



**STOCKWELL
HARRIS
WOOLVERTON
MUEHL**

A Professional Corporation

1545 River Park Drive, Suite 330
Sacramento, California 95815-4616
(916) 924-1862
(916) 924-3541 FAX
www.shww.com

STEVEN I. HARRIS GEORGE WOOLVERTON JEFFREY T. LANDRES MICHAEL L. TERRY EDWARD S. MUEHL TED L. HIRSCHBERGER LINDA S. FREEMAN IAN D. PAIGE VANESSA I. HENDERSON * JAN P. FUCHS * ERIC G. HELPHREY RENEE D. LOGOLUSO BARRANCE Q. ZAKAR * DANIEL J. YSABAL *	LISA R. KERNER SCOTT T. JELENSKY GAIL D. RACKLIFFE JOSEPH E. ZUCKERMAN KIMBERLY A. HANSEN ANNE C. BOBCHICK JOHN T. BILLINGSLEA ANTHONY CANNIZZO PAULA N. HARRIS †† LISA A. HANHART	JAMES C. SHIPLEY AURORA VASQUEZ LISA A. VIDMAR GEORGE E. MURPHY CAMELIA GAMBICA AARON M. PROSIN SAMUEL L. TOLWIN JAMES R. LAVIN HILARY A. McLAUGHLIN GEORGE FOGY BRIAN D. PEDERSON NEDA S. SWEDELSON †††† JOHN W. HICKS THOMAS P. MOOS L. STEVEN HATTENDORF FREDERIC J. PHANELF CHRISTIAN M. SANTOS SHEA L. CONWAY DALE E. YOUNG * JONATHAN M. FREEMAN MARK H. WILLENS ††† SHERRIE L. McCracken PETER S. KIM DEREK A. KUHNEN	PAUL S. WOLSEY SU TRAN JANET ORMOND ANDRIZZI EDITTE ALSEN JENNIFER L. BOECK †††† DEBRA ODOM KUTTNAUER STEPHEN L. TURK SUSAN G. GEIER JENNIFER A. HABER SHARON E. DIDION ALEXANDER G. ABDOLIN STEVEN A. SCHWARTZ MICHAEL V. VARON TODD E. WHATES TODD M. MOBLEY WHITNEY DAVIS-HOUSTON KEVIN M.T. WHITE ANGELA M. SEKI †††† MATTHEW B. WOOLVERTON MARYAM MIRMIRAN JESSE EVAN KOZMA RICHARD K. GREEN †††††† ROBYN I. KATCHEM KELLY A. SIECKMAN	BRENDAN A. O'MELIA CARLA F. T. MULLER MONIQUE PRIDE BROOKS * † HEIDI P. PIERCE †††††† EMMANUEL K. NSAHLAI * PENNY PAXTON * †††††††† SARAH J. JAFFE DAVID J. CARASH DARLENE EVANS ANNETTE KAZANDJIAN ALISSA TOBIN ZEA JEANNIE M. LAGORIO KATHLEEN PRUITT KIMBERLEY S. GASKILL EDWARD J. LECLERE CHRISTOPHER D. WARREN KYLE ROBERT HANSEN ALEXANDER W. HANSEN DENISE J. YANAGISAWA SARAH L. LOPEZ ANDREW J. LYNCH ROBERT A. MOORE TRAVIS M. BAILEY
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* CERTIFIED SPECIALIST WORKERS' COMPENSATION LAW THE
STATE BAR OF CALIFORNIA BOARD OF LEGAL SPECIALIZATION
† ALSO LICENSED IN THE STATE OF ILLINOIS
†† ALSO LICENSED IN THE STATE OF NEW YORK
††† ALSO LICENSED IN WASHINGTON D.C. AND THE STATE OF GEORGIA
†††† ALSO LICENSED IN THE STATE OF NEVADA
††††† ALSO LICENSED IN THE STATE OF TEXAS
†††††† ALSO LICENSED IN THE DISTRICT OF COLUMBIA AND STATE OF WASHINGTON
††††††† ALSO LICENSED IN THE STATE OF VIRGINIA
†††††††† ALSO LICENSED IN THE STATE OF PENNSYLVANIA

