Claim Summary - Payments

1/1/1901 - 9/23/2014

Claim No: VE060031
Loss Date: 10/1/2005
Claimant: Anderson, Tiffany
Insured: Vector JPA

Medical

Effective Date	Transaction Type	Check Number	Payee	From Through	Pay Amount	Running Total
11/15/2005	M47 - Physician	3629	CORKY HULL MEDICAL ASSOCIATES, INC.	10/13/2005 - 10/13/2005	57.80	57.80
11/17/2005	M10 - DO NOT USE BR Fee	3650	ALLIED MANAGED CARE	11/8/2005 - 11/8/2005	5.19	62.99
12/20/2005	M21 - Hospital/Surgery Ctr	3726	DAMERON HOSPITAL ASSOCIATION	10/13/2005 - 10/13/2005	15.38	78.37
12/20/2005	M21 - Hospital/Surgery Ctr	3726	DAMERON HOSPITAL ASSOCIATION	10/17/2005 - 10/17/2005	13.03	91.40
12/20/2005	M47 - Physician	3721	CORKY HULL MEDICAL ASSOCIATES, INC.	10/17/2005 - 10/17/2005	11.69	103.09
12/20/2005	M47 - Physician	3721	CORKY HULL MEDICAL ASSOCIATES, INC.	10/17/2005 - 10/17/2005	72.25	175.34
12/21/2005	M10 - DO NOT USE BR Fee	3745	ALLIED MANAGED CARE	12/13/2005 - 12/13/2005	31.76	207.10
1/10/2006	M47 - Physician	3801	CORKY HULL MEDICAL ASSOCIATES, INC.	10/14/2005 - 10/14/2005	11.69	218.79
1/10/2006	M47 - Physician	3801	CORKY HULL MEDICAL ASSOCIATES, INC.	10/14/2005 - 10/14/2005	35.70	254.49
1/13/2006	M10 - DO NOT USE BR Fee	3823	ALLIED MANAGED CARE	1/5/2006 - 1/5/2006	1.19	255.68
3/2/2006	M47 - Physician	3930	CORKY HULL MEDICAL ASSOCIATES, INC.	10/13/2005 - 10/13/2005	18.70	274.38
3/6/2006	M10 - DO NOT USE BR Fee	3946	ALLIED MANAGED CARE	2/13/2006 - 2/13/2006	-1.87	272.51
5/23/2006	M47 - Physician	4251	CORKY HULL MEDICAL ASSOCIATES, INC.	10/20/2005 - 10/20/2005	11.69	284.20
5/23/2006	M47 - Physician	4251	CORKY HULL MEDICAL ASSOCIATES, INC.	10/20/2005 - 10/20/2005	72.25	356.45
5/23/2006	M47 - Physician	4252	CORKY HULL MEDICAL ASSOCIATES, INC.	10/25/2005 - 10/25/2005	11.69	368.14
5/23/2006	M47 - Physician	4252	CORKY HULL MEDICAL ASSOCIATES, INC.	10/25/2005 - 10/25/2005	72.25	440.39
	Totals for Medical					$440.39

	Total
Grand Totals	$440.39

Payment Summary	
M47 - Physician	$375.71
M10 - DO NOT USE BR Fee	$36.27

**=Payment transaction which has not been committed R=Transaction is a reversal F=Transaction is a refund X=Transaction is a reversed refund*

M21 - Hospital/Surgery Ctr	$28.41
Total	**$440.39**

**=Payment transaction which has not been committed R=Transaction is a reversal F=Transaction is a refund X=Transaction is a reversed refund*

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:
INDUSTRY
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☒ Other Gov't, Specify: Spec. Dist
OCCUPATION

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):
SEX
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: ☐
AGE
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
DAILY HOURS
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning: Rash - legs - stomach area
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip): McDonald Island
20a. COUNTY: San Joaquin
21. ON EMPLOYER'S PREMISES? ☐ Yes ☒ No
DAYS PER WEEK
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.: Field
23. Other Workers injured or ill in this event? ☐ Yes ☒ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold: dipper for sampling water
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.

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)

loyee: 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 Absland
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.*

IING 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.

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

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION

NAME: Anderson, Tiffany K **DOS:** 10/13/2005 10-13-05

DOB: 8/22/1970

CONSENT

I hereby authorize the Dameron Hospital occupational Health Department to:

- ☐ Obtain a complete medical history and physical examination including any required medical tests
- ☐ Provide medical treatment for a work-related injury
- ☐ Obtain a urine specimen and/or breath sample for drug and/or alcohol testing

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I hereby authorize the Dameron Hospital Occupational Health Department to furnish to an agent, designee or representative of ***SJ Mosquito and Vector Control*** the results of my medical evaluation and/or treatment including past or present records pertaining to employment history, medical history, test results, urine drug and/or breath alcohol test results, services rendered or treatment provided to me.

USE

I understand that this medical information will be used for the purpose of determining my ability to perform the essential functions of my job with ***SJ Mosquito and Vector Control***.

RESTRICTIONS

I understand that ***SJ Mosquito and Vector Control*** may use these medical records only for employment-related purposes and that they may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

DURATION

This authorization is effective immediately and shall remain in effect for one year from **10/13/2005**

ADDITIONAL COPY

I understand that I have a right to receive a copy of this form and that a copy of this document is as valid as the original.

I would like a copy of this form ☐ Yes ☒ No Received: ☐ Yes ☐ No Initial _____

SIGNATURE

Employee signature

Witness Signature

Date: 10/13/200

Non-DOT Drug Screens Only

List current meds: ☐ None

Rx: _____

_____

OTC: _____

DOCTOR' S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Occupational Injury Clinic
20 W. Acacia Street , STE # 2 Linacia 1st Flo
Stockton, CA 95204-

10-13-05

STATE OF CALIFORNIA

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the **employer's worker's compensation insurance carrier** or the **self-insured employer.** Failure to file a timely doctor's report may result in assessment of a civil penalty. **In case of diagnosed or suspected pesticide poisoning** send a copy of this report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24-hours.

