Ronald M. Stein, Inc.

PROFESSIONAL LAW CORPORATION
4521 QUAIL LAKES DRIVE • STOCKTON, CA 95207-5257
(209) 957-9744 • FAX (209) 957-3005

November 17, 2006

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

Re: Donald R. Meidinger vs San Joaquin County.--Mosquito and Vector Control District
DOI: 10/13/06
WCAB No:
Claim No: VE0700038

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.

Respectfully submitted,

RONALD M. STEIN, INC.
Professional Law Corporation

Ronald M. Stein
RMS/
Encl.
cc:

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 your benefits. This 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% to 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.

Ronald M. Stein may not split attorney fees and give a referral to an attorney out of the attorney fees awarded in this case.

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 _____ ***Date*** 11/14/06

Employee's Name (Print) Donald R. Meidinger

Attorney's Signature _____ ***Date*** 11/14/06

Law Office of Ronald M. Stein
a Professional Corporation
4521 Quail Lakes Drive
Stockton, CA 95207
(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 a felony.

Law Offices of
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4521 Quail Lakes Drive
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Telephone: 209-957-9744
Facsimile: 209-957-3005

Attorney for Applicant

WORKERS' COMPENSATION APPEALS BOARD

OF THE STATE OF CALIFORNIA

DONALD R. MEIDINGER Applicant, vs. SAN JOAQUIN COUNTY MOSQUITO &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 14th day of NOVEMBER, 2006 at Stockton, California

Applicant

Ronald M. Stein
Applicant Attorney

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 November 17, 2006, I served the attached:

APPLICATION FOR ADJUDICATION OF CLAIM & SUPPORTING DOCUMENTS

WCAB Case:

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

Mr. Donald R. Meidinger

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

Ms. Angela Phillips
AIMS
P.O. Box 28100
Fresno, CA 93729

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 November 17, 2006 at Stockton, California.

Deborah Harris

Deborah Harris

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS

ORIGINAL

WORKERS' COMPENSATION APPEALS BOARD

SEE REVERSE SIDE FOR INSTRUCTIONS

APPLICATION FOR ADJUDICATION OF CLAIM
(PRINT OR TYPE NAMES AND ADDRESSES)

CASE No. STK207071

M r. Donald R. Meidinger

Social Security No.:

(APPLICANT, IF OTHER THAN INJURED EMPLOYEE)

VS.

San Joaquin County.--Mosquito and Vector Control District

(EMPLOYER - STATE IF SELF-INSURED)

AIMS

(EMPLOYER'S INSURANCE CARRIER OR, IF SELF-INSURED, ADJUSTING AGENCY)

(INJURED EMPLOYEE'S ADDRESS AND ZIP CODE)

(APPLICANT'S ADDRESS AND ZIP CODE)

7759 S. Airport Wy.
Stockton, CA 95206

(EMPLOYER'S ADDRESS AND ZIP CODE)

P.O. Box 28100
Fresno, CA 93729

(INSURANCE CARRIER OR ADJUSTING AGENCY'S ADDRESS)

IT IS CLAIMED THAT:

1. The injured employee, born _____ (DATE OF BIRTH), while employed as a Tech II Assistant Supervisor (OCCUPATION AT TIME OF INJURY) on 10/13/06 (DATE OF INJURY) at _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP CODE)
   By the employer sustained injury arising out of and in the course of employment to
   Heart attack and stress
   (STATE WHAT PARTS OF BODY WERE INJURED)
2. The injury ocurred as follows: Verbally threatened by another supervisor.
   (EXPLAIN WHAT EMPLOYEE WAS DOING AT TIME OF INJURY AND HOW INJURY WAS RECEIVED)
3. Actual earnings at time of injury were: Approx. $4400.00 per mo.
   (GIVE WEEKLY OR MONTHLY SALARY OF HOURLY RATE AND NUMBER OF HOURS WORKED PER WEEK)
   (SEPARATELY STATE VALUE PER WEEK OR MONTH OF TIPS, MEALS, LODGING OR OTHER ADVANTAGES REGULARLY RECEIVED)
4. The injury caused disability as follows: 10/13/06 and continuing
   (SPECIFY LAST DAY OFF WORK DUE TO THIS INJURY AND BEGINNING AND ENDING DATES OF ALL PERIODS OFF DUE TO THIS INJURY)
5. Compensation was paid ____ (YES) N (NO) $ none (TOTAL PAID) $ none (WEEKLY RATE) none (DATE OF LAST PAYMENT)
6. Unemployment insurance or unemployment compensation disability benefits have been received since the date of injury
   ____ (YES) N (NO)
7. Medical treatment was received Y (YES) ____ (NO) continuing (DATE OF LAST TREATMENT) All treatment was furnished by the Employer or Insurance Company Y (YES) ____ (NO) Other treatment was provided or paid for 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) N (NO) doctors not provided or paid for by employer or insurance company who treated or examined for this injury are none
   (STATE NAMES AND ADDRESSES OF SUCH DOCTORS AND NAMES OF HOSPITALS TO WHICH SUCH DOCTORS ADMITTED INJURIES)
8. Other cases have been filed for industrial injuries by this employee as follows:
   none
   (SPECIFY CASE NUMBER AND CITY WHERE FILED)
9. This application is filed because of a disagreement regarding liability for: Temporary disability indemnity X
   Permanent disability indemnity X Reimbursement for medical expense X Medical Treatment X
   Compensation at proper rate X Rehabilitation X Other (Specify) _____
   all benefits per Labor Code
   THE SAME, AND FOR ALL OTHER APPROPRIATE BENEFITS PROVIDED BY LAW. AND APPLICANT REQUESTS A HEARING AND AWARD OF

Dated at Stockton (CITY) California, 11/14/2006 (DATE)

(APPLICANT'S ATTORNEY)

Ronald M. Stein
Law Offices of Ronald M. Stein
4521 Quail Lakes Drive
Stockton, CA 95207-5257, 209-957-9744
(ADDRESS AND TELEPHONE NUMBER OF ATTORNEY)

(APPLICANT'S SIGNATURE)

Donald R. Meidinger

DIA WCAB FORM 1 (REV. 7/81)
A1-Law

84 32595

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.* Donald R. Meidinger — Today's Date. *Fecha de Hoy.* 11/14/06
2. Home Address. *Dirección Residencial.*
3. City. *Ciudad.* — State. *Estado.* — Zip. *Código Postal.*
4. Date of Injury. *Fecha de la lesión (accidente).* 10/13/06
   Time of injury. *Hora en que ocurrió* ____ a.m ____ *p.m.*
5. Address and description of where injury happened . *Dirección/lugar dónde occurió e/ accidente.*
   Lodi, CA
6. Describe injury and part of body affected. *Describa la lesión y la parte del cuerpo afectada.* Heart attack and stress
   Verbally threatened by another supervisor.
7. Social Security Number. *Número de Seguro Social del Empleado*
8. Signature of employee. *Firma del empleado.*

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 /e 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 compañía 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 esta 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

7/1/04 Rev.