LIEN SPECIALISTS
DAVID M. BAUTISTA
TERA OLDFIELD
RINA DEL ROSARIO
SEAN TALIAFERRO

Sent via Facsimile & U.S. Mail – (209) 951-3005

October 26, 2010

Mr. Ronald M. Stein
Ronald M. Stein Law Offices
4521 Quail Lakes Drive
Stockton, CA 95207

**RE: ANDERSON, TIFFANY VS. SAN JOAQUIN COUNTY MOSQUITO
& VECTOR CONTROL**

WCAB NO.: 1) ADJ7004221; 2) ADJ7004227; 3) ADJ7010682
CLAIM NO.: VE0700184
OUR FILE NO.: 300141-040

Dear Mr. Stein:

Regarding the proposal for Stipulations, I am obtaining final authority from my client. I anticipate obtaining it within 30 days. Please be patient and I will forward you over the settlement documents.

As a head's up, consistent with the Panel QME report and temporary disability notice of August 5, 2010 which was courtesy copied to your office, there is a temporary disability overpayment of \$4,571.42 for the period June 8, 2010 through July 30, 2010. Again, this is based on Panel QME Dr. Tabaddor finding the applicant permanent and stationary on June 8, 2010.

LOS ANGELES OFFICE
3580 Wilshire Boulevard, 19TH Floor
Los Angeles, California 90010
(323) 935-6669

ORANGE COUNTY OFFICE
701 South Parker Street, Suite 2200
Orange, California 92668-4736
(714) 479-1180

SAN DIEGO OFFICE
750 "B" Street, Suite 1220
San Diego, California 92101
(619) 696-1436

SAN FRANCISCO OFFICE
222 Kearny Street, 9TH Floor
San Francisco, California 94108
(415) 734-9310

SAN BERNARDINO OFFICE
735 East Carnegie Drive, Suite 270
San Bernardino, California 92408
(909) 381-5553

SAN LUIS OBISPO OFFICE
1150 Osos Street, Suite 202
San Luis Obispo, California 93401-3692
(805) 541-0440

VENTURA OFFICE
2021 Sperry Avenue, Suite 46
Ventura, California 93003-7417
(805) 654-8994

FRESNO OFFICE
1550 East Shaw Avenue, Suite 103
Fresno, California 93710
(559) 226-9030

ANDERSON, TIFFANY VS. SAN JOAQUIN COUNTY MOSQUITO & VECTOR CONTROL

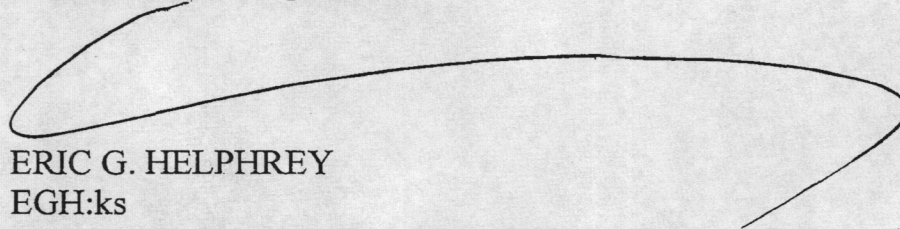
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October 26, 2010

Thank you for your attention to this matter.

Very truly yours,

STOCKWELL, HARRIS, WOOLVERTON & MUEHL
A Professional Corporation



ERIC G. HELPHREY

EGH:ks

cc: Ms. Mackenzie Dawson, AIMS Insurance (Sacramento)
Mr. John Stroh, San Joaquin County Mosquito & Vector Control District

DWC-AD 10003 NOTICE OF OFFER OF REGULAR WORK

For injuries occurring on or after 1/1/05

THIS SECTION TO BE COMPLETED BY EMPLOYER OR CLAIMS ADMINISTRATOR:

Claims Administrator: Acclamation Insurance Management Services, Inc. Claim Number: VE0700184

Based on the medical report of your treating physician Dr. Murata, dated 09/22/2010 you are able to return to your usual occupation or the position you held at the time of your injury on 06/19/2008.