1. INSURED NAME AND ADDRESS
AIMS - Fresno 8046 PO Box 28100, Fresno, CA 93729

PLEASE DO NOT USE THIS COLUMN
Case no
Industry
County
Age
Hazard
Disease
Hospitalization
Occupation
Return Date/Code

2. EMPLOYER NAME
SJ Mosquito and Vector Control

3. Address — No. and Street: 7759 S Airport Way — City: Stockton — Zip: 95206

4. Nature of Business (e.g., food manufacturing, building construction, retailer of women's clothes)

5. PATIENT NAME
Anderson, Tiffany K

6. Sex [ ] Male [X] Female

7. Date of Birth — Mo. Day Year: 08/22/1970

8. Address — No. and Street: 1416 Iris Dr #7 — City: Lodi — Zip: 95242

9. Telephone Number: (209) 333-1037

10. Occupation (Specific Job title)
Tech I

11. Social Security Number
549-23-5133

12. Injured at: WORK PLACE — No. and Street — City: STOCKTON — County: SAN JOAQUIN

13. Date and hour of injury or onset of illness — Mo. Day Yr.: 10/11/2005 — Hour: 09:00 am

14. Date Last Worked — Mo. Day Yr.:

15. Date and hour of first examination or treatment — Mo. Day Yr.: 10/13/2005 — Hour:

16. Have you (or your office) previously treated patient? [ ] Yes [X] No

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. **DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED** (Give specific object, machinery or chemical. Use reverse side if more space is required.)
SEE ATTACHED DICTATION

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use the reverse side if more space is required.)
SEE ATTACHED DICTATION

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)
A. Physical examination
SEE ATTACHED DICTATION

B. X-ray and laboratory results (State if none pending)

20. **DIAGNOSIS** (If occupational illness, specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? [ ] Yes [X] No ICD-9
692.9 Dermatitis, Contact Allergic

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? [X] Yes [ ] No
If "no" please explain.

22. Is there any other current condition that will impede or delay patient's recovery? [ ] Yes [X] No
If "yes" please explain.

23. **TREATMENT RENDERED** (Use reverse side if more space is required.)
SEE ATTACHED DICTATION

If further treatment required, specify treatment.

24. If Hospitalized as inpatient, give hospital name and location. Date admitted — Mo. Day Yr. Estimated duration: Estimated stay

25. **WORK STATUS** Is patient able to perform usual work? [ ] Yes [X] No
If "no", patient can return to: Mo. Day Yr.
Regular work
Modified work 10/13/2005 Specify restrictions

I have not violated Labor Code 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.

Doctor's signature _____ Date: _____ CA License Number C35074

Doctor name and degree (Please type) Donald Rossman, M.D. IRS Number

Case # 78225 Telephone Number

ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR PURPOSE OF OBTAINING OR DENYING WORKERS' COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY

Occupational Injury Clinic

Injury Worksheet

10-2005

Patient

Anderson, Tiffany K
1416 Iris Dr #7
Lodi, CA 95242-

PHONE: (209) 333-1037

Employer

SJ Mosquito and Vector Control
7759 S Airport Way

Stockton, CA 95206-
CONTACT:
PHONE / FAX: (209) 982-4675 x / (209) 982-0120

Guarantor

AIMS - Fresno 8046
PO Box 28100

Fresno, CA 93729-

PHONE / FAX: (559) 227-9891 / (559) 227-1579

Sex: F DOB : 08/22/1970 Age : 35 SSN# : 549-23-5133
Occupation : Tech I
Department :
Injury Location :
Patient History :

Date/Hour of Injury : 10/11/2005 at 09:00 am
Case Number : 78225
Claim Number : Pending

Check In Instructions

Date/Time of Visit : 10/13/2005 at 07:49 am

Page OHS staff @ 929-2541 BEFORE proceeding

Chart Up ____:____ am / pm
Patient Back ____:____ am / pm
Discharged ____:____ am / pm

DRUG AND ALCOHOL TESTING
* None

Results in Stolas: *Date* _____ *Initials* _____

OTHER INSTRUCTIONS
* Company may request: DOT UDS & BAT
* Lab: Quest, Test #35304N, Client #76337

TREATMENT AUTHORIZATION
1. John Stroh
2. Carol Aksland
3. Ed Lucchesi

Service Procedures

Ord.	Compl.		Service Procedures / Service Instructions	Charge
____	____	84483	DOT Panel (co req) - At company request	13.50
____	____	84460	Urine Drug Screen Collection - OIC (co req) - At company request	20.00
____	____	84178	MRO - DOT (co req) - At company request	10.00
____	____	84542	Breath Alcohol Test - OIC (co req) - At company request	20.00
____	____	84461	Urine Drug Screen Collection - ER	20.00
____	____	84543	Breath Alcohol Test - After Hours	20.00

3 DWC- missing 10-13-05

$0046

DAMERON HOSPITAL ASSOCIATION
Occupational Injury Clinic

Initial Visit

10/13/2005 7:49 a.m.

Patient Name: *Nombre de paciente* Tiffany Anderson	**Sex:** *Sexo* ☐ Male *Masculino* ☒ Female *Femenino*	**Birthdate:** *Fecha de nacimiento* 8-22-70	
Street Address: *Domicilio* 1416 Iris Dr. #7	**Status:** ☐ Married *Casado* ☒ Single *Soltero*	**Home Telephone No.:** *Telefono de casa* 209-333-1037	
City, State, Zip: *Ciudad, Estado, Zip* Lodi CA 95242		**Social Security Number:** *Seguro Social* 549-23-5133	
Employer: *Empleador* SJCMVC		**Job Title:** *Ocupacion* Tech I	
Date of Injury: *Fecha de accidente* 10-11-05 Hour 9:00 ☒ A.M. ☐ P.M.	**Date last worked:** *Dia que trabajo ultimo* 10-13-05	**Have you been seen here before?** *Ha venido aqui antes?* ☒ YES/*Si* ☐ NO	
Have you received treatment for this injury elsewhere? *A recibido tratamiento para este accidente en otro lugar?* ☐ YES/*Si* ☒ NO	If yes, where? *Si, Cuando?*	Date *Feche*	

Describe how the injury occurred: *Como ocurrio el accidente* Checking a mosquito breeding source and the bank of the ditch gave way I fell into a four ½-ft ditch filled with water.

SUMMARY OF DIAGNOSIS AND CONDITIONS

Significant Diagnosis	Major Surgery	Medications	Drug Allergies
1. DENIES	1. DENIES	1. XANAX	1. NKDA
2.	2.	2.	2.
3.	3.	3.	3.
4.	4.	4.	4.

