## STATE OF CALIFORNIA DWC DISTRICT OFFICE





Is this a new case?	Yes 🗸	No 🗌	Companion C	ases Exist	Walkthrougl	n Yes No
More than 15 Com	npanion Cases	· 🗌				
10/01/2009					001	549-23-5133
Date:(MM/DD/YY)	YY)				SSN:	3-17-23-3133
		<b>√</b> 9	Specific Injury	06/19/2008		
Case Number 1			Cumulative Injury	(Start Date: MM/DD/		(End Date: MM/DD/YYYY) as the specific date of injury)
Body Part 1:	513	<del> </del>	_	<del> -</del>	Body Part 3:	
Body Part 2:					Body Part 4:	
Other Body Parts:				<del> </del>	<del></del>	
lease check unit to	o be filed on (	check only	one box )			
✓ ADJ [	DEU	SIF	UE	F Voc		NT RSU
ompanion Cases	·					
		<b>√</b> s	pecific Injury	03/26/2009		
Case Number 2	· · · · · · · · · · · · · · · · · · ·	c	umulative Injury	(Start Date: MM/DD/ (If Specific Injury,	•	(End Date: MM/DD/YYYY) is the specific date of injury)
Body Part 1:	513				Body Part 3:	
Body Part 2:					Body Part 4:	
her Body Parts:		_			_	1
DWC-CA form 1023						1

<del></del>		✓ Specific Injury	07/02/2009	
Case Number 3		Cumulative Injury	(Start Date: MM/DD/YYYY)  (If Specific Injury, use the start date as	(End Date: MM/DD/YYYY) s the specific date of injury)
Body Part 1:	513		Body Part 3:	
Body Part 2:			Body Part 4:	
Other Body Parts:				
		Specific Injury	/ /	
Case Number 4		Cumulative Injury	(Start Date: MM/DD/YYYY)  (If Specific Injury, use the start date)	(End Date: MM/DD/YYYY) ate as the specific date of injury)
Body Part 1:			Body Part 3:	
Body Part 2:			Body Part 4:	
Other Body Parts:				,
		Specific Injury	11	
Case Number 5		Cumulative Injur	y (Start Date: MM/DD/YYYY)  (If Specific Injury, use the start d	(End Date: MM/DD/YYYY) ate as the specific date of injury)
Body Part 1:		,	Body Part 3	
Body Part 2:			Body Part 4	·
Other Body Parts:				I

DWC-CA form 10232.1 Rev. 11/2008- Page 2 of 8

## DOCUMENT SEPARATOR SHEET



Donato de Delivera de la la	ADJ		
Product Delivery Unit	ADJ		
Document Type <u>LEGAL DOCS</u>			
Document Title APPLICATION FO	R ADJUDICATION		
Document Date	09/29/2009 MM/DD/YYYY		
Author	LAW OFFICE OF RONALD M. STEIN INC.		
	Office Use Only		
Received Date			
	MM/DD/YYYY		



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

|--|

ADJ		Amended Application	
Case No.			
549-23-5133			
SSN (Numbers Only)			
Venue choice is based upon (Con	apletion of this section is requi	red)	
County of residence of employe	e (Labor Code section 5501.5(a)(	(1) or (d).)	
County where injury occurred (L	abor Code section 5501.5(a)(2) c	or (d).)	
County of principal place of bus	iness of employee's attorney (Lat	oor Code section 5501.5(a)(3) or (d	).)
STK Select 3 - Letter Office Code For Pla	ce/Venue of Hearing (From the D	ocument Cover Sheet)	
Injured Worker (Completion of this	s section is required)		-
TIFFANY			
First Name		MI	
ANDERSON			
Last Name			
1516 SYLVAN WAY APT. 205			<u> </u>
Street Address/PO Box (Please lea	ve blank spaces between number	rs, names or words)	
01 14 H = 0/D0 D= //Dlassa la	eve black opene between numb	ore names or words)	<u> </u>
Street Address2/PO Box (Please le	ave blank spaces between numb	ers, Harries of Words)	
International Address (Please leave	blank spaces between numbers	, names or words)	<del></del>
LODI		CA	95242
City		State	Zip Code
Applicant (If other than injured W	orker)		
Insurance Carrier	Employer	Lien Claimant	
Name (Please leave blank spaces	between numbers, names or word	ds)	
Street Address/PO Box (Please lea	ive blank spaces between numbe	ers, names or words)	
Street Address2/PO Box (Please le	eave blank spaces between numb	pers, names or words)	
City		State	Zip Code
DWC/WCAB Form 1A (11/2008) - (Pag	e 1)		WCAB1

