter, we will assume that you are in agreement with our decision and will close our file. You may contact the State Information and Assistance Officer at 209/948-7980, for further information.

**Be advised that certain statute of limitations apply to the provision of benefits.** If it is necessary to go to the Workers' Compensation Appeals Board to resolve your claim, you **must** file an Application of Adjudication within one year of the date of your injury **or** one year from the date of your last medical treatment. Waiting longer could mean losing your right to benefits. And should you allege your injury has caused you any new and further disability, you must file an Application of Adjudication with the Worker's Compensation Appeals Board. You must do so within five years from the original date of injury. Waiting longer could also mean losing your right to benefits.

Sincerely,

Theresa Antoyan
Claims Assistant

Employer: San Joaquin Co. Mosquito/Vector Control District
File

P.O. Box 28100
Fresno, CA 93729
(559) 227-9891
FAX (559) 227-1579
CAL. LIC. 2772984

ACCLAMATION INSURANCE
MANAGEMENT SERVICES

January 28, 2005

Tiffany Anderson
1830 S. Hutchins, #304
Lodi, CA 95240

Employee: Tiffany Anderson
Employer: San Joaquin Co. Mosquito/Vector Control District
D/Injury: 01-21-05
Claim No. VE050054

Dear Ms. Tiffany Anderson:

Acclamation Insurance Management Services is the Workers' Compensation administrator for your Employer, San Joaquin Co. Mosquito/Vector Control District.

We are sorry to learn of your recent injury at work. We have enclosed a pamphlet, "Facts for Injured Workers", which explains your workers' compensation benefits.

Since this has been accepted as a work related injury, you are entitled to reimbursement for transportation expenses to obtain medical treatment at .34 cents per mile, pursuant to California Labor Code Section 4600. To have this expense reimbursed to you, please complete and return the enclosed form to us. We will then review it for payment. Please make sure the reimbursement request is clearly and accurately itemized and is signed and dated by you.

We wish you a speedy recovery.

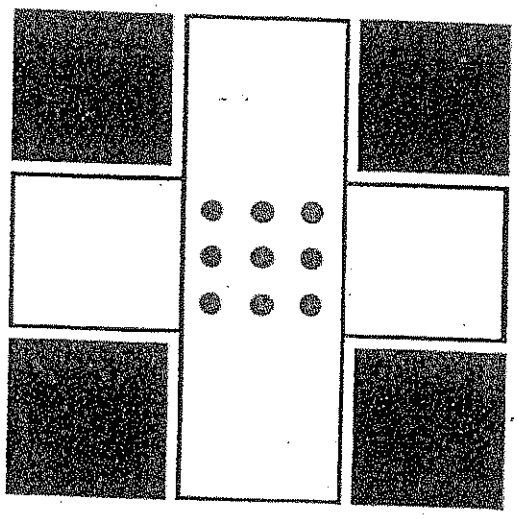
If you have any questions or wish additional information, please contact our office by calling (800) 559-9891.

Sincerely,

Theresa Antoyan
Claims Assistant
TA

cc: Employer: San Joaquin Co. Mosquito/Vector Control District
File

P.O. Box 28100
Fresno, CA 93729
(559) 227-9891
FAX (559) 227-1579
CAL. LIC. 2772984



# FACTS FOR INJURED WORKERS

ACCLAMATION INSURANCE
MANAGEMENT SERVICES

January 28, 2004

Tiffany Anderson
1830 S. Hutchins #304
Lodi, CA 95240

EMPLOYER: San Joaquin Co. Mosquito/Vector Control Dist. CLAIM#: VE050054 D/INJURY: 01-21-05
Under the California Workers' Compensation Law, you are entitled to reimbursement of reasonable mileage to and from medical appointments or treatment for your industrial injury or illness. Mileage will be reimbursed at the rate of 34¢ per mile.

Please use this form to keep track of your trips and submit it to the address below.

| DATE | FROM | TO (DOCTOR'S NAME) | ROUND TRIP MILEAGE |
|---|---|---|---|
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| | | | |

If you desire additional forms, please check here _____ **TOTAL**_____

Signature:_____

P.O. Box 28100
Fresno, CA 93729
(559) 227-9891
FAX (559) 227-1579
CAL LIC 2772984

# INJURED EMPLOYEE INFORMATION FORM

(PLEASE PRINT)

EMPLOYEE NAME: _____ DATE OF BIRTH: _____
SOCIAL SECURITY NO: _____ INJURY DATE: _____

NAME OF EMPLOYER: _____

MARITAL STATUS: _____ # OF DEPENDENTS: _____

HEIGHT: _____ WEIGHT: _____ HAIR COLOR: _____ EYE COLOR: _____

Please describe how the injury occurred: _____

_____

_____

_____

_____ (use back of sheet if more room is needed)

List names & address or phone numbers of any witness:

_____

_____

What is your job title and job duties?: _____

_____

_____

Where were you first taken for treatment of this injury?: _____

What physicians have you seen for this injury?: _____

_____

What is the name, phone number and address of your family physician?: _____

_____

What injuries did you sustain due to this accident?: (i.e.:body part injured?): _____

_____

Have you ever injured this body part before?: ___ yes ___ no. If yes: when: _____

What type of tests have the doctors done at this time?: _____

_____

Have you been released by the doctor at this time? _____ yes _____ no
*if yes date of doctor's release: _____

EMPLOYEE INFORMATION FORM NAME: _____

Please list all sports activities or hobbies you have.:_____
_____

Where did you work for before this employer?: _____
_____

Have you ever filed a workers' comp claim before?:___ NO ___Yes (date:_____)
What was the injury for which you filed the claim?:_____
Did you receive a settlement for that injury?: ____NO ____YES Amount:_____
Name of doctor that treated you for that injury.:_____