Tetanus: **Vision:** Rt 20/ Lt 20/ **Dominant Hand:** (Rt) Lt

PROVIDER NOTES

Subjective: ☑ *dictated*

Objective: ☑ *dictated*

Penalog 40 mg IM

Assesment: ☑ *dictated*

Penalog 50 mg q 6h #16

Orders: X-Ray _____ Lab _____ Injection _____

Results: _____ _____

Treatments: Medications _____ Dose _____ Quantity _____

Medications _____ Dose _____ Quantity _____

Medications _____ Dose _____ Quantity _____

Physician Signature: dlr

13

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

WORK STATUS REPORT

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

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

Occupational Injury Clinic
420 W. Acacia Street , STE # 2 Linacia 1st Floor
Stockton, CA 95204

DATE	: 10/13/2005		
PATIENT	: Anderson, Tiffany K	DATE OF INJURY	: 10/11/2005
EMPLOYER	: SJ Mosquito and Vector Control	SOC. SEC.#	: 549-23-5133
CASE #	: 78225	CLAIM #	: VE060031

SUBJECTIVE:

The patient continues to complain of primarily malaise at this point. She notes that she has had similar symptoms in the winters in the past on a rather recurrent basis, although more generally more marked symptomatology than she is experiencing. She is no longer having pruritus. She is not having any generalized headaches or sore throat at this time. She has no chest or respiratory symptoms, however, she is complaining of some nausea.

OBJECTIVE:

The ears, nose and throat are clear. Her neck is supple. There is no adenopathy. Lungs are clear. Heart: Regular rhythm without murmur. Heart sounds normal. Abdomen is soft, nontender without organomegaly. Skin: There is a very faint erythematous macular rash over the upper back.

ASSESSMENT:

Possible contact allergy. Given her persistent symptoms and the character of the rash, viral exanthem is certainly a possibility. She did have a CBC on her last visit which was essentially normal white count. I will continue to observe her here, however, she is to see her private medical doctor hopefully today for evaluation.

DR/bjg

D: 10/13/2005
T: 10/27/2005

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.

DAMERON HOSPITAL
OCCUPATIONAL INURY CLINIC

only R

WORK STATUS REPORT - WORKSHEET

Employee Name: Anderson, Tiffany K Date of this Examination: 10/13/2005

Employer: SJ Mosquito and Vector Clinic Case Number: 78225

DIAGNOSIS: _____ _____

492.9. _____

CLINICAL STATUS: __**Q1**: Improved, as expected __**Q2**: Improving slowly __**Q3**: No significant change __**Q4**: Worse

PT/OT: __**W1**: Continue as prescribed __**W2**: 3x/wk - 2 week __**W3**:3x/wk – 1 week __**W4**: One visit __**W5**: Non-DHA PT

RECOMMENDED EVALUATION / DIAGNOSTIC STUDIES:

__**E1**: MRI __**E2**: CT Scan __**E3**: NCS __**E4**: Work Conditioning __**E5**: Epidurals __**E6**: Ergo Evaluation

REFERRAL / CONSULT:

__ **R10**: Orthopedist
__ **R11**: Ophthalmologist
__ **R12**: Neurosurgeon
__ **R13**: Hand Specialist
__ **R14**: General Surgeon
__ **R15**: Neurologist
__ **R16**: Psych
__ **R17**: Physiatrist
__ **R18**: ENT
__ **R19**: Dermatology
__ **R20**: Pain Mgmt
__ **R21**: Dentist
__ **R22**: Health Club
__ **R23**: Urology
__ **R24**: Acupuncture
__ **R25**: Podiatrist

WORK STATUS: __ Full work duties __ Modified work duties __ Off balance of shift, modified work ✓ Off balance of shift, full work duties __ No work until next appt. __ Current WS until Specialist appt.

WORK RESTRICTIONS: 10/14/05

No lift / carry >:
__**A09**: 50#
__**A10**: 10-15#
__**A11**: 30#
__**A12**: 5#

No prolonged:
__**A15**:Stand/Walk
__**A16**:Sitting

Other Back/Neck
__**A13**: No frequent lift, bend, twist, stoop at waist
__**A14**: Limit twist / bend at neck
__**A17**: Desk / sedentary only

Lower Extremity
__**A18**: No crawl / kneel / squat
__**A19**: No climbing ladders
__**A20**: Use crutches as directed
__**A21**: Elevate as directed
__**A22**: Use cane as directed

Upper Extremity
__**S10**: Wear splint / sling as directed
__**S11**: No frequent / repetitive use of wrist / hand
__**S12**: No heavy pushing or pulling
__**S13**: No use of arm above shoulder
__**S14**: No forceful hand grasp
__**S15**: No use of injured body part

Miscellaneous
__**S16**: Limited use of injured body part
__**S17**: May advance work activities as tolerated
__**S18**: Keep dressing clean and dry
__**S19**: No operating company vehicles
__**S20**: No exposure to heat
__**S21**: No exposure to cold
__**S22**: No exposure to chemical, vapors, fumes
__**S23**: No welding
__**S24**: Avoid physical altercations
__**S25**: Avoid wearing latex gloves
__**S27**: Limit keyboarding: 45 min/hr
__**S28**: Limit keyboarding: 4 hr/day

PR STATUS:

__ **PR-1**: Periodic Report
__ **PR-2**: Change in Work Status
__ **PR-3**: Change in Pt. Condition
__ **PR-4**: Change in Tx Plan
__ **PR-5**: Referral/Consult
__ **PR-6**: Surgery/Hospitalization
__ **PR-7**: Discharge
__ **PR-8**: Request by Adjuster
__ **PR-9**: Other: _____

DISPOSITION: __**D1**: Consult __**D2**: Final Discharge without residuals, PR-2 to follow
__**D5**: Referral / Transfer of care __**D4**: Final Discharge with residuals, PR-3 to follow
__**D6**: Non-occupational, refer to PMD __**D3**: First Aid

Next scheduled appointment: 1day.

Provider Initial: d/r

DH-WSR Worksheet Revised 4/12/04

✓ Kenalog ICC IM.

