

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:

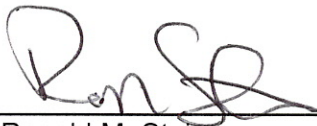
Enclosed please find the following for filing:

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:

RECEIVED
STOCKTON, CA
2006 NOV 27 PM 1:34
DEPT OF INDUSTRY RELATIONS
DWC/WCAB

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

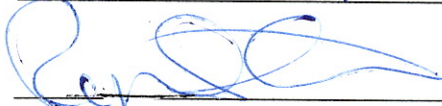


Date 11/14/06

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.

1 Law Offices of
RONALD M. STEIN, SBN 62897
2 4521 Quail Lakes Drive
Stockton, CA 95207-5257
3 Telephone: 209-957-9744
4 Facsimile: 209-957-3005

5 Attorney for Applicant
6
7

8 WORKERS' COMPENSATION APPEALS BOARD
9 OF THE STATE OF CALIFORNIA
10

11 DONALD R. MEIDINGER

12 Applicant,

13 vs.


14 SAN JOAQUIN COUNTY
MOSQUITO & VECTOR CONTROL DISTRICT
15 Defendants

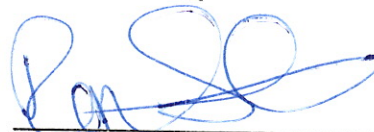
WCAB Case No.

DECLARATION UNDER LABOR CODE
SECTION 4906(g)

16
17 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,
18 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
19 referral, examination or evaluation.

20 Executed on this 1st day of NOVEMBER, 2006 at Stockton, California

21 
22 Applicant

23 
24
25 Ronald M. Stein
26 Applicant Attorney
27
28

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. Meidinaer

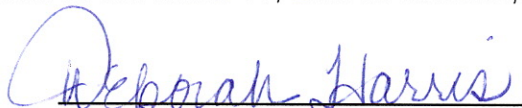
San Joaquin County.--Mosquito and Vector Control
District
7759 S. Airport Wy.
Stockton, CA 95206

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

ORIGINAL

WORKERS' COMPENSATION APPEALS BOARD

SEE REVERSE SIDE
FOR INSTRUCTIONS

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

CASE No. STK 207071

M r. Donald R. Meidinger

(INJURED EMPLOYEE'S ADDRESS AND ZIP CODE)

Social Security No.: _____

(APPLICANT, IF OTHER THAN INJURED EMPLOYEE)
VS.

(APPLICANT'S ADDRESS AND ZIP CODE)

San Joaquin County.--Mosquito and Vector Control District

7759 S. Airport Wy.
Stockton, CA 95206

(EMPLOYER - STATE IF SELF-INSURED)

(EMPLOYER'S ADDRESS AND ZIP CODE)

AIMS

P.O. Box 28100
Fresno, CA 93729

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

(INSURANCE CARRIER OR ADJUSTING AGENCY'S ADDRESS)

IT IS CLAIMED THAT:

1. The injured employee, born _____, while employed as a Tech II Assistant Supervisor
(DATE OF BIRTH) (OCCUPATION AT TIME OF INJURY)
on 10/13/06 at _____
(DATE OF INJURY) (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 occurred 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 N \$ none \$ none none
(YES) (NO) (TOTAL PAID) (WEEKLY RATE) (DATE OF LAST PAYMENT)

6. Unemployment insurance or unemployment compensation disability benefits have been received since the date of injury
N
(YES) (NO)

7. Medical treatment was received Y continuing All treatment was furnished by
(YES) (NO) (DATE OF LAST TREATMENT)
the Employer or Insurance Company Y Other treatment was provided or paid for by _____
(YES) (NO)

none Did Medi-Cal pay for any health care

related to this claim N doctors not provided or paid for by employer or insurance company who treated or examined
(YES) (NO)

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 AND APPLICANT REQUESTS A HEARING AND AWARD OF

THE SAME, AND FOR ALL OTHER APPROPRIATE BENEFITS PROVIDED BY LAW.

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





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)

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

**PETICION DEL EMPLEADO PARA DE COMPENSACIÓN DEL
TRABAJADOR (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.

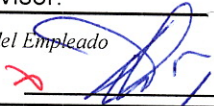
Empleado: Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al (800) 736-7401 para oír información grabada. En la hoja cubierta de esta forma esta la explicación de los beneficios de compensación al trabajador.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

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.

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 ocurrió el accidente.*
Lodi, CA
6. Describe injury and part of body affected. *Describe 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 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 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.

Empleador: Se requiere que Ud. feche esta forma y que provéa copias a su compañía 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.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

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