BH
300141-040

COMPEX

Legal Services, Inc.

Records of. . :	**ANDERSON, TIFFANY**
Defendant . . :	SAN JOAQUIN COUNTY MOSQUITO & VCD
Client/Insured:	STOCKWELL, HARRIS, WOOLVERTON & MUEHL
File Number . :	300141-040/VE0700184
Case Number . :	ADJ7004221
	C509134 ID# INFO: [C50913K]
Location .....:	**DAMERON OCCUPATIONAL HEALTH SERVICES** 525 WEST ACACIA STOCKTON, CA 95203
Record Types. :	OTHERS
Deliver To. . :	**STOCKWELL, HARRIS, WOOLVERTON & MUEHL**
Attention . . :	KATHI STOKES 1545 RIVER PARK DR, SUITE 330 SACRAMENTO, CA 95815

Deposition Date
18 OCT 2011

Office Responsible for Delivery
Rt#:523/Sacramento Field (CA 95815)

Custome 516 A/c# 92

Note (s)

C50913-K

DECLARATION FOR SUBPOENA DUCES TECUM

Case No. ADJ7004221

STATE OF CALIFORNIA, County of SAN JOAQUIN

The undersigned states:
That he/she is (one of) the attorney(s) of record/representative(s) for the applicant/defendant in the action captioned on the subpoena duces tecum. That DAMERON OCCUPATIONAL HEALTH SERVICES has in his/her possession or under his/her control the documents described on the subpoena.
That said documents are material to the issues involved in the case for the following reasons:

These records may contain information that will help in the resolution of this claim.

Declaration for Injuries on or After January 1, 1990 and Before January 1, 1994

That an Employee's Claim for Workers' Compensation Benefits (DWC Form 1) has been filed in accordance with Labor Code Section 5401 by the alleged injured worker whose records are sought, or if the worker is deceased, by dependent(s) of the decedent. (Check box if applicable and part of the declaration below. See instruction on Subpoena.)

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

Executed on October 5, 2011, at Torrance, CA 90503

|S| STOCKWELL, HARRIS, WOOLVERTON & MUEHL	1545 RIVER PARK DR, SUITE 330 SACRAMENTO, CA 95815	916-924-1862
Signature	Address	Telephone

DECLARATION OF SERVICE

STATE OF CALIFORNIA, County of SAN JOAQUIN

I, the undersigned, state that: I served the foregoing subpoena by delivering a true copy thereof, together with a copy of the Declaration in support thereof, to each of the following named persons, personally, at the date and place set forth opposite each name.

Name of person served	Date of service	Place	Phone
PATRICIA (RLN)	10/14/2011	DAMERON OCCUPATIONAL HEALTH SERVICES	209-461-3124

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

Executed on October 14, 2011, at Torrance, CA 90503

Compex Legal Services

Signature

INPATIENT/OUTPATIENT REGISTRATION RECORD

ACCT NUM:	ADMIT DATE/TIME:	DIS DATE/TIME:	MRN:
105715551	06/20/2008 08 38	06/20/2008 08 38	626041

PATIENT INFORMATION:

NAME: ANDERSON, TIFFANY K
ADDRESS: 1416 IRIS DR #7
CITY: LODI
STATE/ZIP: CA 95242
PHONE. (209)333-1037
S.S.#: 549-23-5133

BIRTHDATE: 08/22/1970
AGE: 37
GENDER: FEMALE
MARITAL STATUS: SINGLE
RELIGION: NON
ALIAS:

ACCOUNT INFORMATION:

PAT CLASS: O
HOSP SERV: XRO
KAISER MED REC/INS ID:
FINANCIAL CLASS: 9399-STOLAS-OCC HEALTH EXAMS

ADMIT CLERK:
ADMIT DX: GENERAL MEDICAL EXAM NOS
GENERAL MEDICAL EXAM NOS

PHYSICIAN INFORMATION:

ADMITTING: INJURIES HULL
PRIMARY:

ATTENDING: DONALD L ROSSMAN

NEXT OF KIN:

NAME:
RELATION:
HOME PHONE:
BUSINESS PHONE:

EMERGENCY CONTACT:

NAME:
RELATION:
HOME PHONE:
BUSINESS PHONE:

GUARANTOR INFORMATION:

NAME. ANDERSON, TIFFANY K
ADDRESS: 1416 IRIS DR #7
CITY: LODI
STATE/ZIP. , CA
PHONE: (209)333-1037

RELATIONSHIP: SELF
EMPLOYER NAME: SJ COUNTY MOSQUITO-8046
JOB TITLE: TECH

INSURANCE:

PRIMARY:	SECONDARY:	TERTIARY:
INS PLAN: STOLAS-OCC HEALTH EXAMS	INS PLAN:	INS. PLAN:
ADDR:	ADDR:	ADDR:
CITY.	CITY:	CITY:
STATE/ZIP.	STATE/ZIP:	STATE/ZIP:
POL#.	POL#:	POL#:
GRP#:	GRP#:	GRP#:
SUBS. ANDERSON TIFFANY K	SUBS:	SUBS:
REL TO PT: A	REL TO PT:	REL TO PT:

COMMENTS:

ADVANCE DIRECTIVE:

DAMERON HOSPITAL ASSOCIATION

RADIOLOGY

CC: HULL, INJURIES MD

Procedure: RIGHT KNEE

Three views of the right knee demonstrate the soft tissues and osseous structures intact without any obvious fracture or dislocation seen. Joint space is maintained without any narrowing.

Electronically Signed 06/20/2008 16:32:25
DAVID WONG, MD

D: /T: 06/20/2008 15:01:51/DI: 00004774/DN: 00004774

ANDERSON, TIFFANY
626041

DAMERON HOSPITAL
STOCKTON, CALIFORNIA 95203

RADIOLOGY

DAMERON HOSPITAL
Occupational Health Services

AUTHORIZATION FOR MEDICAL SERVICES

Date	Employee/Applicant Name
6/20/08	TIFFANY ANDERSON
Company Name	**Telephone #**
SJ MOSQUITO ABATEMENT	
Company Authorization By	
FED LUCCHESI	

SERVICES REQUESTED

☒ Treatment of work-related illness or injury

If working for a temporary agency

Agency Name _____

Telephone Number _____

☐ Medical Examination.