Do you have a high school diploma?: ___ YES ___ NO
Did you complete a G.E.D.? ___ YES ___ NO
Do you have any vocational training? ___NO ___ YES--Type: _____
Have you ever been in the military? ___ NO___ YES--Which branch: _____

Please list any medical conditions you may have that not related to this injury
(ie: highblood pressure): _____
_____

Please list all medications that you are currently taking.: _____
_____
_____

Besides workers' comp what other sources of income are you currently receiving?
_____

Are you right or left handed? _____ Right _____ Left _____ Ambidextrous

*I have completed and read the above and find it to be true and correct to the best of my knowledge**

_____
*Signed*

_____
*Date*

_____
*Witness*

**Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance*

# AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

**authorize**_____
(Name of physician or health care provider authorized to use or disclose information)

**To furnish to Acclamation Insurance Management Services or** _____
(Name and address of person/organization to which disclosure is made)

**Health information described below on:** _____
(Patient name)

**For the purpose of:** _____

**This information is limited to the following type and amount of information. (Use dates where appropriate.)**

| | |
|---|---|
| Progress Notes | Immunization Records |
| Consultation Reports | Any and all Records for the last 2 years |
| Laboratory, Pathology Reports | from _____ to _____ |
| Radiology Reports/Imaging Reports | from _____ to _____ |
| Medical Records relating to injury | (date) _____ |
| Other: _____ | |

## DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of health care information relating to the testing, diagnosis or treatment for: (initial appropriate area)

HIV/AIDS virus_____ Mental Health/Psychiatric Disorders_____
Sexually Transmitted Diseases_____ Drug, Alcohol Abuse/Treatment_____

I understand that I have a right to revoke this authorization at any time. I understand that my revocation must be in writing and presented to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months from date of signature.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information. I understand I have a right to receive a copy of this authorization.

**A carbon copy, photo static copy or fax copy of this true release shall be as valid as the original.**

_____ _____
*Signature of Patient, Parent or Legal Guardian* *Patient Date of Birth*

_____ _____
*If signed by other than patient, indicate relationship* *Patient Address*

_____ _____
*Patient telephone number* *Patient Social Security Number*

_____ _____
*Witness signature* *Date*

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

# WORK STATUS REPORT

| | | | |
|---|---|---|---|
| **Employee Name:** | Anderson, Tiffany K | **Date of Visit:** | 02/28/2005 |
| **Social Security No.:** | 549-23-5133 | **Time In:** 09:40 am | **Time Out:** 10:17 am |
| **Employer:** | SJ Mosquito and Vector Contro | | |
| **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:** 02/28/2005 **To:** 02/28/2005

**Work Restrictions:**

E.L. 3/1/05

**Estimated return to full duty:**

## DISPOSITION

**Disposition:** Final Discharge, P&S, no residuals PR2 to follow

**Next Scheduled Appointment:**

*"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 Contro | | |
| **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 EL 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

DH-WSR 8/14/02

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

*"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 Association
## Occupational Health Department

*** Next Appointment Information ***
(Información para su siguiente cita)

| | | | |
|---|---|---|---|
| **For:** | Anderson, Tiffany K | **Today's Date:** | 2/ 7/2005 |
| **Next Appointment Date:** | | **Case Number:** | 66402 |
| **Location:** | ☐ Suite 2 (1st Floor)<br>(209) 461-3196 x3 | ☐ Suite 19 (2nd Floor)<br>(209) 461-3196 x2 | |

***Linacia Building***
***420 W. Acacia***

S.E. corner of Lincoln & Acacia
*(En la esquina Sureste de la calle Lincoln y Acacia)*

**Your appointment**

- Please arrive to your appointment on time.
- Please do not bring children or more than one family member to your appointment.
- If you need to change your appointment, please call us as soon as possible.
- If you do not keep your appointment, we must assume that you have recovered from your injury and you will be returned to full work duties until you return for a follow up visit.

**Parking**

- Parking is available street side, or in our above ground or underground parking lot. There is no charge for parking.

**Please bring all medications you are currently taking to your next visit.**

---

**Su cita**

- Por favor llegue a su cita a tiempo.
- Por favor que no le acompañen niños ni mas de un miembro de su familia a su cita.
- Si necesita cambiar su cita, llamenos cuanto antes.
- Si falta a su cita, asumiremos que se a recuperado de su lesion y sera puesto de nuevo en trabajo regular y sin resctricciones hasta que se ponga en contacto con esta oficina para hacer una cita nueva.

**Estacionamiento**

- Hay estacionamiento disponible en la calle, al lado de la clinica y tambíen en la parte baja del edificio. No tendra que pagar por estacionamiento.

