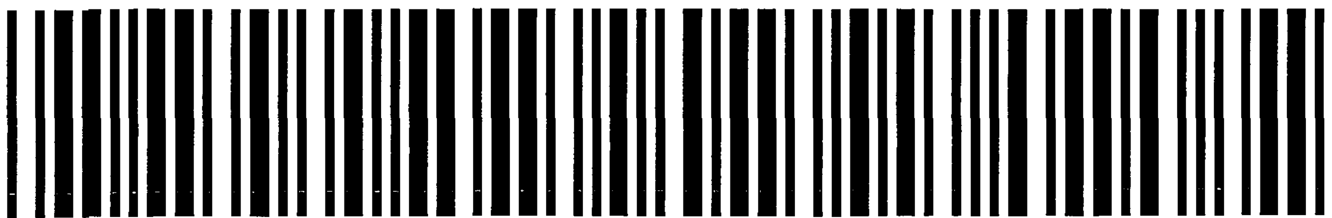
DOCUMENT SEPARATOR SHEET



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.

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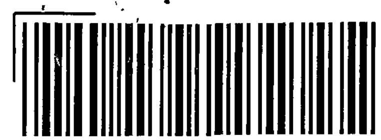
MM/DD/YYYY



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 CA 95242
City State Zip Code

RECEIVED
2009 OCT -6 PM 2:50
DEPT OF INDUSTRIAL RELATIONS
DWC/WCAB

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

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 1 (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

suffered a :

☑ specific injury 06/19/2008 (Date of injury MM/DD/YYYY)

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

The injury occurred at 17963 ENTERPRISE RD
Street Address/PO Box - Please leave blank spaces between numbers, names or words

ESCALON	CA	95320
City	State	Zip Code

(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 LARVICIDING PASTURE WITH THE USE OF PELLET TRUCK.

3. Actual earnings at the time of injury:

Rate of Pay $ 918.00 ☐ 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: 06/19/2008 (MM/DD/YYYY)

First Period of Disability: Start Date 06/19/2008 (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: CONTINUINC
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:

DOI03/26/09
Case Number 1

Case Number 3

DOI07/02/09
Case Number 2

Case Number 4

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

Is the Applicant Represented? [✓] Yes [ ] No **If "No", applicant is to sign and date below.**

If "Yes", applicant's representative is to complete the following and is to sign and date below.

[✓] Law Firm/Attorney [ ] Non-Attorney Representative

LAW OFFICE OF RONALD M. STEIN INC.
Law Firm or Company Name (If Applicable)

4813094
Law Firm Number (If Applicable)

RONALD — M
Attorney/Representative First Name — MI

STEIN
Attorney/Representative Last Name

4521 QUAIL LAKES DR
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

STOCKTON — CA — 95207
City — State — Zip Code

Applicant Attorney/Representative Signature — Applicant Signature

Dated at STOCKTON, California
City

Date 09/29/2009
MM/DD/YYYY

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)

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

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

Any person who makes or causes to be made any knowingly false, or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of felony.

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

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 benficios de compensación al trabjador.

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 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 "felonía".

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

1. Name *Nombre* Tiffany Kay Anderson — Today's Date *Fecha de Hoy* 9/29/09
2. Home Address. *Dirección Residencial* 1516 Sylvan Way, Apt. 205
3. City *Ciudad* Lodi — State. *Estado* CA — Zip *Código Postal* 95242
4. Date of Injury *Fecha de la lesión (accidente)* 06/19/2008

   Time of injury. *Hora en que ocurrió* ________ a m ________ *p m*
5. Address and description of where injury happened . *Dirección/lugar dónde occurió el accidente*

   17963 Enterprise Road, Escalon, CA
6. Describe injury and part of body affected. *Describa la lesión y la parte del cuerpo afectada* right knee

   Applicant was larviciding pasture with the use of pellet truck.
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 notación abajo.***

9. Name of employer *Nombre del empleador* ________
10. Address *Dirección* ________
11. Date employer first knew of injury *Fecha en que el empleador supo por primera vez de la lesión o accidente* ________
12. Date claim form was provided to employee *Fecha en que se le entregó al empleado la petición* ________
13. Date employer received claim form *Fecha en que el empleado devolvió la petición al empleador* ________
14. Name and address of insurance carrier or adjusting agency *Nombre y dirección de la compañia de seguros o agencia administradora de seguros*

    ____
15. Insurance Policy Number. *El número de la póliza del Seguro* ________
16. Signature of employer representative *Firma del representante del empleador* ________
17. Title. *Título* ________ 18. Telephone. *Teléfono* ________

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 completed form from employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: Se requiere que Ud. feche ésta forma y que provéa copias a su compañia de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presntado 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/Recibodel Empleado

State of California
Department of Industrial Relations
Division of Workers' Compensation

FEE DISCLOSURE STATEMENT

If you choose to be represented by an attorney, your attorney's fees will be deducted from benefits. The fee will be approved by the Workers Compensation Appeals Board, with consideration given to the: (1) responsibility assumed by the attorney; (2) care exercised in representing you; (3) time involved; and, (4) results obtained.