☐ Pre-employment ☐ DOT-Initial ☐ DOT -Recertification

☐ Other _____

☐ Drug Screen ☐ DOT ☐ Non-DOT

☐ Breath Alcohol ☐ DOT ☐ Non-DOT

☐ Pre-employment ☐ Random ☐ Reasonable Suspicion

☐ Post Accident ☐ Other

Special Instructions KNEE

Appointment: **Date:** ____/____/____

Time _____ AM/PM

Dameron Hospital Occupational Health Services
420 W. Acacia Str[illegible] Stockton, CA 95203 209-461-3196 [illegible]X 209-461-3123

WORK STATUS REPORT

Employee:	Tiffany Anderson	**Exam Date:**	08/12/2008
Employee ID:	549-23-5133	**Time In:**	10:30 AM **Time Out:** 11:19 AM
Employer:	SJ Mosquito & Vector Control	**Guarantor:**	AIMS-SACTO 8049
Date of Injury:	6/19/2008	**Claim No:**	VE0700184

Work Status: MODIFIED WORK DUTIES
Effective 08/12/2008

Work Restrictions: WORK RESTRICTIONS: No squatting, kneeling or crawling. No climbing ladders. Wear splint/brace as directed. No prolonged standing or walking.

Diagnosis: Knee effusion, Right
Sprain/strain knee, cruciate ligament

Evaluating Clinician: Mike Dixon PA-C
Donald Rossman M.D.--

***Request for Treatment Authorization**

Date of Request	Treatment	Status
08/12/2008	Referral - Orthopedist	Obtain Authorization

* A separate "Request for Treatment Authorization" with supporting documentation will be submitted to the Claims Examiner

Final Disposition: Referred out

Printed 8/12/2008

Employer Copy

Dameron Hospital Occupational Health Services
420 W. Acacia Stre[redacted] Stockton, CA 95203 209-461-3196 [redacted] 209-461-3123

WORK STATUS REPORT

Employee:	Tiffany Anderson	**Exam Date:**	08/05/2008
Employee ID:	549-23-5133	**Time In:**	10:30 AM **Time Out:** 11:47 AM
Employer:	SJ Mosquito & Vector Control	**Guarantor:**	AIMS-SACTO 8049
Date of Injury:	6/19/2008	**Claim No:**	VE0700184

Work Status: MODIFIED WORK DUTIES
Effective 08/05/2008 to 08/12/2008

Work Restrictions: WORK RESTRICTIONS. No squatting, kneeling or crawling. No climbing ladders. Wear splint/brace as directed. No prolonged standing or walking.

Diagnosis: Knee effusion, Right
Sprain/strain knee, cruciate ligament

Evaluating Clinician: Mike Dixon PA-C
Donald Rossman M.D.

Next Scheduled Appointment:

Date	Time	Provider	Specialty
8/12/2008	1:20 PM	Dixon, Mike	Occupational Health Services

08.05.08
- Reviewed case w/ Tiffany & Makenzie.

8.12.08
→ Finish PT
- Transfer care to Dr Mercado

Printed 8/5/2008

Employer Copy

Dameron Hospital Occupational Health Services
420 W. Acacia St[illegible], Stockton, CA 95203 209-461-3196 [illegible]X 209-461-3123

WORK STATUS REPORT

Employee:	Tiffany Anderson	**Exam Date:**	07/29/2008
Employee ID:	549-23-5133	**Time In:**	2:00 PM **Time Out:** 3:32 PM
Employer:	SJ Mosquito & Vector Control	**Guarantor:**	AIMS-SACTO 8049
Date of Injury:	6/19/2008	**Claim No:**	VE0700184

Work Status: MODIFIED WORK DUTIES
Effective 07/29/2008 to 08/05/2008

Work Restrictions: WORK RESTRICTIONS: No squatting, kneeling or crawling. No climbing ladders. Wear splint/brace as directed. No prolonged standing or walking.

Diagnosis: Knee effusion, Right
Sprain/strain knee, cruciate ligament

Evaluating Clinician: Mike Dixon PA-C
Donald Rossman M.D.

***Medical Services:** Propoxyphene/Aceta 100-650mg

Michael R. Dixon

*This is a general overview of the visit, it is not a complete list of billable services

***Request for Treatment Authorization**

Date of Request	Treatment		Status
07/29/2008	Consult - Orthopedist	Murata 8.6.08	Obtain Authorization

* A separate "Request for Treatment Authorization" with supporting documentation will be submitted to the Claims Examiner

Next Scheduled Appointment:

Date	Time	Provider	Specialty
8/5/2008	10:20 AM	Dixon, Mike	Occupational Health Services

7.31.08
- Reviewed case w/ Tiffany today; ∅ mod duty per employer. Notified of tear & FO ortho consult.

MD

→ RTC 1 wk / finish PT (3 left)

Printed 7/29/2008

Employer Copy

Dameron Hospital Occupational Health Services
420 W. Acacia S , Stockton, CA 95203 209-481-3198 [redacted]: 209-481-3123

WORK STATUS REPORT

Employee:	Tiffany Anderson	**Exam Date:**	07/22/2008
Employee ID:	549-23-5133	**Time In:**	1:35 PM **Time Out:** 2:33 PM
Employer:	SJ Mosquito & Vector Control	**Guarantor:**	AIMS-SACTO 8049
Date of Injury:	6/19/2008	**Claim No:**	

Work Status: MODIFIED WORK DUTIES
Effective 07/22/2008 to 07/29/2008

Work Restrictions: WORK RESTRICTIONS: No squatting, kneeling or crawling. No climbing ladders. Wear splint/brace as directed. No prolonged standing or walking.

Diagnosis: Knee effusion, Right
Sprain/strain knee, cruciate ligament

Evaluating Clinician: Mike Dixon PA-C
~~Donald Rossman M.D~~

***Medical Services:** Ibuprofen - 800 mg

Michael V. Dixon

*This is a general overview of the visit, it is not a complete list of billable services

***Request for Treatment Authorization**

Date of Request	Treatment	Status
07/22/2008	MRI - Knee	Obtain Authorization

* A separate "Request for Treatment Authorization" with supporting documentation will be submitted to the Claims Examiner

Next Scheduled Appointment:

Date	Time	Provider	Specialty
7/29/2008	2:00 PM	Dixon, Mike	Occupational Health Services

Adjuster
Mckenzie Dawson
916.563.1900
Ext. 242
FAX 916-563.1919

— knee: ☐
— meds: ☐
— see ortho
— RTW 7-10 days

PD

Printed 7/22/2008

Employer Copy

Dameron Hospital Occupational Health Services
420 W. Acacia Str , Stockton, CA 95203 209-461-3196 X 209-461-3123

WORK STATUS REPORT

Employee:	Tiffany Anderson	**Exam Date:**	07/15/2008
Employee ID:	549-23-5133	**Time In:**	11:26 AM **Time Out:** 12:16 PM
Employer:	SJ Mosquito & Vector Control	**Guarantor:**	AIMS-SACTO 8049
Date of Injury:	6/19/2008	**Claim No:**	

Work Status: MODIFIED WORK DUTIES
Effective 07/15/2008 to 07/22/2008

Work Restrictions: WORK RESTRICTIONS: No squatting, kneeling or crawling. No climbing ladders. Wear splint/brace as directed. No prolonged standing or walking.

Diagnosis: Knee effusion, Right
Sprain/strain knee, cruciate ligament

Evaluating Clinician: Mike Dixon PA-C
Donald Rossman M.D.