**Favor de traer toda la medicina que esta tomando a su siguiente cita.**

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

# WORK STATUS REPORT

| | | | |
|---|---|---|---|
| **Employee Name:** | Anderson, Tiffany K | **Date of Visit:** | 01/31/2005 |
| **Social Security No.:** | 549-23-5133 | **Time In:** 08:00 am | **Time Out:** 08:47 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:** 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
**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 | **Date of Visit:** | 01/26/2005 |
| **Social Security No.:** | 549-23-5133 | **Time In:** 08:25 am | **Time Out:** 09:57 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:** Off balance of shift; return to full w **From:** 01/26/2005 **To:** 01/27/2005

PTN-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 | **Date of Visit:** | 01/26/2005 |
| **Social Security No.:** | 549-23-5133 | **Time In:** 08:25 am | **Time Out:** 09:57 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:** Off balance of shift; return to full w **From:** 01/26/2005 **To:** 01/27/2005

**Work Restrictions:**

RTN - 1-27-05

**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 Association
## Occupational Health Department

*** Next Appointment Information ***
(Información para su siguiente cita)

| | | | |
|---|---|---|---|
| **For:** | Anderson, Tiffany | **Today's Date:** | 1/26/2005 |
| **Next Appointment Date:** | | **Case Number:** | 66402 |
| **Location:** | ☐ Suite 2 (1st Floor)<br>(209) 461-3196 x3 | ☐ Suite 19 (2nd Floor)<br>(209) 461-3196 x2 | |

***Linacia Building***
***420 W. Acacia***

S.E. corner of Lincoln & Acacia
*(En la esquina Sureste de la calle Lincoln y Acacia)*

**Your appointment**

- Please arrive to your appointment on time.
- Please do not bring children or more than one family member to your appointment.
- If you need to change your appointment, please call us as soon as possible.
- If you do not keep your appointment, we must assume that you have recovered from your injury and you will be returned to full work duties until you return for a follow up visit.

**Parking**

- Parking is available street side, or in our above ground or underground parking lot. There is no charge for parking.

**Please bring all medications you are currently taking to your next visit.**

---

**Su cita**

- Por favor llegue a su cita a tiempo.
- Por favor que no le acompañen niños ni mas de un miembro de su familia a su cita.
- Si necesita cambiar su cita, llamenos cuanto antes.
- Si falta a su cita, asumiremos que se a recuperado de su lesion y sera puesto de nuevo en trabajo regular y sin resctricciones hasta que se ponga en contacto con esta oficina para hacer una cita nueva.

**Estacionamiento**

- Hay estacionamiento disponible en la calle, al lado de la clinica y tambien en la parte baja del edificio. No tendra que pagar por estacionamiento.

**Favor de traer toda la medicina que esta tomando a su siguiente cita.**

## EXAMINATION AND/OR TREATMENT AUTHORIZATION

**Employer:** SAN JOAQUIN CO. MOSQUITO & VECTOR CONTROL

7759 S Airport Way

STOCKTON CA 95206

TO DOCTOR: DAMERON OCCUPATIONAL HEALTH DATE: 1/26/05

420 W. Acacia St #19 EMPLOYEE TIFFANY ANDERSON

STOCKTON CA 95203 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 Ahlman DEPT OFFICE

---

* **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 Donald Kerman MD

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)

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

ACCLAMATION INSURANCE MANAGEMENT SERVICES
209-227-0801
P.O. Box 28109
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.

## EMPLOYER

1. FIRM NAME: SAN JOAQUIN CO. MOSQUITO & VECTOR CONTROL DISTRICT
1a. Policy Number:
Please do not use this column
2. MAILING ADDRESS: (Number, Street, City, Zip): 7759 SOUTH AIRPORT WAY STOCKTON CA 95206
2a. Phone Number: 209 982-4675
CASE NUMBER
3. LOCATION if different from Mailing Address (Number, Street, City and Zip):
3a. Location Code:
OWNERSHIP
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 Gov't, Specify: Special Dist.
INDUSTRY

## 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):
OCCUPATION
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☒ 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: ☒
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): 1/25/05
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy): 1/26/05
SEX
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
AGE
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip): District yard
20a. COUNTY: San Joaquin
21. ON EMPLOYER'S PREMISES? ☒ Yes ☐ No
DAILY HOURS
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 ☒ No
DAYS PER WEEK
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold: weeds
WEEKLY HOURS
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.: Standing and jumping on the weeds to pack them down in garbage dumpster.
WEEKLY WAGE
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
COUNTY
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
NATURE OF INJURY
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
PART OF BODY

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*.
SOURCE

## EMPLOYEE

30. EMPLOYEE NAME: Tiffany Anderson
31. SOCIAL SECURITY NUMBER: 549-23-5133
32. DATE OF BIRTH (mm/dd/yy): 08/22/70
EVENT
33. HOME ADDRESS (Number, Street, City, Zip): 1830 S Hutchins #304 Lodi CA 95240
33a. PHONE NUMBER: 209 333-1037
SECONDARY SOURCE
34. SEX ☐ Male ☒ 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 ☒ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED: salaries/wages
EXTENT OF INJURY
38. GROSS WAGES/SALARY: $ 1421. 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
Date (mm/dd/yy): 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.

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.

***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.*

**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.**

**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.* T. Mary Anderson Today's Date. *Fecha de Hoy.* 1-26-05
2. Home Address. *Dirección Residencial.* 1X 903 S. Hutchins #304
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.* 7751 S. Airport Way / Undergrowing Brush
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* head to toe rash or hives
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.J. County Mosquito Vector Control
10. Address. *Dirección.* 7751 S. Airport 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.* Declaration Insurance PO Box 29100 Fresno CA 93729
15. Insurance Policy Number. *El número de la póliza de Seguro.* ____
16. Signature of employer representative. *Firma del representante del empleador.* Paul Ubelaker
17. Title. *Título.* Supervisor 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.

ACCLAMATION INSURANCE
MANAGEMENT SERVICES

November 7, 2005

Tiffany Anderson
1416 Iris Drive, #7
Lodi, CA 95242

Employee: Tiffany Anderson
Employer: San Joaquin County Mosquito/VCD
Claim No: VE060031
D/Injury: 10-11-05

Dear Ms. Tiffany Anderson:

Based on a review of your file it appears you have recovered from your injury without any permanent disability. For this reason, we assume that you are not in need of further medical treatment and are having no further problems from your injury.