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

WORK STATUS REPORT

Employee Name: Anderson, Tiffany K
Social Security No.: 549-23-5133
Employer: SJ Mosquito and Vector Control
Date of Injury: 10/11/2005
Clinic Case Number: 78225
Date of Visit: 10/13/2005
Time In: 07:49 am **Time Out:** 09:49 am
Guarantor: AIMS - Fresno 8046
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 10-14-05 **From:** 10/13/2005 **To:** 10/14/2005

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

DAMERON HOSPITAL Occupational Health Services
420 West Acacia Street, Suite C, Stockton, CA 95203 (209) 461-3196 Fax: (209) 461-3123

Follow Up Appointments

While you are recovering from your injury, we want to make your visits to our facility as convenient as possible with minimal waiting times. To help us achieve this goal, we ask that you please follow these basic guidelines:

1. **Please arrive to your appointment on time.**

2. **If possible, please do not bring children or more than one family member to your appointment.**

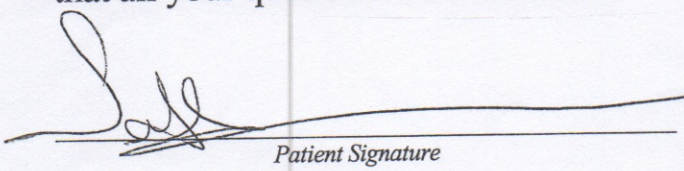
3. **If you need to change your appointment, please call us as soon as possible.**

4. **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.**

Following these guidelines will avoid unnecessary delays for all of our patients and keep your waiting time to a minimum. Thank you for helping us to make your visits as pleasant and convenient as possible.

If you have *ANY* questions about these guidelines, please do not hesitate to ask.

Please sign below indicating that these guidelines were explained to you and that all your questions were answered.



Patient Signature

10/13/2005
Date

Name: Anderson, Tiffany K

Case No.: 78225

10-1405

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		

What 2 pages were ~~~~ faxed to Stroh?

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 w **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)

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

DH-WSR 8/14/02

DAMERON HOSPITAL
OCCUPATIONAL INURY CLINIC

WORK STATUS REPORT - WORKSHEET

R

Employee Name: Anderson, Tiffany K Date of this Examination: 10/14/2005

Employer: SJ Mosquito and Vector Clinic Case Number: 78225

DIAGNOSIS: _____ _____

_____ _____

CLINICAL STATUS: __**Q1**: Improved, as expected __**Q2**: Improving slowly __**Q3**: No significant change __**Q4**: Worse

PT/OT: __**W1**: Continue as prescribed __**W2**: 3x/wk - 2 week __**W3**:3x/wk – 1 week __**W4**: One visit __**W5**: Non-DHA PT

RECOMMENDED EVALUATION / DIAGNOSTIC STUDIES:

__**E1**: MRI __**E2**: CT Scan __**E3**: NCS __**E4**: Work Conditioning __**E5**: Epidurals __**E6**: Ergo Evaluation

REFERRAL / CONSULT:

__ **R10**: Orthopedist
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__ **R12**: Neurosurgeon
__ **R13**: Hand Specialist
__ **R14**: General Surgeon
__ **R15**: Neurologist
__ **R16**: Psych
__ **R17**: Physiatrist
__ **R18**: ENT
__ **R19**: Dermatology
__ **R20**: Pain Mgmt
__ **R21**: Dentist
__ **R22**: Health Club
__ **R23**: Urology
__ **R24**: Acupuncture
__ **R25**: Podiatrist

WORK STATUS:

__ ~~Full work duties~~
__ ~~Modified work duties~~
__ Off balance of shift, modified work
__ Off balance of shift, full work duties
__ No work until next appt.
__ Current WS until Specialist appt.

WORK RESTRICTIONS: 10/15/05

No lift / carry >:
__**A09**: 50#
__**A10**: 10-15#
__**A11**: 30#
__**A12**: 5#

No prolonged:
__**A15**:Stand/Walk
__**A16**:Sitting

Other Back/Neck
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PR STATUS:

__ **PR-1**: Periodic Report
__ **PR-2**: Change in Work Status
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__ **PR-4**: Change in Tx Plan
__ **PR-5**: Referral/Consult
__ **PR-6**: Surgery/Hospitalization
__ **PR-7**: Discharge
__ **PR-8**: Request by Adjuster
__ **PR-9**: Other: _____

DISPOSITION:

__**D1**: Consult
__**D5**: Referral / Transfer of care
__**D6**: Non-occupational, refer to PMD
__**D2**: Final Discharge without residuals, PR-2 to follow
__**D4**: Final Discharge with residuals, PR-3 to follow
__**D3**: First Aid

Next scheduled appointment: Mon.

Provider Initial: dlv

V5. TEMP

Occupational Injury Clinic
420 W. Acacia Street , STE # 2 Linacia 1st Floor
Stockton, CA 95204

DATE	: 10/14/2005		
PATIENT	: Anderson, Tiffany K	DATE OF INJURY	: 10/11/2005
EMPLOYER	: SJ Mosquito and Vector Control	SOC. SEC.#	: 549-23-5133
CASE #	: 78225	CLAIM #	: VE060031

SUBJECTIVE:

The patient is much better, has no pruritus. Her skin rash is improved. No respiratory difficulties or chest pain. She was complaining of some drowsiness this morning, actually missed her appointment as she was quite drowsy secondary to Benadryl.

OBJECTIVE:

On examination, she is alert in no acute distress. Throat is clear. Neck is without adenopathy. Lungs are clear without wheeze, rales, rhonchi. Breath sounds equal. Heart: Regular rhythm without murmur. Heart sounds normal.

ASSESSMENT:

Allergic skin reaction, contact.

The patient's symptoms are resolving. She is to continue her Benadryl in the evening and she will follow up if her symptoms increase, otherwise, she will follow up on Monday October 17.

DR/bjg

D: 11/01/2005
T: 11/14/2005

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.