***Medical Services:** Propoxyphene/Aceta 100-650mg

*This is a general overview of the visit, it is not a complete list of billable services

***Request for Treatment Authorization**

Date of Request	Treatment	Status
07/15/2008	PT/OT OFFSITE	Finished

* A separate "Request for Treatment Authorization" with supporting documentation will be submitted to the Claims Examiner

Next Scheduled Appointment:

Date	Time	Provider	Specialty
7/22/2008	2:00 PM	Dixon, Mike	Occupational Health Services

* MRI (R) knee - ordered

- Finish PT (6 left)

- RTC 1 wk

- meds: [illegible] - Ibp 800mg

Printed 7/15/2008

Employer Copy

Dameron Hospital Occupational Health Services
420 W. Acacia St[illegible], Stockton, CA 95203 209-461-3196 [illegible]X 209-461-3123

WORK STATUS REPORT

Employee:	Tiffany Anderson	**Exam Date:**	07/08/2008
Employee ID:	549-23-5133	**Time In:**	10:10 AM **Time Out:** 10:50 AM
Employer:	S.J.Mosquito & Vector Control	**Guarantor:**	AIMS-SACTO 8049
Date of Injury:	6/19/2008	**Claim No:**	

Work Status: MODIFIED WORK DUTIES
Effective 07/08/2008 to 07/15/2008

Work Restrictions: WORK RESTRICTIONS: No squatting, kneeling or crawling. No climbing ladders. Wear splint/brace as directed. No prolonged standing or walking.

Diagnosis: Knee effusion, Right
Sprain/strain knee, cruciate ligament

Evaluating Clinician: Mike Dixon PA-C
Donald Rossman M.D.

***Medical Services:** TENS Unit - Application

Michael R. Dixon

*This is a general overview of the visit, it is not a complete list of billable services

Next Scheduled Appointment:

Date	Time	Provider	Specialty
7/15/2008	11:20 AM	Dixon, Mike	Occupational Health Services

— intermittent @ knee effusion

— may need MRI later

— Darvocet

— brace for

— TENS unit

Printed: 7/8/2008

Employer Copy

Dameron Hospital Occupational Health Services
420 W. Acacia St ,, Stockton, CA 95203 209-461-3196 AX 209-461-3123

WORK STATUS REPORT

Employee:	Tiffany Anderson	**Exam Date:**	06/30/2008
Employee ID:	549-23-5133	**Time In:**	09:55 AM **Time Out:** 10:51 AM
Employer:	SJ Mosquito & Vector Control	**Guarantor:**	AIMS-SACTO 8049
Date of Injury:	6/19/2008	**Claim No:**	

Work Status: MODIFIED WORK DUTIES
Effective 06/30/2008 to 07/08/2008

Work Restrictions: WORK RESTRICTIONS: No squatting, kneeling or crawling. No climbing ladders. Wear splint/brace as directed. No prolonged standing or walking.

Diagnosis: Knee effusion, Right
Sprain/strain knee, cruciate ligament

Evaluating Clinician: Dan Stringari PA-C
Corky Hull M.D.

Next Scheduled Appointment:

Date	Time	Provider	Specialty
7/8/2008	10:20 AM	Dixon, Mike	Occupational Health Services

- 2 PT left — RTC [illegible] wk

\# TENS unit

- brace

- meds: [illegible] / [illegible] [illegible] @ home

Printed. 6/30/2008

Employer Copy

Dameron Hospital Occupational Health Services
420 W Acacia St , Stockton, CA 95203 209-461-3196 209-461-3123

WORK STATUS REPORT

Employee:	Tiffany Anderson	**Exam Date:**	06/23/2008
Employee ID:	549-23-5133	**Time In:**	07:06 AM
Employer:	SJ Mosquito & Vector Control	**Guarantor:**	AIMS-SACTO 8049
Date of Injury:	6/19/2008	**Claim No:**	

Work Status: MODIFIED WORK DUTIES
Effective 06/23/2008 to 06/30/2008

Work Restrictions: WORK RESTRICTIONS: No squatting, kneeling or crawling. No climbing ladders. Wear splint/brace as directed. No prolonged standing or walking.

Diagnosis: Knee effusion, Right
Sprain/strain knee, cruciate ligament

Evaluating Clinician: Mike Dixon PA-C
Donald Rossman M.D.

***Request for Treatment Authorization**

Date of Request	Treatment	Status
06/23/2008	PT/OT OFFSITE	Finished

* A separate "Request for Treatment Authorization" with supporting documentation will be submitted to the Claims Examiner

Next Scheduled Appointment:

Date	Time	Provider	Specialty
6/30/2008	10:00 AM	Dixon, Mike	Occupational Health Services

Printed 6/23/2008

Employer Copy

Dameron Hospital Occupational Health Services
420 W. Acacia St[redacted], Stockton, CA 95203 209-461-3196 FAX 209-461-3123

WORK STATUS REPORT

Employee:	Tiffany Anderson	**Exam Date:**	06/20/2008
Employee ID:	549-23-5133	**Time In:**	07:58 AM **Time Out:** 09:41 AM
Employer:	SJ Mosquito & Vector Control	**Guarantor:**	AIMS-SACTO 8049
Date of Injury:	6/19/2008	**Claim No:**	

Work Status: MODIFIED WORK DUTIES
Effective 06/20/2008 to 06/23/2008

Work Restrictions: WORK RESTRICTIONS: *No squatting, kneeling or crawling. No climbing ladders. Wear splint/brace as directed. No prolonged standing or walking.*

Patient Injury Description: CHIEF COMPLAINT: Tiffany states that on June 19, 2008, while working for SJ Mosquito & Vector Control, she injured the right leg while she was climbing up and down the bed of the truck for two days.

Diagnosis: Knee effusion, Right
Sprain/strain knee, cruciate ligament

Evaluating Clinician: Mike Dixon PA-C
Donald Rossman M.D.