If you feel that you are in need of further medical care or that you are having some residual disability resulting from the dermatitis, contact allergic, then please contact me in order that we might make arrangements for necessary medical care. If we do not hear from you within 30 days from the date of this letter, we will assume that you are in agreement with our decision and will close our file. You may contact the State Information and Assistance Office 209/948-7980, for further information.

**Be advised that certain statute of limitations apply to the provision of benefits.** If it is necessary to go to the Workers' Compensation Appeals Board to resolve your claim, you **must** file an Application of Adjudication within one year of the date of your injury **or** one year from the date of your last medical treatment. Waiting longer could mean losing your right to benefits. And should you allege your injury has caused you any new and further disability, you must file an Application of Adjudication with the Worker's Compensation Appeals Board. You must do so within five years from the original date of injury. Waiting longer could also mean losing your right to benefits.

Sincerely,

Theresa Antoyan
Claims Assistant
TA

Employer: San Joaquin County Mosquito/VCD
File

P.O. Box 28100
Fresno, CA 93729
(559) 227-9891
FAX (559) 227-1579
CAL. LIC. 2772984

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

# WORK STATUS REPORT

| | | | |
|---|---|---|---|
| **Employee Name:** | Anderson, Tiffany K | **Date of Visit:** | 10/25/2005 |
| **Social Security No.:** | 549-23-5133 | **Time In:** 07:25 am | **Time Out:** 07:55 am |
| **Employer:** | SJ Mosquito and Vector Control | | |
| **Date of Injury:** | 10/11/2005 | **Guarantor:** | AIMS - Fresno 8046 |
| **Clinic Case Number:** | 78225 | **Claim Number:** | Pending |

## CLINICAL STATUS

**Diagnosis:** Dermatitis, Contact Allergic

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

## EVALUATION AND TREATMENT PLAN

**Physical / Occupational Therapy:**

**Recommended Evaluation / Diagnostic Studies:**

## WORK STATUS

**Work Status:** Full work duties **From:** 10/25/2005 **To:** 10/25/2005

**Work Restrictions:**

**Estimated return to full duty:**

## DISPOSITION

**Disposition:** Final Discharge,P&S, no residuals PR2 to follow

**Next Scheduled Appointment:**

*"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:** | 10/20/2005 |
| **Social Security No.:** | 549-23-5133 | **Time In:** 08:52 am | **Time Out:** 09:54 am |
| **Employer:** | SJ Mosquito and Vector Control | | |
| **Date of Injury:** | 10/11/2005 | **Guarantor:** | AIMS - Fresno 8046 |
| **Clinic Case Number:** | 78225 | **Claim Number:** | Pending |

## CLINICAL STATUS

**Diagnosis:** Dermatitis, Contact Allergic

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:** 10/20/2005 **To:** 10/25/2005

**Work Restrictions:**

**Estimated return to full duty:**

## DISPOSITION

**Disposition:**

**Next Scheduled Appointment:** 07:20 am 10/25/2005

*"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:** | 10/17/2005 |
| **Social Security No.:** | 549-23-5133 | **Time In:** 07:48 am | **Time Out:** 08:32 am |
| **Employer:** | SJ Mosquito and Vector Control | | |
| **Date of Injury:** | 10/11/2005 | **Guarantor:** | AIMS - Fresno 8046 |
| **Clinic Case Number:** | 78225 | **Claim Number:** | Pending |

## CLINICAL STATUS

**Diagnosis:** Dermatitis, Contact Allergic

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:** 10/17/2005 **To:** 10/20/2005

**Work Restrictions:**

**Estimated return to full duty:**

## DISPOSITION

**Disposition:** 8:20 AM 10/20/05 change due to PPA Training Schedule

**Next Scheduled Appointment:** ~~3:00 pm~~ ~~10/20/2005~~ eam slot

*"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

DR/WSR 8/1/05

ACCLAMATION INSURANCE
MANAGEMENT SERVICES

October 14, 2005

Tiffany Anderson
1416 Iris Drive, #7
Lodi, CA 95242

Employee: Tiffany Anderson
Employer: San Joaquin County Mosquito/VCD
D/Injury: 10-11-05
Claim No: VE060031

Dear Ms. Tiffany Anderson:

Acclamation Insurance Management Services is the Workers' Compensation administrator for your Employer, San Joaquin County Mosquito/VCD.

We are sorry to learn of your recent injury at work. We have enclosed a pamphlet, "Facts for Injured Workers", which explains your workers' compensation benefits.

Since this has been accepted as a work related injury, you are entitled to reimbursement for transportation expenses to obtain medical treatment at .34 cents per mile, pursuant to California Labor Code Section 4600. To have this expense reimbursed to you, please complete and return the enclosed form to us. We will then review it for payment. Please make sure the reimbursement request is clearly and accurately itemized and is signed and dated by you.

We wish you a speedy recovery.

If you have any questions or wish additional information, please contact our office by calling (800) 559-9891.

Sincerely,

Theresa Antoyan
Claims Assistant
TA

Employer: San Joaquin County Mosquito/VCD
File

P.O. Box 28100
Fresno, CA 93729
(559) 227-9891
FAX (559) 227-1579
CAL. LIC. 2772984

ACCLAMATION INSURANCE
MANAGEMENT SERVICES

October 14, 2005

Tiffany Anderson
1416 Iris Drive, #7
Lodi, CA 95242

EMPLOYER: San Joaquin County Mosquito/VCD; CLAIM#: VE060031; DATE/INJURY: 10-11-05

Under the California Workers' Compensation Law, you are entitled to reimbursement of reasonable mileage to and from medical appointments or treatment for your industrial injury or illness. Mileage will be reimbursed at the rate of 34¢ per mile.

