

STATE OF CALIFORNIA
Division of Workers Compensation - Medical Unit
 P.O. Box 71010, Oakland, CA 94612
 (510) 286-3700 or (800) 794-6900

QUALIFIED MEDICAL EVALUATOR'S FINDINGS SUMMARY FORM
UNREPRESENTED INJURED EMPLOYEE CASES ONLY

EMPLOYEE

Tiffany Anderson **549-23-5133** **6/29/2011**
 1 Employee Name (First, Middle, Last) 2 Social Sec No (Optional) 3 Date of Injury (Mo/ Dy /Yr)
2 N Avena Ave **Lodi, CA** **95240** **(209) 625-8575**
 4 Street Address City Zip 5 Phone

CLAIMS ADMINISTRATOR *(if none, enter Employer information)*

AIMS ACCLAMATION INSURANCE MANAGEMENT SERVICES

6. Name
P.O. Box 269120 **Sacramento, CA** **95826-9120** **(916) 563-1900**
 7. Street Address City Zip 8 Phone

EVENT DATES

12/29/2011 **3/27/2012** **11 Date of Referral for Medical Testing/Consultation**
 9 Date of Appointment Call 10 Date of initial Examination
 12. Date AME/QME's Report Served on all Parties 12b Date(s) of all prior report(s) served by this QME?

DISPUTED MEDICAL ISSUES AND CONCLUSIONS

13 The following medical issues will be used to determine the injured employee's eligibility for workers' compensation benefits

(Check the appropriate box)

	Yes	No	Pending or Info Not Sent
a Has the condition reached permanent and stationary status or maximum medical improvement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b Is there permanent impairment/disability?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
c Did work cause or contribute to the injury or illness?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d If permanent disability exists, is apportionment warranted?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
e. Is there a need for current or future medical care?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Can this employee now return to his/her usual job?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
If yes			
i Without restrictions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If YES, Date _____
ii With restrictions	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	If YES, Date _____

BASIS FOR CONCLUSIONS

(Check the appropriate box)

	Yes	No	Pending or Info Not Sent
14. Are there subjective complaints	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15 Are there any abnormal physical or psychological examination findings?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Are impairments described and measured using			
(For non-psyche injuries) the AMA Guides?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(For psyche injuries) the GAF and 2005 PD Schedule?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

- | | Yes | No | Pending or
Info Not Sent |
|--|-------------------------------------|-------------------------------------|-----------------------------|
| 17 If the AMA Guides are used, are percentages of impairment stated? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18 Are there any relevant diagnostic test results (x-ray/laboratory)? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 19. What are the diagnoses? (List) _____ | | | |
| 20. Were medical records reviewed? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21 Were other physicians consulted? _____ | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 22 Are there any unresolved disputed issues beyond the scope of your licensure or clinical competency that should be addressed by an evaluator in a different specialty? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 23. If the answer to #22 is yes, what disputed issue(s)? _____ | | | |
| 24 Based on the answer in #23, what specialty (or specialties)? _____ | | | |

QME

22 Signature *Khosrow Tabaddor* Date 4-10-12

23 Name Khosrow Tabaddor, M.D. Specialty Orthopaedic Surgeon

24. Street Address 8221 N. Fresno St City Fresno Zip 93720

25 Phone (559) 222-2294 Cal License No A 0040537

Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))

I, Dianne A, declare.
(Print Name)

- 1 I am over the age of 18 and I am not a party to this case
2. My business address is 8221 N. Fresno St, Fresno, CA 93720
- 3 On the date shown below, I served this QME Findings Summary Form with the original, or a true and correct copy of the original, comprehensive medical-legal report, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by
 - B placing the sealed envelope for collection and mailing following our ordinary business practices I am readily familiar with this business's practice for collecting and processing correspondence for mailing On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U S Postal Service in a sealed envelope with postage fully prepaid

Means of service
(For each addressee,
Enter A-F as appropriate)

Date

Addressee and Address

B	4-30-12	Tiffany Anderson, 2 N Avena Ave Lodi CA 95240
B	4-30-12	Mackenzie Dawson, P O Box 269120 Sacramento CA 95826-9120
B	4-30-12	L/O Stockwell Harris Woolverton Muehl, 1545 River Park Dr Ste 330 Sacramento CA 9

When report addresses PD:

4-30-12 Disability Evaluation Unit, DWC, Stockton

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date Signed 4-30-12

deep
(Signature of Declarant)

Dianne A.
(Print Name)

State of California
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT
AME or QME Declaration of Service of Medical - Legal Report (Lab, Code § 4062.3(i))

Case Name: Tiffany Anderson v AIMS ACCLAMATION INSURANCE MANAGEMENT SE
(employee name) *(claims administrator name, or if none employer)*

Claim No.: VE0700184 **EAMS or WCAB Case No. (if any):** _____

I, Nicholas Dennie, declare

- 1 I am over the age of 18 and I am not a party to this case
- 2 My business address is 8221 N. Fresno St, Fresno, CA 93720
- 3 On the date shown below, I served this QME Findings Summary Form with the original, or a true and correct copy of the original, comprehensive medical-legal report, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by

- A depositing the sealed envelope with the U S Postal Service with the postage fully prepaid
- X** placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U S Postal Service in a sealed envelope with postage fully prepaid.
- C placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier
- D placing the sealed envelope for pick up by a professional messenger service for service
(Messenger must return to you a completed declaration of personal service)
- E personally delivering the sealed envelope to the person or firm named below at the address shown below

<u>Means of service</u>	<u>Date Served</u>	<u>Addressee and Address</u>
<i>(For each addressee. Enter A-F as appropriate)</i>		
<u>B</u>	<u>4/30/2012</u>	<u>Tiffany Anderson, 2 N Avena Ave Lodi CA 95240</u>
<u>B</u>	<u>4/30/2012</u>	<u>AIMS ACCLAMATION INSURANCE MANAGEMENT SERVICES, P O Box 269120</u>
<u>B</u>	<u>4/30/2012</u>	<u>L/O Stockwell Harris Woolverton Muehl, 1545 River Park Dr Ste 330 Sacramento CA 9</u>

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date 4/30/2012

Nick Dennie
(Signature of Declarant)

Nicholas Dennie
(Print Name)