

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

ADJ7004227		Date of Injury 00/19	9/2000	
Case No.			MM/DD/YYYY	
549-23-5133				
SSN (Numbers Onl	ly)			
Venue Choice is b	ased upon: (Completion of t	his section is required)		
County of reside	ence of employee (Labor Code	e section 5501.5(a)(1) or (d).)		
County where in	njury occurred (Labor Code se	ction 5501.5(a)(2) or (d).)		
✓ County of princi	pal place of business of emplo	oyee's attorney (Labor Code section	5501.5(a)(3) or (d).)
STK				
	e Code For Place/Venue of H	earing (From the Document Cover S	Sheet)	
Applicant (Comple	etion of this section is requir	ed)		
TIFFANY				
First Name			MI	
ANDERSON				
Last Name				
2 N AVENA AV	ENUE			
		ween numbers, names or words)		
				05040
LODI			CA State	95242 Zip Code
City			Otate	Zip Code
Employer #1 Inform	mation (Completion of this s	ection is required)		
Insured	✓ Self-Insured	Legally Uninsured	Unins	ured
SAN IOAOUIN	COUNTY MOSOUITO AN	ID VECTOR CONTROL DISTR	ICT	
		ween numbers, names or words)		
7759 S AIRPORT			1.	
Employer Street Ac	dress/PO Box (Please leave l	blank spaces between numbers, nar	nes or words)	
STOCKTON			CA	95206
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 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		er is adjusted by	
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Name (Please leave blank spaces between numbers, names or words) Street Address/PO Box (Please leave blank spaces between numbers, names or words) City Employer #3 Information (Completion of this section is required) Insured Self-Insured Legally Uninsured	State	Zip Code
City Employer #3 Information (Completion of this section is required) Insured Self-Insured Legally Uninsured	State	Zip Code
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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 Name (Please leave blank spaces between numbers, names or words))	
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or	r 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)		

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Employer #4 Information (Completion of this section is required)		
Insured Self-Insured Legally Uninsured	Unins	sured
Employer Name (Please leave blank spaces between numbers, names or words)		
Employer Street Address/PO Box (Please leave blank spaces between numbers, n	names or words)	
City nsurance Carrier Information f known and if applicable - include even if carrier is adjusted by claims admin	State nistrator)	Zip Code
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claims Administrator Information (if known and if applicable)		
Name (Please leave blank spaces between numbers, names or words)		
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)	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 The parties hereto stipulate to the issuance of an Award and/or Order, based upon equirements of Labor Code section 5313:	State	
Name (Please leave blank spaces between numbers, names or words) Street Address/PO Box (Please leave blank spaces between numbers, names or words) City The parties hereto stipulate to the issuance of an Award and/or Order, based upon equirements of Labor Code section 5313: TIFFANY Employees First Name	State	
Name (Please leave blank spaces between numbers, names or words) Street Address/PO Box (Please leave blank spaces between numbers, names or words) City The parties hereto stipulate to the issuance of an Award and/or Order, based upon equirements of Labor Code section 5313: TIFFANY Employees First Name ANDERSON	State	
Name (Please leave blank spaces between numbers, names or words) Street Address/PO Box (Please leave blank spaces between numbers, names or words) City The parties hereto stipulate to the issuance of an Award and/or Order, based upon equirements of Labor Code section 5313: TIFFANY Employees First Name	State	
ANDERSON Employees Last Name birth date 08/22/1970 , MM/DD/YYYY	State	s, and waive the

More than 4 Companion	Cases	
	✓ Specific Injury	
ADJ7004221		06/19/2008
Case Number 1	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: 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:	
y the employer(s) and their ins	surer(s) listed above and who su	stained injury(ies) arising out of and in the course of employmen
UGHT KNEE		