Please use this form to keep track of your trips and submit it to the address below.

| DATE | FROM | TO (DOCTOR'S NAME) | ROUND TRIP MILEAGE |
|---|---|---|---|
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If you desire additional forms, please check here _____ **TOTAL**_____

Signature:_____

P.O. Box 28100
Fresno, CA 93729
(559) 227-9891
FAX (559) 227-1579
CAL. LIC. 2772984

# AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

ıthorize_____
(Name of physician or health care provider authorized to use or disclose information)

furnish to Acclamation Insurance Management Services or _____
(Name and address of person/organization to which disclosure is made)

alth information described below on: _____
(Patient name)

r the purpose of: _____

is information is limited to the following type and amount of information. (Use dates where appropriate.)

Progress Notes
Consultation Reports
Laboratory, Pathology Reports
Radiology Reports/Imaging Reports
Medical Records relating to injury
Other: _____

Immunization Records
Any and all Records for the last 2 years
from _____ to _____
from _____ to _____
(date) _____

## DISCLOSURES REQUIRING SPECIAL CONSENT:

/ signature below specifically authorizes the release of health care information relating to the testing, diagnosis treatment for: (initial appropriate area)

HIV/AIDS virus_____
Sexually Transmitted Diseases_____
Mental Health/Psychiatric Disorders_____
Drug, Alcohol Abuse/Treatment_____

nderstand that I have a right to revoke this authorization at any time. I understand that my revocation must be in iting and presented to the Health Information Management Department. I understand that the revocation will t apply to information that has already been released in response to this authorization. I understand that the vocation will not apply to my insurance company when the law provides my insurer with the right to contest a im under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or ndition:_____

I fail to specify an expiration date, event or condition, this authorization will expire in six months from date of gnature.

ither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing provide this authorization. I understand that I may inspect or copy the information to be used or disclosed, as ovided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an authorized redisclosure and the information may not be protected by federal confidentiality rules. If I have estions about disclosure of my health information, I can contact the Director of Health Information. I understand ave a right to receive a copy of this authorization.

**carbon copy, photo static copy or fax copy of this true release shall be as valid as the original.**

_____ *gnature of Patient, Parent or Legal Guardian*

_____ *Patient Date of Birth*

_____ *signed by other than patient, indicate relationship*

_____ *Patient Address*

_____ *tient telephone number*

_____ *Patient Social Security Number*

_____ *tness signature*

_____ *Date*

# INJURED EMPLOYEE INFORMATION FORM

(PLEASE PRINT)

EMPLOYEE NAME: _____ DATE OF BIRTH: _____
SOCIAL SECURITY NO: _____ INJURY DATE: _____

NAME OF EMPLOYER: _____

MARITAL STATUS: _____ # OF DEPENDENTS: _____

HEIGHT: _____ WEIGHT: _____ HAIR COLOR: _____ EYE COLOR: _____

Please describe how the injury occurred: _____

_____

_____

_____

_____

_____ (use back of sheet if more room is needed)

List names & address or phone numbers of any witness:

_____

_____

What is your job title and job duties?: _____

_____

_____

Where were you first taken for treatment of this injury?: _____

What physicians have you seen for this injury?: _____

_____

What is the name, phone number and address of your family physician?: _____

_____

What injuries did you sustain due to this accident?: (i.e.:body part injured?): _____

_____

Have you ever injured this body part before?: ___ yes ___ no. If yes: when: _____

What type of tests have the doctors done at this time?: _____

_____

Have you been released by the doctor at this time? _____ yes _____ no
*if yes date of doctor's release: _____

EMPLOYEE INFORMATION FORM NAME: _____

Please list all sports activities or hobbies you have.:_____
_____

Where did you work for before this employer?: _____
_____

Have you ever filed a workers' comp claim before?:___ NO ___Yes (date:_____)
What was the injury for which you filed the claim?:_____
Did you receive a settlement for that injury?: ____NO ____YES Amount:_____
Name of doctor that treated you for that injury.:_____

Do you have a high school diploma?: ___ YES ___ NO
Did you complete a G.E.D.? ___ YES ___ NO
Do you have any vocational training? ___ NO ___ YES--Type: _____
Have you ever been in the military? ___ NO___ YES--Which branch: _____

Please list any medical conditions you may have that not related to this injury
(ie: highblood pressure): _____
_____

Please list all medications that you are currently taking.: _____
_____
_____

Besides workers' comp what other sources of income are you currently receiving?
_____

Are you right or left handed? _____ Right _____ Left _____ Ambidextrous

*I have completed and read the above and find it to be true and correct to the best of my knowledge**

_____
*Signed*

_____
*Date*

_____
*Witness*

**Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance*

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

# WORK STATUS REPORT

| | | | |
|---|---|---|---|
| **Employee Name:** | Anderson, Tiffany K | **Date of Visit:** | 10/14/2005 |
| **Social Security No.:** | 549-23-5133 | **Time In:** 09:50 am | **Time Out:** 10:30 am |
| **Employer:** | SJ Mosquito and Vector Contro | | |
| **Date of Injury:** | 10/11/2005 | **Guarantor:** | AIMS - Fresno 8046 |
| **Clinic Case Number:** | 78225 | **Claim Number:** | Pending |

## CLINICAL STATUS

**Diagnosis:** Dermatitis, Contact Allergic

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 **From:** 10/14/2005 **To:** 10/17/2005