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:

Next Scheduled Appointment: ~~3:00 pm~~ 8:20 AM 10/20/05 ~~10/20/2005~~ change due to PDA Training Schedule con't

"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 8/1/02

DAMERON HOSPITAL
OCCUPATIONAL INURY CLINIC

10-17-05

WORK STATUS REPORT - WORKSHEET

Employee Name: Anderson, Tiffany K Date of this Examination: 10/17/2005

Employer: SJ Mosquito and Vector Clinic Case Number: 78225

DIAGNOSIS: _____ _____

_____ _____

CLINICAL STATUS: __Q1: Improved, as expected __Q2: Improving slowly __Q3: No significant change __Q4: Worse

PT/OT: __W1: Continue as prescribed __W2: 3x/wk - 2 week __W3:3x/wk – 1 week __W4: One visit __W5: Non-DHA PT

RECOMMENDED EVALUATION / DIAGNOSTIC STUDIES:

__E1: MRI __E2: CT Scan __E3: NCS __E4: Work Conditioning __E5: Epidurals __E6: Ergo Evaluation

REFERRAL / CONSULT:

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__ R20: Pain Mgmt
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__ R22: Health Club
__ R23: Urology
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WORK STATUS: ✓ Full work duties __ Modified work duties __ Off balance of shift, modified work __ Off balance of shift, full work duties __ No work until next appt. __ Current WS until Specialist appt.

WORK RESTRICTIONS:

No lift / carry >:
__A09: 50#
__A10: 10-15#
__A11: 30#
__A12: 5#

No prolonged:
__A15:Stand/Walk
__A16:Sitting

Other Back/Neck
__A13: No frequent lift, bend, twist, stoop at waist
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Lower Extremity
__A18: No crawl / kneel / squat
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__A22: Use cane as directed

Upper Extremity
__S10: Wear splint / sling as directed
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__S13: No use of arm above shoulder
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Miscellaneous
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__S23: No welding
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PR STATUS:

__ PR-1: Periodic Report
__ PR-2: Change in Work Status
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__ PR-7: Discharge
__ PR-8: Request by Adjuster
__ PR-9: Other: _____

DISPOSITION: __D1: Consult __D2: Final Discharge without residuals, PR-2 to follow
__D5: Referral / Transfer of care __D4: Final Discharge with residuals, PR-3 to follow
__D6: Non-occupational, refer to PMD __D3: First Aid

Next scheduled appointment: 1 hours Provider Initial: dlv

(1) V.S. Wet. Temp.
(2) CBC.

Occupational Injury Clinic

420 W. Acacia Street , STE # 2 Linacia 1st Floor

Stockton, CA 95204

DATE	: 10/17/2005		
PATIENT	: Anderson, Tiffany K	DATE OF INJURY	: 10/11/2005
EMPLOYER	: SJ Mosquito and Vector Control	SOC. SEC.#	: 549-23-5133
CASE #	: 78225	CLAIM #	: VE060031

SUBJECTIVE:

The patient's rash is improving. She is no longer having symptoms pruritic. She is having some "flu symptoms" at this time. She may have had a fever last evening, general malaise, denies sore throat, no respiratory symptoms, slight nausea.

OBJECTIVE:

She is alert, in no acute distress. She is well hydrated. Ears, nose and throat: There is mild pharyngeal erythema. Neck: Supple, no adenopathy. Lungs: Clear without wheeze, rales, rhonchi. Breath sounds equal. Heart: Regular rhythm without murmur. Heart sounds normal. Abdomen: Soft and nontender without organomegaly or mass. Skin: There are a faint scattered erythematous small macules at the back. There are no inguinal nodes.

ASSESSMENT:

1. Probable allergic reaction.
2. Rule out viral syndrome.

PLAN:
Followup in three days.

DR/bjg

D: 10/17/2005
T: 10/28/2005

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.

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~~ eve flight

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

Signed,

Donald Rossman, (Original signature on file)

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

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

WORK STATUS REPORT

Employee Name: Anderson, Tiffany K
Social Security No.: 549-23-5133
Employer: SJ Mosquito and Vector Control
Date of Injury: 10/11/2005
Clinic Case Number: 78225
Date of Visit: 10/17/2005
Time In: 07:48 am **Time Out:** 08:32 am
Guarantor: AIMS - Fresno 8046
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:

Next Scheduled Appointment: 3:00 pm 10/20/2005

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Case Coordinator Phone: (209) 461-3196 opt.1

10-17-05

DAMERON HOSPITAL CLINICAL LABORATORY
525 West Acacia Street Stockton California 95203
Laboratory Directors: J.L. Dickerson,M.D. R.D. Lawrence,M.D.

NAME: ANDERSON,TIFFANY K

LOC: OCC Injury Clinic
ID: 08599110015
MR: 626041

SEX: F AGE: 35Y DOB: 08/22/1970
DR: HULL,INJURIES,
COPY TO DR: ROSSMAN,DONALD L MD

ACC: M4535 COLLECT: 10/17/2005 08:25 RECEIPT: 10/17/2005 11:51 ORD DR: ROSSMAN,DONALD L MD

	ABN LOW	NORMAL	ABN HIGH			
CBC						
WBC Count		6.2			[4.5-11.0]	10^3/uL
RBC Count		4.62			[3.80-5.30]	10^6/uL
Hemoglobin		13.7			[11.7-16.1]	g/dL
Hematocrit		40.1			[37.0-47.0]	%
MCV		87			[73-100]	fL
MCH		29.7			[26.0-35.0]	pg/Erc
MCHC		34.2			[31.0-36.0]	gHb/dL
PLT Count		231			[150-450]	10^3/uL
RDW-CV		13.4			[11.0-16.0]	%
Differential						
Abs Neutrophil Auto		4.2			[2.2-7.6]	10^3/uL
Abs Lymphocyte Auto		1.4			[1.0-3.8]	10^3/uL
Abs Monocyte Auto		0.3			[0.1-0.9]	10^3/uL
Abs Eosinophil Auto		0.1			[0.00-0.40]	10^3/uL
Abs Basophil Auto		0.1			[0.0-0.1]	10^3/uL
Neutrophil Auto		68			[55-75]	%
Lymphocyte Auto		23			[20-35]	%
Monocyte Auto		6			[2-8]	%
Eosinophil Auto		1.71			[1-4]	%
Basophil Auto			1.44	H	[0-1]	%

dlv

END OF REPORT

DAMERON HOSPITAL CLINICAL LABORATORY
525 West Acacia Street Stockton California 95203
Laboratory Directors: J.L. Dickerson,M.D. R.D. Lawrence,M.D.

