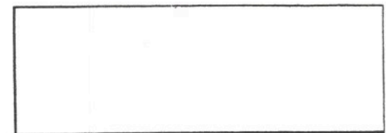
State of California
..ision of Workers' Compensatic.
Disability Evaluation Unit



DEU Use Only

EMPLOYEE'S DISABILITY QUESTIONNAIRE

This form will aid the doctor in determining your permanent impairment or disability. Please complete this form and give it to the physician who will be performing the evaluation. The doctor will include this form with his or her report and submit it to the Disability Evaluation Unit, with a copy to you and your claims administrator.

Employee

Tiffany
First Name

MI

Anderson
Last Name

549-23-5133
SSN (Numbers Only)

2 N Avena Ave
Street Address1/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** **95240**
City State Zip Code

Date of Birth **8/22/1970**
MM/DD/YYYY

Date of Injury **6/29/2011**
MM/DD/YYYY

San Joaquin County Mosquito
Employer

Nature of Employers Business

Claim Number 1 **VE0700184**

Employer Information (Completion of this section is required)

- [ ] Insured
- [x] Self-Insured
- [ ] Legally Uninsured
- [ ] Uninsured

Joaquin County Mosquito & Vector Control District
Employer Name (Please leave blank spaces between numbers, names or words)

7759 S Airport Way
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

Stockton
City

CA
State

Zip Code

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

Acclamation Insurance Management Services
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
City

CA
State

95826
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
City

CA
State

95826
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) Pesticide Applicator (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

suffered a :

- [x] specific injury 06/29/2011 (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 30138 E HWY 120 , Van Vleit Dairy
Street Address/PO Box - Please leave blank spaces between numbers, names or words

Escalon
City
, CA
State
95320
Zip Code .

(State which parts of the body were injured)

Body Part 1: 513 KNEE

Body Part 2: 518 LEG

Body Part 3: 880 BODY SMS

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)

The injured worker was walking the perimeter of the dairy pond with her hand can spraying oil to kill mosquito larva. The water level to the pond was low and the weeds surounding the pond were higher than knee level. While walking through the weeded pond the injured worker walked into a metal T-bar hidden in the grass. The

3. Actual earnings at the time of injury:

Rate of Pay $ 1020.55 ◯ Monthly ☑ Weekly ◯ Hourly

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

Number of hours worked per week 45

4. The injury caused disability as follows:

Last day off work due to injury: 08/18/2011 (MM/DD/YYYY)

First Period of Disability: Start Date 07/19/2011 (MM/DD/YYYY) End Date 7/26/2011 (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: 0

Weekly rate(s): 0

Date of last payment: ______ (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: 08/29/2011
MM/DD/YYYY

Other treatment was provided/paid by: Kaiser Permanente Stockton Facility
(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:

Kaiser Permanente Stockton Facility

Name of Doctor/Hospital/Clinic 1 (Please leave blank spaces between numbers, names or words)

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:

Case Number 1

Case Number 3

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) ______

Claim Number 2 ____

Claim Number 3 ____

Claim Number 4 ____

Claim Number 5 ____

PLEASE ANSWER THE FOLLOWING QUESTIONS FULLY:
How was your evaluating doctor selected? (check one)

- [ ] From a list of doctors provided by the Sate of California, Division of Workers' Compensation
- [x] Other (explain) The Insurance Adjuster

What is the name of the doctore who will be doing the evaluation? **Khosrow Tabaddor, M.D.**

When is your examination scheduled? **11/1/2011**

What were your job duties at the time of your injury?

pesticide applicator in escalon

What is the disability resulting from your injury?

right knee swelling and pain to my upper thigh and a undiagnosed exposure to a chemical

How does this injury affect you in your work?

I have been unable to preform my usual tasks

Have you ever had a disability as a result of another injury or illness? yes

If so, when? 2008, 2009

Please describe the disibility.

right knee orthoscopy

Date 11-1-11 (MM/DD/YYYY)   Signature [signature]