Date you are eligible to return to job: 09/22/2010 (as stated in the above physician's report)

Employer: Employer: San Joaquin County Mosquito & Vector Control District

Job Title: Mosquito Control Technician

Starting Date: 09/22/2010

- This position is at the same location and shift as your pre-injury position.
 This position is at a different location than your pre-injury position, as follows:

- This position is for a different shift than your pre-injury position, as follows:

You may contact John Stroh concerning this position. Phone No.: (209)982-4675

You must return the completed form to the employer or claims administrator listed here:

Employer: San Joaquin County Mosquito & Vector Control Distirct or Acclamation Insurance Management Services, Inc.

This position is expected to last for a total of at least 12 months of work. If this position does not last for a total of at least 12 months of work, you may be entitled to an increase in your permanent disability benefit payments. This position provides wages and compensation of \$1,836.68 bi-weekly, that are equivalent to or more than the wages and compensation paid to you at the time of your injury.

I, Mackenzie Dawson, have obtained the above job offer information from your employer.

If the job offered is at a different location than the job you held at the time of your injury, and you believe the commuting distance to this job from the residence where you lived at the of your injury is not reasonable, you may object to the job offer as not being within a reasonable distance. You may also waive this commuting distance requirement. You will be considered to have waived this requirement if you accept the above offer of work or do not reject the offer within twenty calendar days of receipt of this notice.

Claim Number: VE0700184

THIS SECTION TO BE COMPLETED BY EMPLOYEE:

The employee must accept, reject or object to this offer for regular work and return this form to the employer or claims administrator listed on page one within 20 calendar days of receipt of the offer or it will be deemed that the employee has waived the right to object to the location or shift. The employee should keep a copy of this form for his or her records.

Name of employee: _____

Date offer received: _____

I understand that if my disability is permanent and stationary and the employer has fulfilled its legal obligations related to this offer, my remaining permanent disability payments will be decreased by 15% whether I accept or reject this offer.

Offer of Regular Work at Same Location and/or Shift

I accept this offer of regular work.

I reject this offer of work.

Reason: _____

Note: If either party has a dispute or objection regarding the offer of regular work, or if the employee rejects the offer of regular work, that party may file a Declaration of Readiness with the local district office of the Workers' Compensation Appeals Board (WCAB).

Offer of Regular Work at a Different Location and/or Shift

I understand that I have the right to object to a work offer when the location or shift is different than what I had at the time of my injury.

I accept the offer and waive my right to object to the job location or shift as not being within a reasonable commuting distance from the residence where I lived at the time of my injury.

I reject this offer of work.

Reason: _____

I object to this offer because the job location that has been offered is different than the job location I held at the time of my injury, and I do not believe this job allows a reasonable commute from my residence. I understand if the claims administrator does not agree with this objection, my remaining permanent disability weekly benefit payment may be decreased by 15%.

I object to this offer because the job shift that has been offered is different than the job shift I held at the time of my injury. I understand if the claims administrator does not agree with this objection, my remaining permanent disability weekly benefit payment may be decreased by 15%.

Note: If either party has a dispute or objection regarding the offer of regular work, or if the employee rejects the offer of regular work, that party may file a Declaration of Readiness with the local district office of the Workers' Compensation Appeals Board (WCAB).

Signature: _____

Date: _____

Proof of Service By Mail or Hand Deilvery

I am a resident of the County of Sacramento. I am over the age of eighteen years and not a party to the within matter. My business address is:

P.O. Box 269120, Sacramento, CA 95826

On 11/08/2010, I served the **Notice of Offer of Regular Work** on the party/parties listed below by either method of service described below:

A. Placing a true copy of the **Notice of Offer of Regular Work** in a sealed envelope with postage fully prepaid addressed to each person whose name and address is given below by depositing the envelope in the United States mail.

Or

B. Personally serving a true copy of **Notice of Offer of Regular Work** on each person whose name and address is given below.

Enter the name of the party and indicate the type of service in the box (either A or B as described above.)

Name Type of Service

Tiffany Anderson A
2 N. Avena Ave.
Lodi, CA 95242

✓ Ronald M. Stein, Inc. A
4521 Quail Lakes Drive
Stockton, CA 95207-5257

Stockwell, Harris, Woolverton & Muehl A
Attn: Eric Helphrey
1545 River Park Drive, # 330
Sacramento, CA 95815

San Joaquin County Mosquito & Vector Control Dist. A
Attn: John Stroh
7759 South Airport Way
Stockton, CA 95206

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
Executed at Sacramento on November 8, 2008.

Signature: Melvin G. Jemp