Attorney's fees normally range from 12% - 15% of the benefits awarded. If your attorney has also represented you before the Rehabilitation Unit, there may also be a fee allowed for this representation.

There are certain circumstances where your employer (or his/her insurer) may be liable to pay your attorney's fees. For example, if employer disputes a permanent disability evaluation obtained when you were not represented by an attorney, your employer may, be liable for any attorney fees you incur because of the dispute.

If at any time you no longer wish to be represented by the attorney, you may withdraw from representation by notifying the attorney. If you withdraw from representation, the fee amount found by a workers' compensation judge to be the fair value of any work the attorney did in your case will be deducted from your award.

An Information and Assistance Officer may be able to answer your questions concerning your workers' compensation benefits at no charge to you. He/She may be able to resolve your problems without the need for litigation.

Call this toll-free number: 1-800-736-7401.

Employee's Signature [signature] Date 09/29/2009

Employee's Name Tiffany Kay Anderson

Attorney's Signature [signature] Date 09/29/2009

Attorney's Name Ronald M. Stein

Address 4521 Quail Lakes Drive
Stockton, CA 95207-5257

Phone No. 209-957-9744

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 felony.

Law Offices of
RONALD M. STEIN, SBN 62897
4521 QUAIL LAKES DRIVE
STOCKTON, CA 95207-5257
Telephone: 209-957-9744
Facsimile: 209-957-3005

Attorney For Applicant

WORKERS' COMPENSATION APPEALS BOARD

OF THE STATE OF CALIFORNIA

TIFFANY KAY ANDERSON

Applicant

vs.

SAN JOAQUIN COUNTY
MOSQUITO AND VECTOR
CONTROL DISTRICT

Defendants

WCAB Case No.

DECLARATION UNDER
LABOR CODE
SECTION 4906 (g)

COMES NOW, ATTORNEY and APPLICANT herein, and each states under penalty of perjury and in compliance with Labor Code Section 139.3, that there has been no offer, delivery receipt or acceptance of any rebate, commission, preference, patronage, dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referral, examination or evaluation.

Executed on this ___29TH__ day of __SEPTEMBER___, 2009 at Stockton, CA

Applicant

Ronald M. Stein,
Applicants' Attorney

RONALD M STEIN
ATTORNEY

CHRISTOPHER P WEE
ATTORNEY

Ronald M. Stein, Inc.

PROFESSIONAL LAW CORPORATION

4521 QUAIL LAKES DRIVE • STOCKTON, CA
95207-5257
(209) 957-9744 • FAX (209) 957-3005
rsteinlw@aol.com

CARMEN BLASK
PARALEGAL

September 30, 2009

State of California
Department of Industrial Relations
Workers' Compensation Appeals Board
31 East Channel Street, Room 344
Stockton, CA 95202-2314

Re:	Tiffany Anderson vs San Joaquin County.- Mosquito and Vector Control District		
DOI:	06/19/2008	03/26/2009	07/02/2009
EAMS No:	ADJ		
WCAB No:	Unassigned	Unassigned	Unassigned
Claim No:	VE0700184		

Dear Board:

Enclosed please find the following for filing:

1. Application for Adjudication of Claim and supporting documents
2. DWC-1
3. DWC Form 3 - Fee Disclosure Statement
4. Declaration LC 4906(g)
5. Proof of Service to all parties

By copy of this letter, the Defendant employer and its insurance carrier are requested to provide this office with any and all medical reports, related documentation (including videos) concerning this client. Thank you for your time and attention hereto.

Very truly yours,

RONALD M. STEIN, INC.
Professional Law Corporation

Ronald M. Stein
RMS/elc

Enclosure

cc: See Attached Proof of Service

PROOF OF SERVICE - CCP 1013a(3)

I am employed in the County of San Joaquin, State of California. I am over the age of 18 and not a party to the within action; my business address is 4521 Quail Lakes Drive, Stockton, CA 95207 (209) 957-9744.

On October 1, 2009, I served the attached:

APPLICATION FOR ADJUDICATION OF CLAIM AND SUPPORTING DOCUMENTS

WCAB Case: Unassigned, Unassigned, Unassigned

by placing a copy of the original thereof enclosed in a sealed envelope addressed as follows:

State of California
Division of Workers' Compensation
Workers' Compensation Appeals Board
31 East Channel Street, #344
Stockton, CA 95202-2314

Hand Delivered

Tiffany Kay Anderson
1516 Sylvan Way, Apt. 205
Lodi, CA 95242

San Joaquin County.- Mosquito and Vector Control District
7759 South Airport Way
Stockton, CA 95206

Mackenzie Dawson
AIMS
P.O. Box 269120
Sacramento, CA 95826

BY MAIL

I caused such envelope to be deposited in the mail with postage thereon fully prepaid. I am readily familiar with this firm's practice of collection and processing correspondence for mailing. It is deposited with U.S. postage service on that same day in the ordinary course of business.
I am aware that on motion of party served, service is presumed invalid if postal cancellation date or postage meter date is more than one (1) day after date of deposit for mailing affidavit.
I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Executed on October 1, 2009 at Stockton, California.

Erica Cayabyab