***Medical Services:** Propoxyphene/Aceta 100-650mg
X-ray - Knee, Complete RIGHT
Knee - Brace (Vega)

*This is a general overview of the visit, it is not a complete list of billable services

Treatment Level: Consistent with California Labor Code definition of **MEDICAL TREATMENT**

Causation:

Next Scheduled Appointment:

Date	Time	Provider	Specialty
6/23/2008	07:00 AM	Dixon, Mike	Occupational Health Services

PT 3x2 (PT/OT)

PRE 1 wk

meds / brace

Printed 6/20/2008

Employer Copy

Dameron Hospital Occupational Health Servic

Flow Sheet

Appt Date & Time: 6/20/2008 WCN
Appt Time: 08:10 Walk In
Arrival Time: 07:58
Time Called:
Staff ID. WALK-IN

Patient Anderson, Tiffany Job.
Patient ID 549-23-5133 Company ID SJMOSQUI
Med Rec #
Phone 209-333-1037 DOB 8/22/1970
Address 1416 Iris Dr #7 Age. 37
Lodi CA 95242

Company: SJ Mosquito & Vector Control
Contact: John Stroh
Phone: 209-982-4675 Fax. 209-982-0120
Address: 7759 S Airport Way
Stockton, CA 95206

Patient Notes **AUTH GIVEN BY ED LUCHESSI 6/20/2008 07:57 AM - FROJAS**

Insurance
Ins Plan AIMS-SACTO 8049
Adjuster

Address *PO BOX 269120, Sacramento, CA 95826*
Phone 916-563-1900 Fax. 916-563-1919

ICD9 Code(s)
Diagnosis
Accident Description
Physician ID HULL
Injury Date 6/19/2008 Injury ID 1 Treatment ID 1
Physician Assigned Wk Status Unknown

Location ID: DHA
Length of Care. 0 days Target 0 days

Work Comp - New Injury
Notes

WNC (SJMOSQUI)

Completed By	Orders	Qty	Fee Code	Discount Price	Billed By
	WC New Injury	1.00		0 00	
	Breath Alcohol Test - Co Req Invoice To CO SJMOSQUI	1 00	BAT	20 00	
	UDS Collection - Co Req Invoice To CO SJMOSQUI	1 00	DSCOLL	20 00	
	UDS Collection - ER Invoice To CO SJMOSQUI	1 00	DSCOLLER	20.00	
	Drug Screen - DOT 5 Panel - Co Req Invoice To CO SJMOSQUI	1 00	DSDOT5	13 50	
	Obtain copy of DWC-1	1 00		0 00	
	Interpreter Fee	1.00	INTERPRE	0.00	
	Work Status Report	1 00		0 00	
	Patient Aftercare Instructions	1 00		0 00	
	Employer Instructions - Work Comp	1 00		0.00	

****

CHECK IN
Treatment Authorization 982-4675
1 John Stroh
2 Carol Aksland
3 Eddie Lucchesi

Discharged By _____ *Time Out.* _____ *Invoice #.* _____ *Net Total:* _____ *Batch #.* _____

Appointment ID 74037

Invoice #. _____ *Net Total.* _____ *Batch #:* _____

O \REPORTS\ORDERS\Flow Sheet and Forms_v7 23#0397

Dameron Hospital Occupational Health Servic

Flow Sheet

Appt Date & Time: 6/20/2008 WCN
Appt Time: 08:10 Walk In
Arrival Time: 07:58
Time Called:
Staff ID. WALK-IN

Patient Anderson, Tiffany
Patient ID 549-23-5133
Med Rec #
Phone 209-333-1037
Address 1416 Iris Dr #7
Lodi CA 95242

Job:
Company ID SJMOSQUI
DOB: 8/22/1970
Age: 37

Company. SJ Mosquito & Vector Control
Contact. John Stroh
Phone. 209-982-4675 Fax: 209-982-0120
Address. 7759 S Airport Way
Stockton, CA 95206

DRUG & ALCOHOL TESTING
* None

* Company may request. DOT UDS & BAT
* Lab Quest, Test #35304N, Client #76337

OTHER EMPLOYER-SPECIFIC INSTRUCTIONS
* None

****

CHECK OUT
WORK STATUS
* Fax work status to Eddie Lucchesi, 982-0120

OTHER EMPLOYER-SPECIFIC INSTRUCTIONS
* Verbal positive results to Anyone in the treatment authorization

****

EMERGENCY ROOM INSTRUCTIONS
1 Page OHS staff @ 461-1302 BEFORE patient is seen
2 Obtain Treatment Authorization
3 Complete UDS and/or BAT per Check-In instructions
4 Discharge Give copy of work status, COC & BAT to patient

NOTE a '*' next to a price indicates the price shown is different than the standard price

$73.50

Discharged By _____ *Time Out.* _____ *Invoice #:* _____ *Net Total:* _____ *Batch #* _____

Invoice #: _____ *Net Total:* _____ *Batch #* _____

Appointment ID 74037

O:\REPORTS\ORDERS\Flow Sheet and Forms_v7 23#0397

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION

Name **Anderson, Tiffany** Date: **06/20/2008**

DOB **08/22/1970**

CONSENT

I hereby authorize the Dameron Hospital Occupational Health Department to:

- ☑ Obtain a complete medical history and physical examination including any required medical tests
- ☑ Provide medical treatment for a work-related injury
- ☐ Obtain a urine specimen and/or breath sample for drug and/or alcohol testing

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I hereby authorize the Dameron Hospital Occupational Health Department to furnish to an agent, designee or representative of ***SJ Mosquito & Vector Control*** the results of my medical evaluation and/or treatment including past or present records pertaining to employment history, medical history, test results, urine drug and/or breath alcohol test results, services rendered or treatment provided to me

USE

I understand that this medical information will be used for the purpose of determining my ability to perform the essential functions of my job with ***SJ Mosquito & Vector Control***

RESTRICTIONS

I understand that ***SJ Mosquito & Vector Cont*** may use these medical records only for employment-related purposes and that they may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

DURATION

This authorization is effective immediately and shall remain in effect for one year from: ***06/20/2008***

ADDITIONAL COPY

I understand that I have a right to receive a copy of this form and that a copy of this document is as valid as the original

I would like a copy of this form. ☐ Yes ☐ No

Received: ☐ Yes ☐ No Initial _____

Date **06/20/2008**

Employee signature

Witness Signature

Non-DOT Drug Screens Only

List current meds: ☐ None

Rx: _____

OTC: _____

DAMERON HOSPITAL Occupational Health Services
420 West Acacia Street, Suite ..., Stockton, CA 95203 (209) 461-3... Fax: (209) 461-3123

Follow Up Appointments

While you are recovering from your injury, we want to make your visits to our facility as convenient as possible with minimal waiting times. To help us achieve this goal, we ask that you please follow these basic guidelines:

1. **Please arrive to your appointment on time.**
2. **If possible, please do not bring children or more than one family member to your appointment.**
3. **If you need to change your appointment, please call us as soon as possible.**
4. **If you do not keep your appointment, we must assume that you have recovered from your injury and you will be returned to full work duties until you return for a follow up visit.**

Following these guidelines will avoid unnecessary delays for all of our patients and keep your waiting time to a minimum. Thank you for helping us to make your visits as pleasant and convenient as possible.

If you have *ANY* questions about these guidelines, please do not hesitate to ask.

Please sign below indicating that these guidelines were explained to you and that all your questions were answered.

Patient Signature 6-20-80 *Date*

Name.

Case No

Dameron Hospital Occupational Health Services				(209) 461-3196
PATIENT NAME	SSN	BIRTH DATE	INJURY DATE	VISIT DATE
Tiffany Anderson	549-23-5133	08/22/1970	06/19/2008	8/12/2008
PRACTITIONER NAME				
Mike Dixon, PA-C	Donald Rossman, M.D.			