Employer Informati	ion (Completion of this sec	tion is requir	ed)		
<b>✓</b> Insured	Self-Insured	Leg	ally Uninsured	Uninsu	ured
	COUNTY MOSQUITO			TRIC	
Employer Name (Pl	lease leave blank spaces bet	ween number	s, names or words)		
7759 SOUTH AI					
Employer Street Ad	ddress/PO Box (Please leave	blank spaces	between numbers, na	mes or words)	
STOCKTON				CA	95206
City				State	Zip Code
nsurance Carrier I	nformation (If known and if	applicable -	include even if carrie	r is adjusted by	claims administrator
AIMS	,				
	me (Please leave blank spaces	between numbe	rs, names or words)		
P.O. BOX 26912	vn				
	eet Address/PO Box (Please lea	ve blank space	s between numbers, nan	nes or words)	<del> </del>
SACRAMENTO	•			CA	95826
City	<u> </u>			State	Zip Code
	ator Information (If known a	nd if applicat	ole)		
		• • •	•		
MACKENZIE D	AWSON blank spaces between numbers	names or word	is)	· · · · · · · · · · · · · · · · · · ·	
		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
P.O. BOX 26912					
Street Address/PO B	lox (Please leave blank spaces t	oetween numbe	rs, names or words)		
SACRAMENTO	)			CA	95826
City				State	Zip Code
	AT (Complete all relevant i	nformation):	TE		Zip Code
				State CH I	Zip Code
IT IS CLAIMED TH	. born 08/22/1970	, while	TEO	CH I	Zip Code
IT IS CLAIMED TH	, born 08/22/1970 (DATE OF BIRTH: MM/D	, while		CH I	
T IS CLAIMED TH	only one) 08/22/1970 08/22/1970 08/22/1970 07/	, while	employed as a(n)	CH I	
T IS CLAIMED TH	only one) 08/22/1970 08/22/1970 08/22/1970 07/	, while	employed as a(n)	CH I	
T IS CLAIMED TH.  1. The injured worker,  (Choose  √ special suffered a :	only one) 08/22/1970 08/22/1970 08/22/1970 07/	, while (02/2009 ary: MM/DD/YYYY	e employed as a(n)	CH I (OCCUPATION A	
IT IS CLAIMED TH.  1. The injured worker,  (Choose  √ special suffered a:	, born $\frac{08/22/1970}{\text{(DATE OF BIRTH: MM/D}}$ only one) $07/$ ecific injury $\frac{0}{\text{(Date of injury)}}$ mulative injury which began	, while (02/2009 ary: MM/DD/YYYY	e employed as a(n)	CH I  (OCCUPATION A	AT THE TIME OF INJURY)
IT IS CLAIMED TH  1. The injured worker,  (Choose  √ special suffered a:	t, born $\frac{08/22/1970}{\text{(DATE OF BIRTH: MM/D}}$ only one) $\frac{07/}{\text{(Date of injury)}}$ ecific injury which began and the dat	, while (02/2009 ary: MM/DD/YYYY)  on (Start Date	employed as a(n)	CH I  (OCCUPATION A  ended on(Enc	AT THE TIME OF INJURY) I Date: MM/DD/YYYY)
1. The injured worker,  (Choose  Suffered a:	t, born $\frac{08/22/1970}{\text{(DATE OF BIRTH: MM/D}}$ only one) $\frac{07/}{\text{(Date of injury)}}$ ecific injury which began and the dat	, while (02/2009 ary: MM/DD/YYYY)  on (Start Date	employed as a(n)  math display="block" and employees and employees are already as a a a a a a a a a a a a a a a a a a	CH I  (OCCUPATION A  ended on(Enc	AT THE TIME OF INJURY) I Date: MM/DD/YYYY)