**Work Restrictions:**

**Estimated return to full duty:**

## DISPOSITION

**Disposition:**

**Next Scheduled Appointment:** 07:40 am 10/17/2005

*"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

DH-WSR 8/14/02

# FACSIMILE COVER PAGE

| | | | |
|---|---|---|---|
| **To :** | **John Stroh** | **From :** | Dameron Hospital |
| **Sent :** | 10/14/2005 at 10:31:14 AM | **Pages :** | 2 (including Cover) |
| **Subject :** | anderson, tiffany | | |

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

# WORK STATUS REPORT

| | | | |
|---|---|---|---|
| **Employee Name:** | Anderson, Tiffany K | **Date of Visit:** | 10/13/2005 |
| **Social Security No.:** | 549-23-5133 | **Time In:** 07:49 am | **Time Out:** 09:49 am |
| **Employer:** | SJ Mosquito and Vector Control | | |
| **Date of Injury:** | 10/11/2005 | **Guarantor:** | AIMS - Fresno 8046 |
| **Clinic Case Number:** | 78225 | **Claim Number:** | Pending |

## CLINICAL STATUS

**Diagnosis:** Dermatitis, Contact Allergic

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:** 10/13/2005 **To:** 10/14/2005

10-14-05

**Work Restrictions:**

**Estimated return to full duty:**

## DISPOSITION

**Disposition:**

**Next Scheduled Appointment:** 08:40 am 10/14/2005

*"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

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.

## EMPLOYER

1. FIRM NAME: San Joaquin Co. Mosquito & Vector Control
1a. Policy Number:
Please do not use this column
2. MAILING ADDRESS: (Number, Street, City, Zip): 7759 S. Airport Way Stockton CA 95206
2a. Phone Number: 209 982-4675
CASE NUMBER
3. LOCATION if different from Mailing Address (Number, Street, City and Zip):
3a. Location Code:
OWNERSHIP
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 Gov't, Specify: Spec. Dist
INDUSTRY

## 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):
OCCUPATION
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 (mm/dd/yy): 10-13-05
SEX
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
AGE
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip): McDonald Island
20a. COUNTY: San Joaquin
21. ON EMPLOYER'S PREMISES? ☐ Yes ☒ No
DAILY HOURS
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
DAYS PER WEEK
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
WEEKLY HOURS
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.
WEEKLY WAGE
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.
COUNTY
27. Name and address of physician (number, street, city, zip): Dameron Hospital 420 W. Acacia St Stockton
27a. Phone Number: 209 461-3196
NATURE OF INJURY
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
PART OF BODY

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*.
SOURCE

## EMPLOYEE

30. EMPLOYEE NAME: Tiffany Anderson
31. SOCIAL SECURITY NUMBER: 549 23 5133
32. DATE OF BIRTH (mm/dd/yy): 8/22/70
EVENT
33. HOME ADDRESS (Number, Street, City, Zip): 1416 Iris Dr Lodi CA 95242
33a. PHONE NUMBER: 209 333-1037
SECONDARY SOURCE
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
EXTENT OF INJURY
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

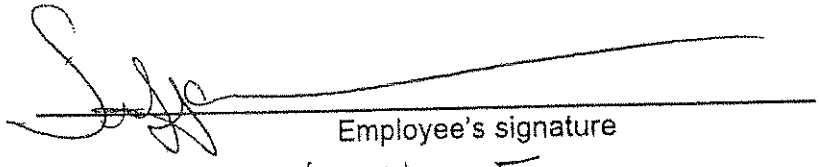
Completed By (type or print): Carol Aksland
Signature & Title: Carol Aksland - Secretary
Date (mm/dd/yy): 10/13/05

* 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.

SAN JOAQUIN COUNTY MOSQUITO AND
VECTOR CONTROL DISTRICT

To Whom It May Concern:

I Acknowledge That I Have Received DWC Form 1. "Employee's Claim For Workers' Compensation Benefits".



Employee's signature

DATE SIGNED 10-11-05

dwcfrm.doc 11/12/96

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.

***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.*

**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.**

**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. Sore 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.

***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.*

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

*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.

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

# WORK STATUS REPORT

| | | | |
|---|---|---|---|
| **Employee Name:** | Anderson, Tiffany K | **Date of Visit:** | 06/21/2004 |
| **Social Security No.:** | 549-23-5133 | **Time In:** 09:20 am | **Time Out:** 10:09 am |
| **Employer:** | SJ Mosquito and Vector Contro | | |
| **Date of Injury:** | 06/07/2004 | **Guarantor:** | Gregory B Bragg and Associ |
| **Clinic Case Number:** | 56808 | **Claim Number:** | Pending |

## CLINICAL STATUS

**Diagnosis:** Dermatitis, Contact Irritant

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

## EVALUATION AND TREATMENT PLAN

**Physical / Occupational Therapy:**

**Recommended Evaluation / Diagnostic Studies:**

## WORK STATUS

**Work Status:** Full work duties **From:** 06/21/2004 **To:** 06/21/2004

**Work Restrictions:**

**Estimated return to full duty:**

## DISPOSITION

**Disposition:** Final Discharge,P&S, no residuals PR2 to follow

**Next Scheduled Appointment:**

*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

DH-WSR 8/14/02

## Emily Nicholas

**From:** GBBAI 5020 Entry [webmaster@gbbragg.com]
**Sent:** Thursday, June 10, 2004 8:27 AM
**To:** rebecca.braswell@gbbragg.com; jennifer.hamelin@gbbragg.com; quilter22000@yahoo.com; emnicholas@worldnet.att.net
**Subject:** 5020 Claim: 2004023776 entered.