	ed temporary disability for t		06/20/2008 MM/DD/YYYY	through	
08/13/2010) for which inde	emnity has been paid at	\$ 602.59	par wook	
MM/DD/YYYY			Indemnity Pa	per week. aid	
2(a).The injury(ies) cau	sed additional temporary d	isability for the period	MM/	n/a /DD/YYYY	
throughMI	n/a at the	rate of \$Rate	in the amou		ity Paid
3. The injury(ies) cause	ed permanent disability of 4	4 % for	which indemnity	is payable at \$	230.00
per week beginning	ALL DUE AND PAYA	ABLE in the sum of \$	2,760.00	_ , less credit for	Indemnity Rate such payments
previously made.	And a life pension of \$	per we	ek thereafter.		
Labor Code §4658(d)	adjustment:	Life Pension			
Increase rate to \$	as of				
✓ Decrease rate to \$	195.50 as of	MM/DD/YYYY	temporary dis	payable \$2,346. Sability credit at disability p	of \$4,571.42 Dayout for
		MM/DD/YYYY	ADJ7010682 (D	OI: 3/26/09) c	of \$1,173.00,
There is is	has / has not (Select of Not a need for medical treases and/or liens are payable	one) been previously iss	sued in case no(s from the effects		
An informal rating There is is is Medical-legal expense.	Not a need for medical tree	one) been previously iss atment to cure or relieve e by defendant as follow	sued in case no(s from the effects		
An informal rating There is is is Medical-legal expense.	Not a need for medical treases and/or liens are payable	one) been previously iss atment to cure or relieve e by defendant as follow	sued in case no(s from the effects		
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An informal rating ☐ There is ☐ is Medical-legal expense FUTURE MEDICAL	Not a need for medical treases and/or liens are payable. TREATMENT TO APPROPRIES Trequests a fee of \$	one) been previously issetment to cure or relieve the by defendant as follow PLICANT'S RIGHT I	sued in case no(s from the effects		
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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 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) 95207 STOCKTON City Zip Code ated Applicant Attorney Signature

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Defendant's Attorney or Authorized Representative:		
✓ Law Firm/Attorney		
ERIC		
First Name		
HELPHREY		
ast 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	CA	95815
City	State	Zip Code
Pated		
Defendant's Attorney or Authorized Representative: Law Firm/Attorney Non Attorney Representative	Defense Attorney	Signature
MM/DD/YYYY Defendant's Attorney or Authorized Representative:	Defense Attorney	Signature
MM/DD/YYYY Defendant's Attorney or Authorized Representative: Non Attorney Representative	Defense Attorney	Signature
MM/DD/YYYY Defendant's Attorney or Authorized Representative: Non Attorney Representative	Defense Attorney	Signature
MM/DD/YYYY Defendant's Attorney or Authorized Representative: Law Firm/Attorney Non Attorney Representative First Name Last Name	Defense Attorney	Signature
MM/DD/YYYY Defendant's Attorney or Authorized Representative: Law Firm/Attorney Non Attorney Representative First Name	Defense Attorney	Signature
Defendant's Attorney or Authorized Representative: Law Firm/Attorney Non Attorney Representative First Name Last Name	Defense Attorney	Signature
MM/DD/YYYY Defendant's Attorney or Authorized Representative: Law Firm/Attorney Non Attorney Representative First Name Last Name	Defense Attorney	Signature
Defendant's Attorney or Authorized Representative: Law Firm/Attorney Non Attorney Representative First Name Last Name	Defense Attorney	Signature
MM/DD/YYYY Defendant's Attorney or Authorized Representative: Non Attorney Representative First Name Last Name Last Name Law Firm Number	Defense Attorney	Signature
MM/DD/YYYY Defendant's Attorney or Authorized Representative: Non Attorney Representative First Name Last Name Last Name Law Firm Number	Defense Attorney	Signature Zip Code
Defendant's Attorney or Authorized Representative: Law Firm/Attorney Non Attorney Representative First Name Last Name Law Firm Number Law Firm Name Address/PO Box (Please leave blank spaces between numbers, names or words) City Defendant's Attorney or Authorized Representative: Non Attorney Representative		
MM/DD/YYYY Defendant's Attorney or Authorized Representative: Law Firm/Attorney Non Attorney Representative First Name Last Name Last Name Law Firm Number Law Firm Name Address/PO Box (Please leave blank spaces between numbers, names or words)		Zip Code

Defendant's Attorney or Authorized Representative:		
Law Firm/Attorney Non Attorney Representative		
First Name		
Last Name		
ast Name		
Firm Number		
Law Firm Name		
Address/PO Box (Please leave blank spaces between numbers, names or wo	rds)	
City	State	Zip Code
DatedMM/DD/YYYY	Defense Attorney	Signature
nterpreter Licence Number:		
		N
Interpreter Name	Interpreter Lice	ense Number



