STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
STIPULATIONS WITH REQUEST FOR AWARD

ADJ7004227
Case No.

Date of Injury 06/19/2008
MM/DD/YYYY

549-23-5133
SSN (Numbers Only)

Venue Choice is based upon: (Completion of this section is required)

☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

☑ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

STK
Select 3 Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Applicant (Completion of this section is required)

TIFFANY
First Name

MI

ANDERSON
Last Name

2 N AVENA AVENUE
Address/PO Box (Please leave blank spaces between numbers, names or words)

LODI
City

CA
State

95242
Zip Code

Employer #1 Information (Completion of this section is required)

☐ Insured ☑ Self-Insured ☐ Legally Uninsured ☐ Uninsured

SAN JOAQUIN COUNTY MOSQUITO AND 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

95206
Zip Code

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

PERMISSIBLY SELF INSURED
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

PO 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)

AIMS INSURANCE
Name (Please leave blank spaces between numbers, names or words)

PO BOX 269120
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

SACRAMENTO — City
CA — State
95826 — Zip Code

Employer #2 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

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

City — State — Zip Code

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

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City — State — Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Employer #3 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

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

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Employer #4 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

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

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

The parties hereto stipulate to the issuance of an Award and/or Order, based upon the following facts, and waive the requirements of Labor Code section 5313:

1. TIFFANY
Employees First Name

ANDERSON ,
Employees Last Name

birth date 08/22/1970 ,
MM/DD/YYYY

while employed at STOCKTON CONTROL DISTRICT , CA
State

as a(n) TECHNICIAN I , in
Occupation Group

☐ More than 4 Companion Cases

☑ Specific Injury

ADJ7004221
Case Number 1

☐ Cumulative Injury

06/19/2008
(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 513 KNEE Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

☐ Specific Injury

Case Number 2

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

☐ Specific Injury

Case Number 3

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

☐ Specific Injury

Case Number 4

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

by the employer(s) and their insurer(s) listed above and who sustained injury(ies) arising out of and in the course of employment to

RIGHT KNEE

(Please list all body parts injured)

2. The injury (ies) caused temporary disability for the period 06/20/2008 (MM/DD/YYYY) through 08/13/2010 (MM/DD/YYYY) for which indemnity has been paid at $ 602.59 (Indemnity Paid) per week.

2(a). The injury(ies) caused additional temporary disability for the period n/a (MM/DD/YYYY) through n/a (MM/DD/YYYY) at the rate of $ _____ (Rate) in the amount of $ _____ (Indemnity Paid)

3. The injury(ies) caused permanent disability of 4 % for which indemnity is payable at $ 230.00 (Indemnity Rate) per week beginning ALL DUE AND PAYABLE (MM/DD/YYYY) in the sum of $ 2,760.00, less credit for such payments previously made. ☐ And a life pension of $ _____ (Life Pension) per week thereafter.

Labor Code §4658(d) adjustment:

☐ Increase rate to $ _____ as of _____ (MM/DD/YYYY)

☑ Decrease rate to $ 195.50 as of _____ (MM/DD/YYYY)

☐ Not Applicable

All due and payable $2,346.00 less temporary disability credit of $4,571.42, less permanent disability payout for ADJ7010682 (DOI: 3/26/09) of $1,173.00, leaving a total indemnity credit of $1,052.42.

An informal rating ☐ has / ☑ has not (Select one) been previously issued in case no(s) _____.

4. There ☑ is ☐ is Not a need for medical treatment to cure or relieve from the effects of said injury (ies).

5. Medical-legal expenses and/or liens are payable by defendant as follows:

FUTURE MEDICAL TREATMENT TO APPLICANT'S RIGHT KNEE ONLY

6. Applicant's attorney requests a fee of $ 414.00

☐ Fees to be commuted as follows:

7. Liens Against compensation are payable as follows:

NONE KNOWN.