ca5020r200402377
6.pdf

A new 5020 has been entered. Claim: 2004023776

---

General 5020 fields:
1). Firm Name: San Joaquin County Mosquito & Vector Control District
2). Mailing address: 7759 S. Airport Way Stockton, CA 95206
2a). Phone number: 209-982-4675
7). Date of injury/onset of illness: 06/07/2004
8). Time of injury/onset of illness: 1:00 (pm)
9). Time work began: 7:00 (am)
11). Out for at least one day: no
12). Date last worked: 9/9/9999
14). Still off work: no
15). Paid full days wages last/injury date: yes
16). Salary being continued: no
17). Date of employer's knowledge: 6/8/2004
18). Date employee provided claim form: 6/8/2004
19). Specific injury/illness: Rash started at ankles and legs and spread up over rest of body.
20). Location where occured: McGurk property
20a). County: San Joaquin
22). Department where occured: In the field
24). Equipment:
25). Activity: Looking in vegetation, checking for mosquito breeding sources.
26). How: Walking through brush looking for mosquito sources, came in contact with posion oak.
30). Employee name: Anderson, Tiffany
31). SSN: 549235133
32). Date of birth: 8/22/1970
33a). Phone Number: 209 3339249
34). Sex: Female
35). Occupation: Mosq. Control Tech. I
36). Date of hire: 4/19/2004
37). Employee works: 8 hours per day.
5 days per week.
40 total weekly hours.
37a). Employment status: regular_fulltime
38). Gross wages/salary: 1308 per bi-weekly

---

12.72.199.47

---

ACCLAMATION INSURANCE
MANAGEMENT SERVICES

September 30, 2004

Tiffany Anderson
1830 S. Hutchins, #304
Lodi, CA 95240

Employee: Tiffany Anderson
Employer: San Joaquin County Mosquito/Vector Control District
Claim No: V04023776
D/Injury: 06-07-04

Dear Ms. Tiffany Anderson:

Based on a review of your file it appears you have recovered from your injury without any permanent disability. For this reason, we assume that you are not in need of further medical treatment and are having no further problems from your injury.

If you feel that you are in need of further medical care or that you are having some residual disability resulting from the injury to your dermatitis, contact irritant, then please contact me in order that we might make arrangements for necessary medical care. If we do not hear from you within 30 days from the date of this letter, we will assume that you are in agreement with our decision and will close our file. You may contact the State Information and Assistance Officer at 209/948-7759, for further information.

**Be advised that certain statute of limitations apply to the provision of benefits.** If it is necessary to go to the Workers' Compensation Appeals Board to resolve your claim, you **must** file an Application of Adjudication within one year of the date of your injury **or** one year from the date of your last medical treatment. Waiting longer could mean losing your right to benefits. And should you allege your injury has caused you any new and further disability, you must file an Application of Adjudication with the Worker's Compensation Appeals Board. You must do so within five years from the original date of injury. Waiting longer could also mean losing your right to benefits.

Sincerely,

Theresa Antoyan
Claims Assistant

cc: Employer: Carol Aksland, Secretary, San Joaquin County Mosquito/Vector Control Dist.
File

P.O. Box 28100
Fresno, CA 93729
(559) 227-9891
FAX (559) 227-1579
CAL. LIC. 2772984

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

# WORK STATUS REPORT

| | | | |
|---|---|---|---|
| **Employee Name:** | Anderson, Tiffany K | **Date of Visit:** | 06/09/2004 |
| **Social Security No.:** | 549-23-5133 | **Time In:** 07:55 am | **Time Out:** 08:45 am |
| **Employer:** | SJ Mosquito and Vector Control | | |
| **Date of Injury:** | 06/07/2004 | **Guarantor:** | Gregory B Bragg and |
| **Clinic Case Number:** | 56808 | **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

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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 — DO NOT USE THIS COLUMN
2. MAILING ADDRESS (Number and Street, City, ZIP): 1830 S Hutchins #304 Lodi CA 95240 — 2A. PHONE NUMBER: 333-9249 — Case No.
3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP) — 3A. LOCATION CODE — Ownership
4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc. — 5. STATE UNEMPLOYMENT INSURANCE ACCT. NO. — Industry
6. TYPE OF EMPLOYER — ☐ PRIVATE ☐ STATE ☐ CITY ☒ COUNTY ☐ SCHOOL DIST. ☐ OTHER GOVERNMENT - SPECIFY _____ — Occupation

**EMPLOYEE**

7. EMPLOYEE NAME: Tiffany Anderson — 8. SOCIAL SECURITY NUMBER: 549-23-5133 — 9. DATE OF BIRTH (mm/dd/yy): 8-22-70 — Sex
10. HOME ADDRESS (Number and Street, City, ZIP): 1830 S. Hutchins #304 Lodi CA 95240 — 10A. PHONE NUMBER: 333-9249 — Age
11. SEX — ☐ MALE ☒ FEMALE — 12. OCCUPATION (Regular job title - NO initials, abbreviations or numbers) — 13. DATE OF HIRE (mm/dd/yy) — Daily hours
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? — Days per week
15. GROSS WAGES/SALARY $_____ per _____ — 16. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? ☐ YES, $ _____ per _____ ☐ NO — Weekly hours

**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) — Weekly wage
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 ☐ — County
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) — Nature of injury
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 — Part of body
30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City): McGurk Property — 30A. COUNTY: SJ — 30B. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO — Source
31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop. — 32. OTHER WORKERS INJURED/ILL IN THIS EVENT? ☐ YES ☐ NO — Event
33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold: weeds — Sec. Source
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 — Extent of Injury
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

| Completed by (type or print) | Signature | Title | Date |
|---|---|---|---|
| | | | |

FORM 5020 (REV. 6)

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 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 "felonía".**

**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.* McCurdy 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 compañía 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.* Carol Abeland
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*

SAN JOAQUIN COUNTY MOSQUITO AND
VECTOR CONTROL DISTRICT

To Whom It May Concern:

I Acknowledge That I Have Received DWC Form 1. "Employee's Claim For Workers' Compensation Benefits".