NAME: ANDERSON,TIFFANY K

SEX: F AGE: 35Y DOB: 08/22/1970
DR: HULL,INJURIES,
COPY TO DR: ROSSMAN,DONALD L MD

LOC: OCC Injury Clinic
ID: 08599110015
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Abs Monocyte Auto		0.3			[0.1-0.9]	10^3/uL
Abs Eosinophil Auto		0.1			[0.00-0.40]	10^3/uL
Abs Basophil Auto		0.1			[0.0-0.1]	10^3/uL
Neutrophil Auto		68			[55-75]	%
Lymphocyte Auto		23			[20-35]	%
Monocyte Auto		6			[2-8]	%
Eosinophil Auto		1.71			[1-4]	%
Basophil Auto			1.44	H	[0-1]	%

dlv

END OF REPORT

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

DH-WSR 8/1/02

10-20-105

DAMERON HOSPITAL
OCCUPATIONAL INURY CLINIC

WORK STATUS REPORT - WORKSHEET

Employee Name: Anderson, Tiffany K Date of this Examination: 10/20/2005

Employer: SJ Mosquito and Vector Clinic Case Number: 78225

DIAGNOSIS: _____ _____

_____ _____

CLINICAL STATUS: __Q1: Improved, as expected __Q2: Improving slowly __Q3: No significant change __Q4: Worse

PT/OT: __W1: Continue as prescribed __W2: 3x/wk - 2 week __W3:3x/wk – 1 week __W4: One visit __W5: Non-DHA PT

RECOMMENDED EVALUATION / DIAGNOSTIC STUDIES:

__E1: MRI __E2: CT Scan __E3: NCS __E4: Work Conditioning __E5: Epidurals __E6: Ergo Evaluation

REFERRAL / CONSULT:

__ R10: Orthopedist
__ R11: Ophthalmologist
__ R12: Neurosurgeon
__ R13: Hand Specialist
__ R14: General Surgeon
__ R15: Neurologist
__ R16: Psych
__ R17: Physiatrist
__ R18: ENT
__ R19: Dermatology
__ R20: Pain Mgmt
__ R21: Dentist
__ R22: Health Club
__ R23: Urology
__ R24: Acupuncture
__ R25: Podiatrist

WORK STATUS: __ Full work duties __ ~~Off balance of shift, modified work~~ __ No work until next appt.
__ Modified work duties __ Off balance of shift, full work duties __ Current WS until Specialist appt.

WORK RESTRICTIONS: 10/20/05

No lift / carry >:
__A09: 50#
__A10: 10-15#
__A11: 30#
__A12: 5#

No prolonged:
__A15:Stand/Walk
__A16:Sitting

Other Back/Neck
__A13: No frequent lift, bend, twist, stoop at waist
__A14: Limit twist / bend at neck
__A17: Desk / sedentary only

Lower Extremity
__A18: No crawl / kneel / squat
__A19: No climbing ladders
__A20: Use crutches as directed
__A21: Elevate as directed
__A22: Use cane as directed

Upper Extremity
__S10: Wear splint / sling as directed
__S11: No frequent / repetitive use of wrist / hand
__S12: No heavy pushing or pulling
__S13: No use of arm above shoulder
__S14: No forceful hand grasp
__S15: No use of injured body part

Miscellaneous
__S16: Limited use of injured body part
__S17: May advance work activities as tolerated
__S18: Keep dressing clean and dry
__S19: No operating company vehicles
__S20: No exposure to heat
__S21: No exposure to cold
__S22: No exposure to chemical, vapors, fumes
__S23: No welding
__S24: Avoid physical altercations
__S25: Avoid wearing latex gloves
__S27: Limit keyboarding: 45 min/hr
__S28: Limit keyboarding: 4 hr/day

PR STATUS:

__ PR-1: Periodic Report
__ PR-2: Change in Work Status
__ PR-3: Change in Pt. Condition
__ PR-4: Change in Tx Plan
__ PR-5: Referral/Consult
__ PR-6: Surgery/Hospitalization
__ PR-7: Discharge
__ PR-8: Request by Adjuster
__ PR-9: Other: _____

DISPOSITION:

__D1: Consult
__D5: Referral / Transfer of care
__D6: Non-occupational, refer to PMD
__D2: Final Discharge without residuals, PR-2 to follow
__D4: Final Discharge with residuals, PR-3 to follow
__D3: First Aid

Next scheduled appointment: ~~1 Week~~ TV 25

Provider Initial: dlv

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

WORK STATUS REPORT

Employee Name: Anderson, Tiffany K
Social Security No.: 549-23-5133
Employer: SJ Mosquito and Vector Control
Date of Injury: 10/11/2005
Clinic Case Number: 78225
Date of Visit: 10/20/2005
Time In: 08:52 am **Time Out:** 09:54 am
Guarantor: AIMS - Fresno 8046
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

Occupational Injury Clinic

Recheck Worksheet

Patient	Employer	Guarantor
nderson, Tiffany K 1416 Iris Dr #7 Lodi, CA 95242	SJ Mosquito and Vector Control 7759 S Airport Way Stockton, CA 95206	AIMS - Fresno 8046 PO Box 28100 Fresno, CA 93729
Phone: (209) 333-1037	Contact : John Stroh Phone : (209) 982-4675 x Fax : (209) 982-0120	Phone : (559) 227-9891 Fax : (559) 227-1579

Sex: Female **DOB** : 08/22/1970 **Age:** 35
Social Security # : 549-23-5133
Occupation : Tech I
Department :

Date/Hour of Injury : 10/11/2005 at 09:00 am
Last Work Date :
Case Number : 78225
Claim Number : Pending

Date/Time of Visit : 10/20/2005 at 08:52 am

Check In Instructions

Page OHS staff @ 929-2541 BEFORE proceeding

DRUG AND ALCOHOL TESTING
* None

OTHER INSTRUCTIONS
* Company may request: DOT UDS & BAT
* Lab: Quest, Test #35304N, Client #76337