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

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, medicallegal 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	Date of Injury 03/26/2009		
Case No.	MM/I	DD/YYYY	
549-23-5133			
SSN (Numbers Only)			
Venue Choice is based upon: (Comple	tion of this section is required)		
County of residence of employee (La	bor 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	l).)
STK			
Select 3 Letter Office Code For Place/Ver	nue of Hearing (From the Document Cover Sheet)		
Applicant (Completion of this section i	is required)		
TIFFANY			
First Name		MI	
ANDERSON			
ANDERSON Last Name			
Last Name 2 N AVENA AVENUE			
Last Name 2 N AVENA AVENUE	aces between numbers, names or words)		
Last Name 2 N AVENA AVENUE Address/PO Box (Please leave blank spa	aces between numbers, names or words)		05040
Last Name 2 N AVENA AVENUE Address/PO Box (Please leave blank spa	aces between numbers, names or words)	CA_State	95242 7in Code
Last Name 2 N AVENA AVENUE Address/PO Box (Please leave blank spa	aces between numbers, names or words)	CA State	95242 Zip Code
Last Name 2 N AVENA AVENUE			
Last Name 2 N AVENA AVENUE Address/PO Box (Please leave blank spa LODI City	of this section is required)		Zip Code
Last Name 2 N AVENA AVENUE Address/PO Box (Please leave blank spanned) LODI City Employer #1 Information (Completion of Self-Insured)	of this section is required) red Legally Uninsured	State	Zip Code
Last Name 2 N AVENA AVENUE Address/PO Box (Please leave blank spanned) LODI City Employer #1 Information (Completion of Self-Insured) SAN JOAQUIN COUNTY MOSQU	of this section is required)	State	Zip Code
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nsurance Carrier Information (if known and if applicable - include even if carrier	is adjusted by	ciaims administrate
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nsurance Carrier Name (Please leave blank spaces between numbers, names or words)		
PO BOX 269120	or words)	
nsurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names	s of words)	
SACRAMENTO	CA State	95826 Zip Code
laims 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 Name (Please leave blank spaces between numbers, names or words)		
Employer Street Address/PO Box (Please leave blank spaces between numbers, nam	es or words)	
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if known and if applicable - include even if carrier is adjusted by claims adminis Insurance Carrier Name (Please leave blank spaces between numbers, names or words)		Zip Code

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ame (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
mployer #3 Information (Completion of this section is required)		
Insured Self-Insured Legally Uninsured	Unins	ured
Employer Name (Please leave blank spaces between numbers, names or words)		
Employer Street Address/PO Box (Please leave blank spaces between numbers, names of	or words)	
Dity	State	Zip Code
nsurance Carrier Information		Zip Code
nsurance Carrier Information if known and if applicable - include even if carrier is adjusted by claims administrate	or)	Zip Code
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Employer #4 Infor	mation (Completion of this	section is required)		
Insured	Self-Insured	Legally Uninsured	Unins	sured
Employer Name (P	lease leave blank spaces bet	ween numbers, names or words)	
Employer Street Ac	ddress/PO Box (Please leave	blank spaces between numbers	, names or words)	
City nsurance Carrier I if known and if ap		arrier is adjusted by claims adı	State ministrator)	Zip Code
Insurance Carrier Na	me (Please leave blank spaces b	between numbers, names or words)		
Insurance Carrier Str	eet Address/PO Box (Please lea	ve blank spaces between numbers,	names or words)	
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City Claims Administra	tor Information (if known a	nd if applicable)	State	Zip Code
Claims Administra	tor Information (if known and blank spaces between numbers,		State	Zip Code
Claims Administra	blank spaces between numbers,		State	Zip Code
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Name (Please leave I Street Address/PO Bo City The parties hereto s requirements of Lab	blank spaces between numbers, ox (Please leave blank spaces b	names or words)	State	Zip Code
Name (Please leave I Street Address/PO Bo	blank spaces between numbers, ox (Please leave blank spaces betipulate to the issuance of an our Code section 5313:	names or words) etween numbers, names or words)	State	Zip Code
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More than 4 Companion	Cases	
	Specific Injury	
ADJ7070682		03/26/2009
Case Number 1	Cumulative Injury	(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYYY) (If Specific Injury, use the start date as the specific date of injury)
4		(ii Specific Injury, use the start date as the specific date of injury)
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) (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:	
		를 그 병원 경험을 가득하면 하는 것이 되었다. 그는 사람들은 사람들이 되었다면 함께 가는 다른 사람들이 되었다.
by the employer(s) and their in	nsurer(s) listed above and who s	ustained injury(ies) arising out of and in the course of employm

