STATE OF CALIFORNIA
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET

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

More than 15 Companion Cases [ ]

10/01/2009
Date:(MM/DD/YYYY)

SSN: 549-23-5133

[✓] Specific Injury

Case Number 1

[ ] Cumulative Injury 06/19/2008 (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 513

Body Part 3:

Body Part 2:

Body Part 4:

Other Body Parts:

Please check unit to be filed on (check only one box)

[✓] ADJ [ ] DEU [ ] SIF [ ] UEF [ ] VOC [ ] INT [ ] RSU

Companion Cases

[✓] Specific Injury

Case Number 2

[ ] Cumulative Injury 03/26/2009 (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 513

Body Part 3:

Body Part 2:

Body Part 4:

Other Body Parts:

Case Number 3

☑ Specific Injury

☐ Cumulative Injury

07/02/2009
(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 513

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

Case Number 4

☐ Specific Injury

☐ Cumulative Injury

/ /
(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

Case Number 5

☐ Specific Injury

☐ Cumulative Injury

/ /
(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

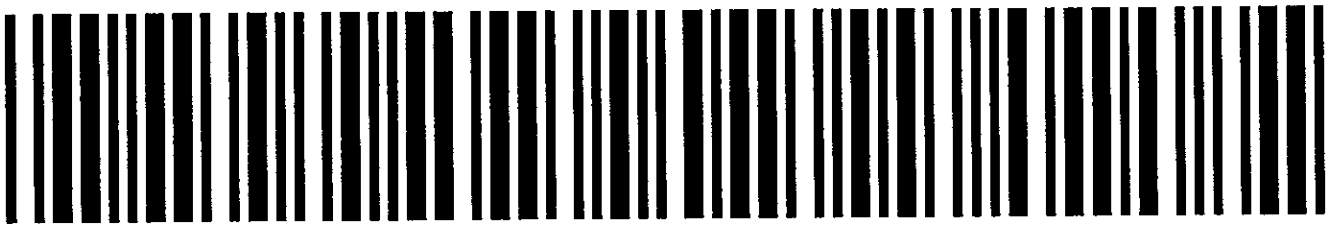
Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

DOCUMENT SEPARATOR SHEET



Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: APPLICATION FOR 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
Case No.

☐ Amended Application

549-23-5133
SSN (Numbers Only)

Venue choice is based upon (Completion of this section is required)

☑ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

☐ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

STK
Select 3 - Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Injured Worker (Completion of this section is required)

TIFFANY
First Name

MI

ANDERSON
Last Name

1516 SYLVAN WAY APT. 205
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

International Address (Please leave blank spaces between numbers, names or words)

LODI
City

CA
State

95242
Zip Code

Applicant (If other than Injured Worker)

☐ Insurance Carrier ☐ Employer ☐ Lien Claimant

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

WCAB1

Employer Information (Completion of this section is required)

☑ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

SAN JOAQUIN COUNTY.- MOSQUITO AND VECTOR CONTROL DISTRIC
Employer Name (Please leave blank spaces between numbers, names or words)

7759 SOUTH AIRPORT WAY
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

STOCKTON | CA | 95206
City | State | Zip Code

Insurance Carrier Information (If known and if applicable - include even if carrier is adjusted by claims administrator)

AIMS
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

P.O. BOX 269120
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

SACRAMENTO | CA | 95826
City | State | Zip Code

Claims Administrator Information (If known and if applicable)

MACKENZIE DAWSON
Name (Please leave blank spaces between numbers, names or words)

P.O. BOX 269120
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

SACRAMENTO | CA | 95826
City | State | Zip Code

IT IS CLAIMED THAT (Complete all relevant information):

1. The injured worker, born 08/22/1970 (DATE OF BIRTH: MM/DD/YYYY), while employed as a(n) TECH I (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

☑ specific injury 07/02/2009 (Date of injury: MM/DD/YYYY)

suffered a :

☐ cumulative injury which began on _____ (Start Date: MM/DD/YYYY) and ended on _____ (End Date: MM/DD/YYYY)

The injury occurred at 16049 S. HENRY RD
Street Address/PO Box - Please leave blank spaces between numbers, names or words

ESCALON, CA 95320.
City | State | Zip Code

WCAB1

(State which parts of the body were injured)

Body Part 1: 513 KNEE

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

2. The injury occurred as follows:

(EXPLAIN WHAT THE WORKER WAS DOING AT THE TIME OF INJURY AND HOW THE INJURY OCCURED)

APPLICANT WAS TREATING PASTURE ACCESSED BY CLIMBING FENCES.

3. Actual earnings at the time of injury:

Rate of Pay $ 971.00 ☐ Monthly ☑ Weekly ☐ Hourly

State value of tips, meals, lodging, or other advantages, regularly received $ _____ ☐ Monthly ☐ Weekly ☐ Hourly

Number of hours worked per week 40

4. 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) End Date _____ (MM/DD/YYYY)

Second Period of Disability: Start Date _____ (MM/DD/YYYY) End 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 disability benefits (state disability) since the date of injury? ☐ Yes ☑ No

7. Medical treatment:
Medical treatment was received: ☑ Yes ☐ No

All treatment was furnished by the Employer or Insurance Carrier: ☑ Yes ☐ No

Date of last treatment: CONTINUING
MM/DD/YYYY

Other treatment was provided/paid by: NONE
(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

Did Medi-Cal pay for any health care related to this claim? ☐ Yes ☑ No

Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or examined for this injury, but that were not provided or paid for by the employer or insurance carrier:

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 spaces between numbers, names or words)

8. Other cases have been filed for industrial injuries by this worker as follows:

DOI06/19/08
Case Number 1

Case Number 3

DOI03/26/09
Case Number 2

Case Number 4

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

- ☑ Temporary disability indemnity
- ☑ Reimbursement for medical expense
- ☑ Medical treatment
- ☑ Compensation at proper rate
- ☑ Permanent disability indemnity
- ☑ Rehabilitation
- ☐ Supplemental Job Displacement/Return to Work
- ☑ Other (Specify) ALL BENEFITS PER LAB