8.Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

9.Other stipulations:

SEE ATTACHED ADDENDUM INCORPORATED HEREIN

Dated 12-23-10
MM/DD/YYYY

Applicant

Applicant's Attorney or Authorized Representative:

☑ Law Firm/Attorney ☐ Non Attorney Representative

RONALD
First Name

STEIN
Last Name

4813094
Firm Number

RONALD STEIN STOCKTON
Law Firm name

4521 QUAIL LAKES DRIVE
Address/PO Box (Please leave blank spaces between numbers, names or words)

STOCKTON
City

CA
State

95207
Zip Code

Dated 12/23/10
MM/DD/YYYY

Applicant Attorney Signature

Defendant's Attorney or Authorized Representative:

☑ Law Firm/Attorney ☐ Non Attorney Representative

ERIC
First Name

HELPHREY
Last Name

5185268
Firm Number

STOCKWELL HARRIS SACRAMENTO
Law Firm Name

1545 RIVER PARK DRIVE SUITE 330
Address/PO Box (Please leave blank spaces between numbers, names or words)

SACRAMENTO
City

CA
State

95815
Zip Code

Dated _____
MM/DD/YYYY

_____
Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Dated _____
MM/DD/YYYY

_____
Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Dated MM/DD/YYYY

Defense Attorney Signature

Interpreter Licence Number:

Interpreter Name

Interpreter License Number

RE: ANDERSON, TIFFANY VS. SAN JOAQUIN COUNTY MVCD
WCAB: ADJ7010682; ADJ7004221;

ADDENDUM TO STIPULATIONS WITH REQUEST FOR AWARD – PARAGRAPH 9

Permanent disability is based on Panel QME Dr. Tabaddor dated June 8, 2010, August 20, 2010 and September 7, 2010 at 2% permanent disability. This settlement resolves any and all claims for temporary disability (medical, TPD, TTD, wage loss, or any other form of TD) through the date of the award. This settlement resolves any and all claims of penalty(s), filed or not, including but not limited to Labor Code Sections 4650 and 5814 related to untimely payment and/or alleged failure to pay TD, PD, medical-legal or medical treatment, mileage/transportation, out-of-pocket expenses, home care/housekeeping or any other benefit. Any previously submitted claims for benefits need to be resubmitted with time as specified by the labor code to pay. The parties stipulate that there are no other claims or issues for workers' compensation benefits at this time. The parties stipulate no interest will be owing on accrued sums if payment is made within 30 days of this award.

Defendant entitled to a future indemnity credit of $2,225.42 against the case cited herein as well as ADJ7004227 (date of injury: June 19, 2008). The applicant dismisses any claims or rights to workers' compensation benefits regarding the third right knee claim on or about July 2, 2009 (ADJ7004221). Defendant enjoys a future indemnity claim asserted in either ADJ7004227 (date of injury: June 19, 2008) or ADJ7010682 (date of injury: March 26, 2009). The attorney fees of $ 621.00 will be paid in addition to the sums outlined herein.

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
STIPULATIONS WITH REQUEST FOR AWARD

ADJ7010682
Case No.

Date of Injury 03/26/2009
MM/DD/YYYY

549-23-5133
SSN (Numbers Only)

Venue Choice is based upon: (Completion of this section is required)

☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

☑ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

STK
Select 3 Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Applicant (Completion of this section is required)

TIFFANY
First Name

MI

ANDERSON
Last Name

2 N AVENA AVENUE
Address/PO Box (Please leave blank spaces between numbers, names or words)

LODI
City

CA
State

95242
Zip Code

Employer #1 Information (Completion of this section is required)

☐ Insured ☑ Self-Insured ☐ Legally Uninsured ☐ Uninsured

SAN JOAQUIN COUNTY MOSQUITO AND 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

95206
Zip Code

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

PERMISSIBLY SELF INSURED
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

PO BOX 269120
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

SACRAMENTO — CA — 95826
City — State — Zip Code

Claims Administrator Information (if known and if applicable)

AIMS INSURANCE
Name (Please leave blank spaces between numbers, names or words)

PO BOX 269120
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

SACRAMENTO — CA — 95826
City — State — Zip Code

Employer #2 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

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

City — State — Zip Code

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

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City — State — Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Employer #3 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

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

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Employer #4 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

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

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

The parties hereto stipulate to the issuance of an Award and/or Order, based upon the following facts, and waive the requirements of Labor Code section 5313:

