

ORIGINAL

WORKERS' COMPENSATION APPEALS BOARD

SEE REVERSE SIDE  
FOR INSTRUCTIONS

CASE No. STK 257071

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

M r. Donald R. Meidinger

(INJURED EMPLOYEE'S ADDRESS AND ZIP CODE)

Social Security No. \_\_\_\_\_

(APPLICANT'S ADDRESS AND ZIP CODE)

(APPLICANT, IF OTHER THAN INJURED EMPLOYEE)  
VS.

San Joaquin County.--Mosquito and Vector Control District

7759 S. Airport Wy.  
Stockton, CA 95206

(EMPLOYER'S ADDRESS AND ZIP CODE)

(EMPLOYER - STATE IF SELF-INSURED)

AIMS

P.O. Box 28100  
Fresno, CA 93729

(INSURANCE CARRIER OR ADJUSTING AGENCY'S ADDRESS)

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

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 (NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)  
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) \_\_\_\_\_  
AND APPLICANT REQUESTS A HEARING AND AWARD OF

all benefits per Labor Code  
THE SAME, AND FOR ALL OTHER APPROPRIATE BENEFITS PROVIDED BY LAW.

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

Ronald M. Stein  
(APPLICANT'S ATTORNEY)

Donald R. Meidinger  
(APPLICANT'S SIGNATURE)

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)

DEPT. OF INDUSTRIAL RELATIONS  
STOCKTON  
NOV 14 2 27 PM '06  
WORKERS' COMPENSATION



**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 gravada. 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.* \_\_\_\_\_

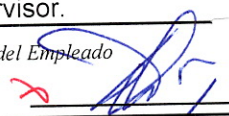
3. City. *Ciudad.* \_\_\_\_\_    State. *Estado.* \_\_\_\_\_    Zip. *Código Postal.* \_\_\_\_\_

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

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.

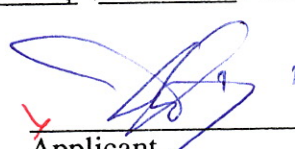
14 SAN JOAQUIN COUNTY  
MOSQUITO & VECTOR CONTROL DISTRICT  
15 Defendants


WCAB Case No.

DECLARATION UNDER LABOR CODE  
SECTION 4906(g)

16 COMES NOW, ATTORNEY and APPLICANT herein, and each states under penalty of  
17 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  
19 consideration, whether in the form of money or otherwise, as compensation or inducement for any  
referral, examination or evaluation.

20 Executed on this 1<sup>st</sup> 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

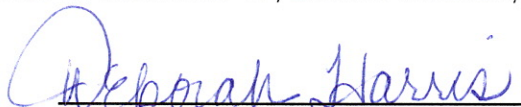
San Joaquin County.--Mosquito and Vector Control  
District  
7759 S. Airport Wy.  
Stockton, CA 95206

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  
Deborah Harris

# 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  
2006 NOV 27 PM 1:34  
DEPT OF INDUST RELATIONS  
DWC/WCAB