CHIEF COMPLAINT: Tiffany states that on June 19, 2008, while working for SJ Mosquito & Vector Control, she injured the right leg while she was climbing up and down the bed of the truck for two days

HISTORY OF PRESENT ILLNESS: This is a follow-up visit for Tiffany Anderson, a 37 year-old Pesticide Applicator, whose primary complaint is pain, stiffness and swelling located in the right leg. She describes it as "throbbing" pain and "burning" pain. She considers it to be unbearable. Tiffany says that it seems to be present on a constant basis and varies with her activity levels. She has noticed that it is made worse by walking. It is improved with PT Her pain level is 3/10. Patient is here for a recheck. She states her pain level today is a 6/10. Her knee is bothered most with prolonged standing. She states that she is improved with ice and PT. She states that she takes her medications as prescribed.

REVIEW OF SYSTEMS: General Health: Good. Constitutional: Negative for fever, malaise. Eyes: Negative for recent change in vision. Cardiovascular: Negative for chest pain, heart trouble Respiratory: Negative for cough, shortness of breath, wheezing Gastrointestinal: Negative for abdominal pain, diarrhea, heartburn, nausea. Genitourinary. Negative for kidney disease Musculoskeletal: Negative for joint pain, joint stiffness, joint swelling. Neurological: Negative for headache Psychiatric Negative for anxiety, depression, difficulty sleeping. Hematologic. Negative for blood disorder, anemia

PAST, FAMILY AND SOCIAL HISTORY: Major Surgery None Marital Status: She is currently not married. Employment Status: She is currently employed in a full time position Other Employment. None.

CURRENT MEDICATIONS: Ibuprofen and Birth Control Pills

ALLERGIES None Known

PHYSICAL EXAMINATION:

General She appears to be in good general health. Gait is slightly antalgic due to intermittent right knee joint swelling There is no sign of pain while at rest. She appears to have pain with movement of the right knee

Right Knee Bruising is absent Deformity of the knee is not present Iliotibial band palpation causes no pain. Joint crepitus is absent Joint effusion is present. Movement of the knee causes pain with full flexion and extension, she is unable to kneel or squat due to pain and swelling right knee joint Patellar tendon is tender. Prepatellar bursa is tender Quadriceps appears weaker on the right when compared to the left. Range of motion is limited, unable to fully extend or flex Scarring is not present The knee is stable. Tenderness to palpation is present in the popliteal space. Now that the joint effusion has decreased, she has developed a slightly positive Mc Murray's consistent with a possible meniscal tear.

DIAGNOSIS. 1 Knee effusion, Right (719 06) 2. Anterior Cruciate Ligament Sprain, Right (844.2).

MEDICAL DECISION MAKING. Transfer care to Dr Murata IOT proceed with surgery to the right knee.

MEDICAL CAUSATION: Based on the available information, this appears to be a work-related condition.

WORK STATUS: MODIFIED work duties.

WORK RESTRICTIONS: No squatting, kneeling or crawling. No climbing ladders. Wear splint/brace as directed. No prolonged standing or walking.

Dameron Hospital Occupational Health Services				(209) 461-3196
PATIENT NAME	SSN	BIRTH DATE	INJURY DATE	VISIT DATE
Tiffany Anderson	549-23-5133	08/22/1970	06/19/2008	8/5/2008
PRACTITIONER NAME				
Mike Dixon, PA-C	Donald Rossman, M.D.			

CHIEF COMPLAINT: Tiffany states that on June 19, 2008, while working for SJ Mosquito & Vector Control, she injured the right leg while she was climbing up and down the bed of the truck for two days.

HISTORY OF PRESENT ILLNESS: This is a follow-up visit for Tiffany Anderson, a 37 year-old Pesticide Applicator, whose primary complaint is pain, stiffness and swelling located in the right leg. She describes it as "throbbing" pain and "burning" pain. She considers it to be unbearable. Tiffany says that it seems to be present on a constant basis and varies with her activity levels. She has noticed that it is made worse by walking. It is improved with PT. Her pain level is 3/10. Patient states that when she attempts to exercise her leg it swells up. She states her pain level is a 3/10 and she takes her medications as prescribed and they help her a lot.

REVIEW OF SYSTEMS: General Health: Good. Constitutional: Negative for fever, malaise. Eyes: Negative for recent change in vision. Cardiovascular: Negative for chest pain, heart trouble. Respiratory: Negative for cough, shortness of breath, wheezing. Gastrointestinal: Negative for abdominal pain, diarrhea, heartburn, nausea. Genitourinary: Negative for kidney disease. Musculoskeletal: Negative for joint pain, joint stiffness, joint swelling Neurological: Negative for headache. Psychiatric: Negative for anxiety, depression, difficulty sleeping. Hematologic: Negative for blood disorder, anemia.

PAST, FAMILY AND SOCIAL HISTORY: Major Surgery: None Marital Status: She is currently not married. Employment Status: She is currently employed in a full time position. Other Employment: None

CURRENT MEDICATIONS Ibuprofen and Birth Control Pills

ALLERGIES: None Known

PHYSICAL EXAMINATION:

General She appears to be in good general health. Gait is slightly antalgic due to intermittent right knee joint swelling. There is no sign of pain while at rest. She appears to have pain with movement of the right knee.

Right Knee. Bruising is absent. Deformity of the knee is not present. Iliotibial band palpation causes no pain. Joint crepitus is absent Joint effusion is present. Movement of the knee causes pain with full flexion and extension, she is unable to kneel or squat due to pain and swelling right knee joint Patellar tendon is tender. Prepatellar bursa is tender Quadriceps appears weaker on the right when compared to the left. Range of motion is limited, unable to fully extend or flex. Scarring is not present The knee is stable Tenderness to palpation is present in the popliteal space. Now that the joint effusion has decreased, she has developed a slightly positive Mc Murray's consistent with a possible meniscal tear.

DIAGNOSIS. 1 Knee effusion, Right (719 06). 2 Anterior Cruciate Ligament Sprain, Right (844 2)

MEDICAL DECISION MAKING. NSC. We will review her case with the carrier today. RTC 1 week. CCTxP, she will see Dr Murata on 08-06-08 for ortho consult.

MEDICAL CAUSATION: Based on the available information, this appears to be a work-related condition.

WORK STATUS: MODIFIED work duties.

WORK RESTRICTIONS: No squatting, kneeling or crawling. No climbing ladders. Wear splint/brace as directed. No prolonged standing or walking.

Dameron Hospital Occupational Health Services				(209) 461-3196
PATIENT NAME	SSN	BIRTH DATE	INJURY DATE	VISIT DATE
Tiffany Anderson	549-23-5133	08/22/1970	06/19/2008	7/29/2008
PRACTITIONER NAME				
Mike Dixon, PA-C	Donald Rossman, M.D.			