Rate of Pay \$ 971.00	(State which parts of the body were	·,
Sody Part 3:    Sody Part 4:	Body Part 1: 513 KNEE	
In the Body Part 4:  The Injury occurred as follows:  EXPLAIN WHAT THE WORKER WAS DOING AT THE TIME OF INJURY AND HOW THE INJURY OCCURED)  APPLICANT WAS TREATING PASTURE ACCESSED BY CLIMBING FENCES.  Actual earnings at the time of injury:  Actual earnings at the time of injury:  Weekly  Hourly  Hourly  Number of hours worked per week 40  In the injury caused disability as follows:  Last day off work due to injury:  OT/02/2009  MINDDYYYY  First Period of Disability:  Start Date  MINDDYYYY  Second Period of Disability:  Start Date  MINDDYYYY  MINDDYYYY  Second Period of Disability:  Start Date  MINDDYYYY  MINDDYYYY  Find Date  MINDDYYYY  MINDDYYYY  AMMODYYYY  MINDDYYYY  MINDDYYYY  AND DATE OF THE INJURY OCCURED)  MINDDYYYY  MINDD	ody Part 2:	
The Injury occurred as follows:  EXPLAIN WHAT THE WORKER WAS DOING AT THE TIME OF INJURY AND HOW THE INJURY OCCURED)  APPLICANT WAS TREATING PASTURE ACCESSED BY CLIMBING FENCES.  Actual earnings at the time of injury:  Rate of Pay \$ 971.00	ody Part 3:	
The injury occurred as follows:  EXPLAIN WHAT THE WORKER WAS DOING AT THE TIME OF INJURY AND HOW THE INJURY OCCURED)  APPLICANT WAS TREATING PASTURE ACCESSED BY CLIMBING FENCES.  Actual earnings at the time of injury:  Monthly State of Pay \$ 971.00	ody Part 4:	
Actual earnings at the time of injury:  Rate of Pay \$ 971.00	· · · · · · · · · · · · · · · · · · ·	
Monthly   State value of tips, meals, lodging, or other advantages, regularly received   Weekly   Hourly   Ho	EXPLAIN WHAT THE WORKER WAS DOING AT THE TIME OF INJURY AND	HOW THE INJURY OCCURED) G FENCES.
. The Injury caused disability as follows:  Last day off work due to injury: 07/02/2009 / MM/DD/YYYY  First Period of Disability: Start Date 07/02/2009 / MM/DD/YYYY  Second Period of Disability: Start Date / MM/DD/YYYY  5. Compensation:  Compensation was paid: Yes No  Total paid: UNKNOWN  Weekly rate(s): \$602.59  Date of last payment: UNKNOWN / MM/DD/YYYY  6. Has the worker received any unemployment insurance benefits and/or any unemployment compensation	Rate of Pay \$ 971.00 Monthly State value of tips, meals, lodging advantages, regularly received Weekly	\$ Weekly
Last day off work due to injury: 07/02/2009   MM/DD/YYYY    Sirst Period of Disability: Start Date 07/02/2009   End Date   MM/DD/YYYY    Second Period of Disability: Start Date   End Date   MM/DD/YYYY    MM/DD/YYYY   MM/DD/YYYY    MM/DD/YYYY   MM/DD/YYYY    MM/DD/YYYY	Number of hours worked per week 40	
First Period of Disability:  Start Date 07/02/2009 End Date MM/DD/YYYY  Second Period of Disability:  Start Date End Date MM/DD/YYYY  MM/DD/YYYY  Second Period of Disability:  Start Date MM/DD/YYYY  Second Period of Disability:  Start Date MM/DD/YYYY  Second Period of Disability:  End Date MM/DD/YYYY  MM/DD/YYYY  Second Period of Disability:  Start Date MM/DD/YYYY  Second Period of Date MM/DD/YYYY  Second Period of Disability:  Start Date MM/DD/YYYY  Second Period of Date MM/DD/YYYY  Second Period of Date MM/DD/YYYY  Second Period of Date MM/DD/YYYY  Secon	. The injury caused disability as follows:	
Start Date 07/02/2009 End Date MM/DD/YYY  Second Period of Disability: Start Date MM/DD/YYY  Second Period of Disability: Start Date MM/DD/YYY  Start Date MM/DD/YYY  Start Date End Date MM/DD/YYY  MM/DD/YYYY  M	Last day on work due to injury.	
Second Period of Disability:    MM/DD/YYYY	First Period of Disability: Start Date 07/02/2009	
Compensation was paid:    Yes	econd renod or bisability.	
Total paid: UNKNOWN  Weekly rate(s): \$602.59  Date of last payment: UNKNOWN  MM/DD/YYYY  B. Has the worker received any unemployment insurance benefits and/or any unemployment compensation	i. Compensation:	
Weekly rate(s): \$602.59  Date of last payment: UNKNOWN  MM/DD/YYYY  S. Has the worker received any unemployment insurance benefits and/or any unemployment compensation	Compensation was paid: Yes No	
Date of last payment: UNKNOWN  MM/DD/YYYY  Has the worker received any unemployment insurance benefits and/or any unemployment compensation	Total paid: UNKNOWN	
MM/DD/YYYY  Has the worker received any unemployment insurance benefits and/or any unemployment compensation	Weekly rate(s): \$602.59	
6. Has the worker received any unemployment insurance benefits and/or any unemployment compensation	MM/DD/YYYY	
	6. Has the worker received any unemployment insurance benefits and/or a disability benefits (state disability) since the date of injury? Yes	nny unemployment compensation ✓ No

WCAB1 \_

7. Medical treatment: Medical treatment was received:	✓ Yes  No
All treatment was furnished by the Employer or Insurar	nce Carrier:
Date of last treatment: CONTINUING	
Other treatment was provided/paid by: NONE (NAME	E OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)
Did Medi-Cal pay for any health care related to this	
Names and addresses of doctor(s)/hospital(s)/clini provided or paid for by the employer or insurance	ic(s) that treated or examined for this injury, but that were not carrier:
NONE	
Name of Doctor/Hospital/Clinic 1 (Please leave blank	spaces between numbers, names or words)
NONE	
Name of Doctor/Hospital/Clinic 2 (Please leave blank 8. Other cases have been filed for industrial injuried DOI06/19/08 Case Number 1	
DOI03/26/09 Case Number 2	Case Number 4
J. This application is filed because of a disagreem	hent regarding habinty for.
▼ Temporary disability indemnity	Permanent disability indemnity
Reimbursement for medical expense	Rehabilitation
✓ Medical treatment	Supplemental Job Displacement/Return to Work
✓ Compensation at proper rate	✓ Other (Specify) ALL BENEFITS PER LAB