Employee's signature

DATE SIGNED 6-7-04

# Cal/EPA Environmental Complaint Form - Tracking and Maintenance: Print Complaint

Hello, **Roberta Jetter**. You are now logged in to the Cal/EPA Environmental Complaint Form - Tracking and Maintenance System as a **Central Contact** with **DPR**.

Time left until session times out (if no activity): **60** minutes

Logout

**Complaint Record Number: 11992** **Complaint Source: Public** **Submit Date: 9/3/2013, 03:14 PM**

**Displayed below is a printer-friendly record of Complaint Record Number 11992. Use your browser's print button to print a copy.**

## Complainant Information:

Referring URL: http://www.calepa.ca.gov/ContactUs/

Hide/Show Complainant

| | | | |
|---|---|---|---|
| Emergency: | No | Name: | [redacted] |
| Spill: | No | Address: | |
| Confidential: | No | City, St. ZIP: | |
| Follow-up: | Yes | Phone Number: | |
| | | E-Mail: | |

## Complaint Information:

Complaint Address or Location Description

| | |
|---|---|
| Address: | 12751 Thornton Road |
| City, St. ZIP: | LODI , CA 95242 |
| County: | SAN JOAQUIN |
| Location Description: | South of the City of Lodi's Water Treatment and Power plant. |

Alleged Responsible Party

| | |
|---|---|
| **Responsible Person:** | Ed Lucchesi, John R. Stroh(Ret. 2012), & Board of Trustees(2006-2010) |
| **Company Name:** | San Joaquin Mosquito and Vector Control District |
| Address: | 7759 S. Airport Way |
| City, St. ZIP: | STOCKTON CA 95206 |
| Phone Number | (209)982-4675 |

Complaint Marked Related To: Air Solid Waste Pesticides Toxic Substances Water Prop. 65

Date of Occurrence: 04/18/2006 Time: Unknown Ongoing: Unknown

Complaint Description:

Date of Occurrence is unknown but records shown that it was going on around 04/18/2006 to 04/09/2010 when Sam Joaquin County Grand Jury began Investigations. Its unknown if it is still going on at this time.

I sent a letter to Secretary Matt Rodriquez on 10/27/2013 and is shown below.

August 27, 2013

Secretary Matt Rodriquez
California Environmental Protection Agency
1001 I Street
P.O. Box 2815
Sacramento, CA 95812-2815

Dear Secretary Rodriguez,

I am writing for assistance with the investigation of several hazardous conditions at the San Joaquin County Mosquito & Vector Control District (District). These conditions affect the safety and health of employees, and potentially the surrounding environment, including water resources.

Having sustained work injuries myself and enduring the death of a co-worker, it is my hope that your office will compel the District to follow applicable state laws and CalOSHA standards, that District employees are properly trained and advised of potential exposure to hazardous materials, and that the District is held accountable for their misconduct.

More than a year ago, the Division of Occupational Safety and Health conducted an initial investigation with no citations issued. However, my documentation, personal experience, and that of others, is in conflict with the investigator?s findings. Because the investigator was unable to witness field operations alongside employees and/or visit other facilities, the results are incomplete.

For example, after an exposure at the District?s White Slough facility in Lodi, I was interviewed by the San Joaquin County District Attorney?s office regarding the District?s undisclosed use of Formalin. District employees were NEVER informed of the use of this pesticide or provided the MSDS sheet for it. However, the OSHA investigator was not made aware of this facility or the chemicals used there, did not visit the facility, and of course, did not complete environmental studies.

In addition, the ponds at the White Slough facility are not lined, and are located below the water table. It seems this is not safe.

I am asking that Cal-EPA:

1) Investigate the District for:
a. Failure to comply with applicable hazardous material guidelines and California law;
b. Failure to provide for the appropriate safety of their employees; and
c. Failure to disclose the exposure to certain chemicals to their employees
2) Visit the White Slough facility and determine what chemicals/treatments have been applied in the area, whether documented in writing or not
3) Test the bodies of water and surrounding environment for undocumented use of hazardous chemicals, including general microbiological testing, bacterial pathogens, parasites and human viruses
4) Test the bodies of water and surrounding environment for undocumented and/or inappropriate use of Formalin specifically
5) Ensure the District educates and trains employees on the chemicals used, including their exposure risk and appropriate stabilizing medical treatment upon exposure, and that these actions are documented as required by law
6) Ensure the District reports all chemical treatments to the appropriate governmental agencies
7) Provide me with information regarding the handling of this complaint

Please note I have documentation available to support my complaints, including information regarding the use of Formalin at the White Slough facility. I tried to complete the online form and was unable to do so. Therefore, I respectfully request that an investigator from your office contact me and pursue this investigation as soon as possible.

Thank you,

[redacted]

cc: Karen Ross, Secretary, Department of Food and Agriculture
Marty Morgenstern, Secretary, Labor and Workforce Developmental Agency
Christine Baker, Director, Department of Industrial Relations

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