CHIEF COMPLAINT: Tiffany states that on June 19, 2008, while working for SJ Mosquito & Vector Control, she injured the right leg while she was climbing up and down the bed of the truck for two days.

HISTORY OF PRESENT ILLNESS: This is a follow-up visit for Tiffany Anderson, a 37 year-old Pesticide Applicator, whose primary complaint is pain, stiffness and swelling located in the right leg. She describes it as "throbbing" pain and "burning" pain. She considers it to be unbearable. Tiffany says that it seems to be present on a constant basis and varies with her activity levels. She has noticed that it is made worse by walking. It is improved with PT. Her pain level is 10/10. Patient states she has noticed no improvement since last visit Current Treatment: Medication (Prescription). She is taking Ibuprofen and is unsure if its helping reduce her symptoms. Patient denies numbness/tingling sensations She states she is currently not working because her employer cannot accommodate her work restrictions. Physical Therapy. She states the physical therapy has helped to improve her symptoms.

REVIEW OF SYSTEMS: General Health: Good. Constitutional: Negative for fever, malaise. Eyes: Negative for recent change in vision. Cardiovascular: Negative for chest pain, heart trouble. Respiratory: Negative for cough, shortness of breath, wheezing. Gastrointestinal: Negative for abdominal pain, diarrhea, heartburn, nausea. Genitourinary: Negative for kidney disease. Musculoskeletal: Negative for joint pain, joint stiffness, joint swelling. Neurological: Negative for headache. Psychiatric: Negative for anxiety, depression, difficulty sleeping Hematologic: Negative for blood disorder, anemia.

PAST, FAMILY AND SOCIAL HISTORY: Major Surgery: None. Marital Status: She is currently not married Employment Status: She is currently employed in a full time position. Other Employment: None.

CURRENT MEDICATIONS: Ibuprofen and Birth Control Pills

ALLERGIES: None Known

PHYSICAL EXAMINATION:

General: She appears to be in good general health. Gait is slightly antalgic due to intermittent right knee joint swelling. There is no sign of pain while at rest. She appears to have pain with movement of the right knee

Right Knee: Bruising is absent. Deformity of the knee is not present. Iliotibial band palpation causes no pain Joint crepitus is absent Joint effusion is present Movement of the knee causes pain with full flexion and extension; she is unable to kneel or squat due to pain and swelling right knee joint Patellar tendon is tender Prepatellar bursa is tender. Quadriceps appears weaker on the right when compared to the left Range of motion is limited; unable to fully extend or flex. Scarring is not present The knee is stable Tenderness to palpation is present in the popliteal space. Now that the joint effusion has decreased, she has developed a slightly positive Mc Murray's consistent with a possible meniscal tear.

DIAGNOSIS. 1. Knee effusion, Right (719.06). 2. Anterior Cruciate Ligament Sprain, Right (844.2)

MEDICAL DECISION MAKING: Request orthopedic surgeon consult due to positive MRI of the right knee for medial meniscal tear. CCTxP, refilled meds, completed paperwork for disability RTC 7-10 days.

PRESCRIPTIONS: Tiffany has been prescribed the following: (RX1) Propoxyphene/APAP Dosage: 100 mg./650 mg. Dispense: 20 Instructions: One tablet every four hours as needed for pain. Refills: None. She has been instructed in medication use and side effects. She has been instructed of the impact medication (Propoxyphene/APAP) has on driving and machine operation.

MEDICAL CAUSATION: Based on the available information, this appears to be a work-related condition.

WORK STATUS: MODIFIED work duties.

WORK RESTRICTIONS: No squatting, kneeling or crawling. No climbing ladders. Wear splint/brace as directed. No prolonged standing or walking.

Dameron Hospital Occupational Health Services (209) 461-3198

PATIENT NAME	SSN	BIRTH DATE	INJURY DATE	VISIT DATE
Tiffany Anderson	549-23-5133	08/22/1970	06/19/2008	7/22/2008

PRACTITIONER NAME	
Mike Dixon, PA-C	Donald Rossman, M D

CHIEF COMPLAINT: Tiffany states that on June 19, 2008, while working for SJ Mosquito & Vector Control, she injured the right leg while she was climbing up and down the bed of the truck for two days.

HISTORY OF PRESENT ILLNESS: This is a follow-up visit for Tiffany Anderson, a 37 year-old Pesticide Applicator, whose primary complaint is pain, stiffness and swelling located in the right leg. She describes it as "throbbing" pain and "burning" pain She considers it to be unbearable Tiffany says that it seems to be present on a constant basis and varies with her activity levels. She has noticed that it is made worse by walking. It is improved with PT. Her pain level is 10/10. Patient states she has noticed no improvement since last visit Current Treatment: Medication (Prescription) She is taking Ibuprofen and is unsure if its helping reduce her symptoms. Patient denies numbness/tingling sensations She states she is currently not working because her employer cannot accommodate her work restrictions. Physical Therapy. She states the physical therapy has helped to improve her symptoms.

REVIEW OF SYSTEMS: General Health. Good. Constitutional. Negative for fever, malaise. Eyes: Negative for recent change in vision. Cardiovascular: Negative for chest pain, heart trouble Respiratory. Negative for cough, shortness of breath, wheezing. Gastrointestinal: Negative for abdominal pain, diarrhea, heartburn, nausea. Genitourinary: Negative for kidney disease. Musculoskeletal: Negative for joint pain, joint stiffness, joint swelling. Neurological: Negative for headache. Psychiatric: Negative for anxiety, depression, difficulty sleeping Hematologic: Negative for blood disorder, anemia

PAST, FAMILY AND SOCIAL HISTORY Major Surgery. None Marital Status: She is currently not married Employment Status. She is currently employed in a full time position Other Employment None

CURRENT MEDICATIONS: Ibuprofen and Birth Control Pills

ALLERGIES: None Known

PHYSICAL EXAMINATION

General She appears to be in good general health Gait is slightly antalgic due to intermittent right knee joint swelling There is no sign of pain while at rest. She appears to have pain with movement of the right knee

Right Knee Bruising is absent. Deformity of the knee is not present. Iliotibial band palpation causes no pain Joint crepitus is absent Joint effusion is present. Movement of the knee causes pain with full flexion and extension, she is unable to kneel or squat due to pain and swelling right knee joint Patellar tendon is tender Prepatellar bursa is tender Quadriceps appears weaker on the right when compared to the left Range of motion is limited, unable to fully extend or flex. Scarring is not present. The knee is stable. Tenderness to palpation is present in the popliteal space. Now that the joint effusion has decreased, she has developed a slightly positive Mc Murray's consistent with a possible meniscal tear

DIAGNOSIS: 1 Knee effusion, Right (719.06). 2. Anterior Cruciate Ligament Sprain, Right (844.2).

MEDICAL DECISION MAKING: Request MRI of the right knee to R/O tear. RTC 1 week CCTxP Finish PT.

