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: No. and Street: WORK PLACE — 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