TREATMENT AUTHORIZATION
1. John Stroh
2. Carol Aksland
3. Ed Lucchesi

Provider's Notes

☑ Dictation Complete

420 W. Acacia Street , STE # 2 Linacia 1st Floor, Stockton, CA 95204
Phone: (209) 461-3196 Fax: (209) 461-7529

DAMERON HOSPITAL
OCCUPATIONAL INURY CLINIC

WORK STATUS REPORT - WORKSHEET

R

Employee Name: Anderson, Tiffany K Date of this Examination: 10/20/2005

Employer: SJ Mosquito and Vector Clinic Case Number: 78225

DIAGNOSIS: _____ _____

_____ _____

CLINICAL STATUS: __**Q1**: Improved, as expected __**Q2**: Improving slowly __**Q3**: No significant change __**Q4**: Worse

PT/OT: __**W1**: Continue as prescribed __**W2**: 3x/wk - 2 week __**W3**:3x/wk – 1 week __**W4**: One visit __**W5**: Non-DHA PT

RECOMMENDED EVALUATION / DIAGNOSTIC STUDIES:

__**E1**: MRI __**E2**: CT Scan __**E3**: NCS __**E4**: Work Conditioning __**E5**: Epidurals __**E6**: Ergo Evaluation

REFERRAL / CONSULT:

__ **R10**: Orthopedist
__ **R11**: Ophthalmologist
__ **R12**: Neurosurgeon
__ **R13**: Hand Specialist
__ **R14**: General Surgeon
__ **R15**: Neurologist
__ **R16**: Psych
__ **R17**: Physiatrist
__ **R18**: ENT
__ **R19**: Dermatology
__ **R20**: Pain Mgmt
__ **R21**: Dentist
__ **R22**: Health Club
__ **R23**: Urology
__ **R24**: Acupuncture
__ **R25**: Podiatrist

WORK STATUS: __ Full work duties __ ~~Off balance of shift, modified work~~ __ No work until next appt.

__ Modified work duties __ Off balance of shift, full work duties __ Current WS until Specialist appt.

10/21/05

WORK RESTRICTIONS:

No lift / carry >:
__**A09**: 50#
__**A10**: 10-15#
__**A11**: 30#
__**A12**: 5#

No prolonged:
__**A15**:Stand/Walk
__**A16**:Sitting

Other Back/Neck
__**A13**: No frequent lift, bend, twist, stoop at waist
__**A14**: Limit twist / bend at neck
__**A17**: Desk / sedentary only

Lower Extremity
__**A18**: No crawl / kneel / squat
__**A19**: No climbing ladders
__**A20**: Use crutches as directed
__**A21**: Elevate as directed
__**A22**: Use cane as directed

Upper Extremity
__**S10**: Wear splint / sling as directed
__**S11**: No frequent / repetitive use of wrist / hand
__**S12**: No heavy pushing or pulling
__**S13**: No use of arm above shoulder
__**S14**: No forceful hand grasp
__**S15**: No use of injured body part

Miscellaneous
__**S16**: Limited use of injured body part
__**S17**: May advance work activities as tolerated
__**S18**: Keep dressing clean and dry
__**S19**: No operating company vehicles
__**S20**: No exposure to heat
__**S21**: No exposure to cold
__**S22**: No exposure to chemical, vapors, fumes
__**S23**: No welding
__**S24**: Avoid physical altercations
__**S25**: Avoid wearing latex gloves
__**S27**: Limit keyboarding: 45 min/hr
__**S28**: Limit keyboarding: 4 hr/day

PR STATUS:

__ **PR-1**: Periodic Report
__ **PR-2**: Change in Work Status
__ **PR-3**: Change in Pt. Condition
__ **PR-4**: Change in Tx Plan
__ **PR-5**: Referral/Consult
__ **PR-6**: Surgery/Hospitalization
__ **PR-7**: Discharge
__ **PR-8**: Request by Adjuster
__ **PR-9**: Other: _____

DISPOSITION: __**D1**: Consult __**D2**: Final Discharge without residuals, PR-2 to follow

__**D5**: Referral / Transfer of care __**D4**: Final Discharge with residuals, PR-3 to follow

__**D6**: Non-occupational, refer to PMD __**D3**: First Aid

Next scheduled appointment: ~~Next~~ TU 25 Provider Initial: dlr

[x] Periodic Report [x] Change in treatment plan [x] Discharged
[x] Change in work status [x] Need for referral or consultation [x] Requested by:_____
[x] Change in patient' s condition [x] Need for surgery or hospitalization [x] Other: _____

Patient Information:

Anderson, Tiffany K
1416 Iris Dr #7 Lodi, CA 95242-
(209) 333-1037

Sex: F

SSN: 549-23-5133
DOB: 08/22/1970
Occupation: Tech I

Claims Administrator:

AIMS - Fresno 8046
Fresno, CA 93729-
(559) 227-9891

Claim Number: VE060031

FAX: (559) 227-1579

Employer:

SJ Mosquito and Vector Control
( ) -

Narrative Report: **Date of Visit:** 10/20/2005

SUBJECTIVE:

Pt improving. No respiratory complaints.

OBJECTIVE:

Alert, no acute distress. ENT clear. Neck no adenopathy. Lungs clear. Heart regular rhythm without murmur. Heart sounds normal. Skin clear at this time.

ASSESSMENT:

Probable allergic reaction. R/o viral syndrome.

PLAN:

1. Return 1 wk

DR

D: 04/24/06
T: 04/25/06

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.

RECEIVED
MAY 01 2006

Work Status: Off balance of shift; return to **From:** 10/20/2005 **To:** 10/25/2005

State of California
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Patient Name: Anderson, Tiffany K **Date of Visit:** 10/20/2005

Primary Treating Physician:
I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3.