PRESCRIPTIONS: Tiffany has been prescribed the following: (RX1) Ibuprofen Dosage: 800 mg Dispense: 90 Instructions: 1 tab PO tid prn Refills: None. She has been instructed in medication use and side effects.

MEDICAL CAUSATION: Based on the available information, this appears to be a work-related condition.

WORK STATUS: MODIFIED work duties.

WORK RESTRICTIONS: No squatting, kneeling or crawling. No climbing ladders Wear splint/brace as directed. No prolonged standing or walking.

Dameron Hospital Occupational Health Services				(209) 481-3196
PATIENT NAME	**SSN**	**BIRTH DATE**	**INJURY DATE**	**VISIT DATE**
Tiffany Anderson	549-23-5133	08/22/1970	06/19/2008	7/15/2008
PRACTITIONER NAME				
Mike Dixon, PA-C	Donald Rossman, M.D.			

CHIEF COMPLAINT: Tiffany states that on June 19, 2008, while working for SJ Mosquito & Vector Control, she injured the right leg while she was climbing up and down the bed of the truck for two days.

HISTORY OF PRESENT ILLNESS: This is a follow-up visit for Tiffany Anderson, a 37 year-old Pesticide Applicator, whose primary complaint is pain, stiffness and swelling located in the right leg. She describes it as "throbbing" pain and "burning" pain. She considers it to be unbearable. Tiffany says that it seems to be present on a constant basis and varies with her activity levels She has noticed that it is made worse by walking. It is improved with PT. Her pain level is 10/10. Patient states she has noticed no improvement since last visit. Current Treatment: Medication (Prescription). She is taking Ibuprofen and is unsure if its helping reduce her symptoms. Patient denies numbness/tingling sensations She states she is currently not working because her employer cannot accommodate her work restrictions. Physical Therapy. She states the physical therapy has helped to improve her symptoms.

REVIEW OF SYSTEMS: General Health. Good Constitutional· Negative for fever, malaise Eyes· Negative for recent change in vision. Cardiovascular: Negative for chest pain, heart trouble. Respiratory Negative for cough, shortness of breath, wheezing. Gastrointestinal. Negative for abdominal pain, diarrhea, heartburn, nausea. Genitourinary: Negative for kidney disease. Musculoskeletal: Negative for joint pain, joint stiffness, joint swelling. Neurological· Negative for headache. Psychiatric Negative for anxiety, depression, difficulty sleeping. Hematologic: Negative for blood disorder, anemia

PAST, FAMILY AND SOCIAL HISTORY. Major Surgery: None Marital Status She is currently not married Employment Status· She is currently employed in a full time position. Other Employment None

CURRENT MEDICATIONS Ibuprofen and Birth Control Pills

ALLERGIES: None Known

PHYSICAL EXAMINATION·

General· She appears to be in good general health. Gait is slightly antalgic due to intermittent right knee joint swelling. There is no sign of pain while at rest She appears to have pain with movement of the right knee

Right Knee Bruising is absent. Deformity of the knee is not present Iliotibial band palpation causes no pain Joint crepitus is absent. Joint effusion is present. Movement of the knee causes pain with full flexion and extension, she is unable to kneel or squat due to pain and swelling right knee joint. Patellar tendon is tender. Prepatellar bursa is tender Quadriceps appears weaker on the right when compared to the left. Range of motion is limited with full extension and flexion. Scarring is not present The knee is stable Tenderness to palpation is present in the popliteal space. Mc Murray's test is negative.

DIAGNOSIS. 1 Knee effusion, Right (719.06) 2. Anterior Cruciate Ligament Sprain, Right (844.2).

MEDICAL DECISION MAKING This is a follow up visit for this medical condition. Overall, the patient's medical condition appears to be worsening. Current treatment includes medications, physical therapy and a home exercise program. I've directed Tiffany to continue physical therapy. I have prescribed the therapist to provide evaluation and treatment. I expect the duration of this therapy to be two weeks. The frequency of therapy treatments should be three times a week. Patient will be taking PT script off-site in Lodi. Knee brace prn. RTC 1 week.

PRESCRIPTIONS: Tiffany has been prescribed the following: (RX1) Propoxyphene/APAP Dosage. 100 mg /650 mg Dispense: 10 Instructions: One tablet every four hours as needed for pain. Refills: None She has been instructed in medication use and side effects She has been instructed of the impact medication (Propoxyphene/APAP) has on driving and machine operation.

MEDICAL CAUSATION: Based on the available information, this appears to be a work-related condition

WORK STATUS: MODIFIED work duties.

WORK RESTRICTIONS: No squatting, kneeling or crawling. No climbing ladders. Wear splint/brace as directed No prolonged standing or walking.

Dameron Hospital Occupational Health Services				(209) 461-3196
PATIENT NAME	SSN	BIRTH DATE	INJURY DATE	VISIT DATE
Tiffany Anderson	549-23-5133	08/22/1970	06/19/2008	7/3/2008
PRACTITIONER NAME				
Mike Dixon, PA-C	Donald Rossman, M.D.			

CHIEF COMPLAINT: Tiffany states that on June 19, 2008, while working for SJ Mosquito & Vector Control, she injured the right leg while she was climbing up and down the bed of the truck for two days.

HISTORY OF PRESENT ILLNESS: This is a follow-up visit for Tiffany Anderson, a 37 year-old Pesticide Applicator, whose primary complaint is pain, stiffness and swelling located in the right leg. She describes it as "throbbing" pain. She considers it to be mild. Tiffany says that it seems to be present on a occasional basis and varies with her activity levels. She has noticed that it is made worse by walking. It is improved with PT. Her pain level is 3/10. Patient states she has noticed an improvement since last visit. Current Treatment: Medication (Prescription). She is taking Ibuprofen and is unsure if its helping reduce her symptoms. Patient denies numbness/tingling sensations She states she is currently not working because her employer cannot accommodate her work restrictions. Physical Therapy. She states the physical therapy has helped to improve her symptoms.

REVIEW OF SYSTEMS: General Health: Good. Constitutional: Negative for fever, malaise. Eyes: Negative for recent change in vision. Cardiovascular: Negative for chest pain, heart trouble. Respiratory: Negative for cough, shortness of breath, wheezing. Gastrointestinal Negative for abdominal pain, diarrhea, heartburn, nausea. Genitourinary: Negative for kidney disease. Musculoskeletal. Negative for joint pain, joint stiffness, joint swelling. Neurological: Negative for headache. Psychiatric: Negative for anxiety, depression, difficulty sleeping. Hematologic: Negative for blood disorder, anemia

PAST, FAMILY AND SOCIAL HISTORY: Major Surgery: None. Marital Status: She is currently not married. Employment Status: She is currently employed in a full time position. Other Employment: None.