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MM/DD/YYYY	for which indemni	ty has been paid at \$ _	per week.	
2(a) The injury/ies) cau	ised additional temporary disab	nility for the period		
2(a). The injury(les) cau	ised additional temporary disab		MM/DD/YYYY	
through	at the rate	e of \$	in the amount of \$	
MN	M/DD/YYYY	Rate	Indemr	nity Paid
3. The injury(ies) cause	ed permanent disability of 2	% for whice	ch 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. Labor Code §4658(d)	And a life pension of \$Li	per week th	nereafter.	
Increase rate to \$				
	as of	MM/DD/YYYY	or, \$1,173.00,	less cred:
Decrease rate to \$	195.50 as of	09/08/2010	of \$2,225.42,	
	195.50 as of	MM/DD/YYYY	defendant a to	tal indemn:
4.There 📝 is 🗌 is I	has / A has not (Select one) Not a need for medical treatments and/or liens are payable by			
An informal rating	Not a need for medical treatme	ent to cure or relieve from defendant as follows:	in case no(s) m the effects of said injury (ies	
An informal rating 4.There ✓ is is is 1 5. Medical-legal expens	Not a need for medical treatme	ent to cure or relieve from defendant as follows:	in case no(s) m the effects of said injury (ies	
An informal rating 4.There	Not a need for medical treatments and/or liens are payable by TREATMENT TO APPLICATION APP	ent to cure or relieve from defendant as follows: CANT'S RIGHT KNE	in case no(s) m the effects of said injury (ies	
An informal rating	Not a need for medical treatments and/or liens are payable by TREATMENT TO APPLICATE TO APPLICATE TO THE PROPERTY OF THE PROPE	ent to cure or relieve from defendant as follows: CANT'S RIGHT KNE	in case no(s) m the effects of said injury (ies	
An informal rating ☐ 4.There ✓ is ☐ is I 5. Medical-legal expens FUTURE MEDICAL	Not a need for medical treatments and/or liens are payable by TREATMENT TO APPLICATE TO APPLICATE TO THE PROPERTY OF THE PROPE	ent to cure or relieve from defendant as follows: CANT'S RIGHT KNE	in case no(s) m the effects of said injury (ies	
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An informal rating	Not a need for medical treatments and/or liens are payable by TREATMENT TO APPLICATE TO APPLICATE TO THE PROPERTY OF THE PROPE	ent to cure or relieve from defendant as follows: CANT'S RIGHT KNE	in case no(s) m the effects of said injury (ies	
An informal rating	Not a need for medical treatmeses and/or liens are payable by TREATMENT TO APPLICATE TO APPLICATE TO THE PROPERTY OF THE PROPE	ent to cure or relieve from defendant as follows: CANT'S RIGHT KNE	in case no(s) m the effects of said injury (ies	
An informal rating	Not a need for medical treatments and/or liens are payable by TREATMENT TO APPLICATE TO APPLICATE TO THE PROPERTY OF THE PROPE	ent to cure or relieve from defendant as follows: CANT'S RIGHT KNE	in case no(s) m the effects of said injury (ies	
An informal rating	Not a need for medical treatmeses and/or liens are payable by TREATMENT TO APPLICATE TO APPLICATE TO THE PROPERTY OF THE PROPE	ent to cure or relieve from defendant as follows: CANT'S RIGHT KNE	in case no(s) m the effects of said injury (ies	
An informal rating	Not a need for medical treatmeses and/or liens are payable by TREATMENT TO APPLICATE TO APPLICATE TO THE PROPERTY OF THE PROPE	ent to cure or relieve from defendant as follows: CANT'S RIGHT KNE	in case no(s) m the effects of said injury (ies	
An informal rating	Not a need for medical treatmeses and/or liens are payable by TREATMENT TO APPLICATE TO APPLICATE TO THE PROPERTY OF THE PROPE	ent to cure or relieve from defendant as follows: CANT'S RIGHT KNE	in case no(s) m the effects of said injury (ies	
An informal rating	Not a need for medical treatmeses and/or liens are payable by TREATMENT TO APPLICATE TO APPLICATE TO THE PROPERTY OF THE PROPE	ent to cure or relieve from defendant as follows: CANT'S RIGHT KNE	in case no(s) m the effects of said injury (ies	

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 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) 95207 **STOCKTON** Zip Code State City Dated Applicant Attorney Signature DWC-CA form 10214 (a) Page 7 (Rev 11/2008)

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Zip Code
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Defendant's Attorney or Authorized Representative:		
Law Firm/Attorney Non Attorney Representation	/e	
First Name		
_ast Name		
Firm Number		
Law Firm Name		
	nes or words)	
Address/PO Box (Please leave blank spaces between numbers, nan	nes or words) State	Zip Code
Address/PO Box (Please leave blank spaces between numbers, nar City		
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