Signature: _____ Date: 10/20/2005

Physician: Donald Rossman, M.D.
Cal. Lic. # C35074
Specialty: Occupational Medicine

Executed at: Dameron Hospital
525 W. Acacia St., Stockton, CA 95203
(209) 461-3196 Opt.3

Next report due no later than 45 days from date of this report

RECEIVED
MAY 01 2006

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

Occupational Injury Clinic

Recheck Worksheet

Patient	Employer	Guarantor
nderson, Tiffany K 1416 Iris Dr #7 Lodi, CA 95242 Phone: (209) 333-1037	SJ Mosquito and Vector Control 7759 S Airport Way Stockton, CA 95206 Contact : John Stroh Phone : (209) 982-4675 x Fax : (209) 982-0120	AIMS - Fresno 8046 PO Box 28100 Fresno, CA 93729 Phone : (559) 227-9891 Fax : (559) 227-1579

Sex: Female **DOB** : 08/22/1970 **Age:** 35
Social Security # : 549-23-5133
Occupation : Tech I
Department :

Date/Hour of Injury : 10/11/2005 at 09:00 am
Last Work Date :
Case Number : 78225
Claim Number : Pending

Date/Time of Visit : 10/25/2005 at 07:25 am

Check In Instructions

Page OHS staff @ 929-2541 BEFORE proceeding

DRUG AND ALCOHOL TESTING
* None

OTHER INSTRUCTIONS
* Company may request: DOT UDS & BAT
* Lab: Quest, Test #35304N, Client #76337

TREATMENT AUTHORIZATION
1. John Stroh
2. Carol Aksland
3. Ed Lucchesi

Provider's Notes

☑ Dictation Complete

dlv

DAMERON HOSPITAL
OCCUPATIONAL INURY CLINIC

WORK STATUS REPORT - WORKSHEET

R

Employee Name: Anderson, Tiffany K Date of this Examination: 10/25/2005

Employer: SJ Mosquito and Vector Clinic Case Number: 78225

DIAGNOSIS: _____ _____

_____ _____

CLINICAL STATUS: __**Q1**: Improved, as expected __**Q2**: Improving slowly __**Q3**: No significant change __**Q4**: Worse

PT/OT: __**W1**: Continue as prescribed __**W2**: 3x/wk - 2 week __**W3**:3x/wk – 1 week __**W4**: One visit __**W5**: Non-DHA PT

RECOMMENDED EVALUATION / DIAGNOSTIC STUDIES:

__**E1**: MRI __**E2**: CT Scan __**E3**: NCS __**E4**: Work Conditioning __**E5**: Epidurals __**E6**: Ergo Evaluation

REFERRAL / CONSULT:

__ **R10**: Orthopedist
__ **R11**: Ophthalmologist
__ **R12**: Neurosurgeon
__ **R13**: Hand Specialist
__ **R14**: General Surgeon
__ **R15**: Neurologist
__ **R16**: Psych
__ **R17**: Physiatrist
__ **R18**: ENT
__ **R19**: Dermatology
__ **R20**: Pain Mgmt
__ **R21**: Dentist
__ **R22**: Health Club
__ **R23**: Urology
__ **R24**: Acupuncture
__ **R25**: Podiatrist

WORK STATUS:

__ Full work duties
__ Modified work duties
__ Off balance of shift, modified work
__ Off balance of shift, full work duties
__ No work until next appt.
__ Current WS until Specialist appt.

WORK RESTRICTIONS:

No lift / carry >:
__**A09**: 50#
__**A10**: 10-15#
__**A11**: 30#
__**A12**: 5#

No prolonged:
__**A15**:Stand/Walk
__**A16**:Sitting

Other Back/Neck
__**A13**: No frequent lift, bend, twist, stoop at waist
__**A14**: Limit twist / bend at neck
__**A17**: Desk / sedentary only

Lower Extremity
__**A18**: No crawl / kneel / squat
__**A19**: No climbing ladders
__**A20**: Use crutches as directed
__**A21**: Elevate as directed
__**A22**: Use cane as directed

Upper Extremity
__**S10**: Wear splint / sling as directed
__**S11**: No frequent / repetitive use of wrist / hand
__**S12**: No heavy pushing or pulling
__**S13**: No use of arm above shoulder
__**S14**: No forceful hand grasp
__**S15**: No use of injured body part

Miscellaneous
__**S16**: Limited use of injured body part
__**S17**: May advance work activities as tolerated
__**S18**: Keep dressing clean and dry
__**S19**: No operating company vehicles
__**S20**: No exposure to heat
__**S21**: No exposure to cold
__**S22**: No exposure to chemical, vapors, fumes
__**S23**: No welding
__**S24**: Avoid physical altercations
__**S25**: Avoid wearing latex gloves
__**S27**: Limit keyboarding: 45 min/hr
__**S28**: Limit keyboarding: 4 hr/day

PR STATUS:

__ **PR-1**: Periodic Report
__ **PR-2**: Change in Work Status
__ **PR-3**: Change in Pt. Condition
__ **PR-4**: Change in Tx Plan
__ **PR-5**: Referral/Consult
__ **PR-6**: Surgery/Hospitalization
__ **PR-7**: Discharge
__ **PR-8**: Request by Adjuster
__ **PR-9**: Other: _____

DISPOSITION:

__**D1**: Consult
__**D5**: Referral / Transfer of care
__**D6**: Non-occupational, refer to PMD
__**D2**: Final Discharge without residuals, PR-2 to follow
__**D4**: Final Discharge with residuals, PR-3 to follow
__**D3**: First Aid

Next scheduled appointment: _____

Provider Initial: dlr

V.S.

State of California
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

In accordance with CCR Title 8, Section 9785, this report is being submitted for the following reason:

[ ] Periodic Report [ ] Change in treatment plan [x] Discharged
[ ] Change in work status [ ] Need for referral or consultation [ ] Requested by:_____
[ ] Change in patient' s condition [ ] Need for surgery or hospitalization [ ] Other: _____

Patient Information:

Anderson, Tiffany K
1416 Iris Dr #7 Lodi, CA 95242-
(209) 333-1037

Sex: F

SSN: 549-23-5133
DOB: 08/22/1970
Occupation: Tech I

Claims Administrator:

AIMS - Fresno 8046
Fresno, CA 93729-
(559) 227-9891

Claim Number: VE060031

FAX: (559) 227-1579

Employer:

SJ Mosquito and Vector Control
( ) -

Narrative Report: **Date of Visit:** 10/25/2005

SUBJECTIVE:

Pt asymptomatic. No skin or respiratory symptoms.

OBJECTIVE:

Alert, no acute distress. Lungs clear. Heart regular rhythm without murmur. Heart sounds normal. Skin clear.

ASSESSMENT:

Probable allergic reaction resolved.

PLAN:

1. Discharge from care without residual.

DR

D: 04/24/06
T: 04/25/06

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.

RECEIVED
MAY 01 2006

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

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

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

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

I 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
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:

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_____
Sexually Transmitted Diseases_____
Mental Health/Psychiatric Disorders_____
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

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*

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

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