1. TIFFANY
Employees First Name

ANDERSON ,
Employees Last Name

birth date 08/22/1970 ,
MM/DD/YYYY

while employed at STOCKTON CONTROL DISTRICT , CA
State

as a(n) TECHNICIAN I , in
Occupation Group

☐ More than 4 Companion Cases

☑ Specific Injury

ADJ7070682
Case Number 1

☐ Cumulative Injury

03/26/2009
(Start Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

(End Date: MM/DD/YYYY)

RIGHT

Body Part 1: 513 KNEE Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

☐ Specific Injury

Case Number 2

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

(End Date: MM/DD/YYYY)

Body Part 1: Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

☐ Specific Injury

Case Number 3

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

(End Date: MM/DD/YYYY)

Body Part 1: Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

☐ Specific Injury

Case Number 4

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

(End Date: MM/DD/YYYY)

Body Part 1: Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

by the employer(s) and their insurer(s) listed above and who sustained injury(ies) arising out of and in the course of employment to

RIGHT KNEE

(Please list all body parts injured)

2. The injury (ies) caused temporary disability for the period _____ (MM/DD/YYYY) through _____ (MM/DD/YYYY) for which indemnity has been paid at $ _____ (Indemnity Paid) per week.

2(a). The injury(ies) caused additional temporary disability for the period _____ (MM/DD/YYYY) through _____ (MM/DD/YYYY) at the rate of $ _____ (Rate) in the amount of $ _____ (Indemnity Paid)

3. The injury(ies) caused permanent disability of 2 % for which indemnity is payable at $ 230.00 (Indemnity Rate) per week beginning 09/08/2010 (MM/DD/YYYY) in the sum of $ 1,380.00, less credit for such payments previously made. ☐ And a life pension of $ _____ (Life Pension) per week thereafter.

Labor Code §4658(d) adjustment:

☐ Increase rate to $ _____ as of _____ (MM/DD/YYYY)

☑ Decrease rate to $ 195.50 as of 09/08/2010 (MM/DD/YYYY)

☐ Not Applicable

or, $1,173.00, less credit of $2,225.42, leaving defendant a total indemnity credit of $1,052.42.

An informal rating ☐ has / ☑ has not (Select one) been previously issued in case no(s) _____.

4. There ☑ is ☐ is Not a need for medical treatment to cure or relieve from the effects of said injury (ies).

5. Medical-legal expenses and/or liens are payable by defendant as follows:

FUTURE MEDICAL TREATMENT TO APPLICANT'S RIGHT KNEE ONLY

6. Applicant's attorney requests a fee of $ 207.00

☐ Fees to be commuted as follows:

7. Liens Against compensation are payable as follows:

NONE KNOWN.

8.Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

9.Other stipulations:

SEE ATTACHED ADDENDUM INCORPORATED HEREIN.

Dated 12-23-10
MM/DD/YYYY

Applicant

Applicant's Attorney or Authorized Representative:

☑ Law Firm/Attorney ☐ Non Attorney Representative

RONALD
First Name

STEIN
Last Name

4813094
Firm Number

RONALD STEIN STOCKTON
Law Firm name

4521 QUAIL LAKES DRIVE
Address/PO Box (Please leave blank spaces between numbers, names or words)

STOCKTON
City

CA
State

95207
Zip Code

Dated 12/23/10
MM/DD/YYYY

Applicant Attorney Signature

Defendant's Attorney or Authorized Representative:

☑ Law Firm/Attorney ☐ Non Attorney Representative

ERIC
First Name

HELPHREY
Last Name

5185268
Firm Number

STOCKWELL HARRIS SACRAMENTO
Law Firm Name

1545 RIVER PARK DRIVE SUITE 330
Address/PO Box (Please leave blank spaces between numbers, names or words)

SACRAMENTO
City

CA
State

95815
Zip Code

Dated
MM/DD/YYYY

Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Dated
MM/DD/YYYY

Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Dated MM/DD/YYYY

Defense Attorney Signature

Interpreter Licence Number:

Interpreter Name

Interpreter License Number