CURRENT MEDICATIONS: Ibuprofen and Birth Control Pills

ALLERGIES: None Known

PHYSICAL EXAMINATION:

General. She appears to be in good general health Gait is slightly antalgic due to intermittent right knee joint swelling There is no sign of pain while at rest She appears to have pain with movement of the right knee

Right Knee: Bruising is absent. Deformity of the knee is not present. Iliotibial band palpation causes no pain Joint crepitus is absent. Joint effusion is present Movement of the knee causes pain with full flexion and extension, she is unable to kneel or squat due to pain and swelling right knee joint Patellar tendon is tender Prepatellar bursa is tender Quadriceps appears weaker on the right when compared to the left. Range of motion is limited with full extension and flexion. Scarring is not present. The knee is stable. Tenderness to palpation is present in the popliteal space. Mc Murray's test is negative.

DIAGNOSIS: 1 Knee effusion, Right (719.06) 2. Anterior Cruciate Ligament Sprain, Right (844 2)

MEDICAL DECISION MAKING: Add TENS unit to help decrease pain and swelling and increase muscle strength and flexibility. RTC 1 week Finish PT (2 left) She has Ibp 800mg at home. Knee brace as directed. She is off work due to no modified duty at work

MEDICAL CAUSATION: Based on the available information, this appears to be a work-related condition.

WORK STATUS: MODIFIED work duties

WORK RESTRICTIONS: No squatting, kneeling or crawling. No climbing ladders. Wear splint/brace as directed. No prolonged standing or walking.

AFTERCARE INSTRUCTIONS: Finish physical therapy.

Dameron Hospital Occupational Health Services

PATIENT NAME	SSN	BIRTH DATE	INJURY DATE	VISIT DATE
Tiffany Anderson	549-23-5133	08/22/1970	06/19/2008	6/30/2008

PRACTITIONER NAME	
Dan Stringan PA-C, PA11862.	Donald Rossman, M.D.

CHIEF COMPLAINT: Tiffany states that on June 19, 2008, while working for SJ Mosquito & Vector Control, she injured the right leg while she was climbing up and down the bed of the truck for two days.

HISTORY OF PRESENT ILLNESS: This is a follow-up visit for Tiffany Anderson, a 37 year-old Pesticide Applicator, whose primary complaint is pain, stiffness and swelling located in the right leg. She describes it as "throbbing" pain She considers it to be mild. Tiffany says that it seems to be present on a occasional basis and varies with her activity levels. She has noticed that it is made worse by walking It is improved with PT. Her pain level is 3/10. Patient states she has noticed an improvement since last visit. Current Treatment: Medication (Prescription) She is taking Ibuprofen and is unsure if its helping reduce her symptoms. Patient denies numbness/tingling sensations She states she is currently not working because her employer cannot accommodate her work restrictions. Physical Therapy She states the physical therapy has helped to improve her symptoms.

REVIEW OF SYSTEMS: General Health: Good. Constitutional: Negative for fever, malaise. Eyes: Negative for recent change in vision. Cardiovascular: Negative for chest pain, heart trouble. Respiratory: Negative for cough, shortness of breath, wheezing. Gastrointestinal. Negative for abdominal pain, diarrhea, heartburn, nausea Genitourinary: Negative for kidney disease. Musculoskeletal: Negative for joint pain, joint stiffness, joint swelling Neurological: Negative for headache Psychiatric: Negative for anxiety, depression, difficulty sleeping Hematologic: Negative for blood disorder, anemia.

PAST, FAMILY AND SOCIAL HISTORY: Major Surgery: None. Marital Status She is currently not married. Employment Status: She is currently employed in a full time position. Other Employment: None.

CURRENT MEDICATIONS. Ibuprofen and Birth Control Pills

ALLERGIES None Known

PHYSICAL EXAMINATION:

General: She appears to be in good general health Gait is fluid without sign of pain. There is no sign of pain while at rest. She does not appear to have any pain with movement

Right Knee Bruising is absent. Deformity of the knee is not present. Iliotibial band palpation causes no pain. Joint crepitus is absent. Joint effusion is not present. Movement of the knee does not cause pain. Patellar tendon is tender. Prepatellar bursa is tender. Quadriceps appears normal. Range of motion is normal. Scarring is not present The knee is stable. Tenderness to palpation is not present. Mc Murray's test is negative.

DIAGNOSIS: 1 Knee effusion, Right (719.06) 2 Anterior Cruciate Ligament Sprain, Right (844.2).

MEDICAL DECISION MAKING: This is a follow up visit for this medical condition. Overall, the patient's condition is improving as expected. Treatment Plan - Complete current course of physical therapy; discontinue knee support, continue other treatment measures. Disposition - Patient is improving with the current treatment plan, anticipate return to full work duties at the next visit.

MEDICAL CAUSATION. Based on the available information, this appears to be a work-related condition.

WORK STATUS: MODIFIED work duties.

WORK RESTRICTIONS: No squatting, kneeling or crawling. No climbing ladders. Wear splint/brace as directed. No prolonged standing or walking.

AFTERCARE INSTRUCTIONS: Start physical therapy.

Dameron Hospital Occupational Health Services (209) 461-3196

PATIENT NAME	SSN	BIRTH DATE	INJURY DATE	VISIT DATE
Tiffany Anderson	549-23-5133	08/22/1970	06/19/2008	6/23/2008

PRACTITIONER NAME	
Mike Dixon, PA-C	Donald Rossman, M.D.

CHIEF COMPLAINT: Tiffany states that on June 19, 2008, while working for SJ Mosquito & Vector Control, she injured the right leg while she was climbing up and down the bed of the truck for two days.

HISTORY OF PRESENT ILLNESS: This is a follow-up visit for Tiffany Anderson, a 37 year-old Pesticide Applicator, whose primary complaint is pain, stiffness and swelling located in the right leg. She describes it as a "shooting" pain and "pressure". She considers it to be moderate. Tiffany says that it seems to be present on a constant basis and varies with her activity levels She has noticed that it is made worse by walking. It is improved with nothing. She feels it is Rest 5/10 with activity 7/10. Her pain level is 5-7/10.

REVIEW OF SYSTEMS: General Health. Good Constitutional: Negative for fever, malaise Eyes: Negative for recent change in vision. Cardiovascular: Negative for chest pain, heart trouble. Respiratory. Negative for cough, shortness of breath, wheezing Gastrointestinal. Negative for abdominal pain, diarrhea, heartburn, nausea Genitourinary. Negative for kidney disease. Musculoskeletal: Negative for joint pain, joint stiffness, joint swelling. Neurological: Negative for headache. Psychiatric: Negative for anxiety, depression, difficulty sleeping. Hematologic. Negative for blood disorder, anemia.

PAST, FAMILY AND SOCIAL HISTORY. Major Surgery: None Marital Status: She is currently not married. Employment Status: She is currently employed in a full time position. Other Employment: None.

CURRENT MEDICATIONS: Ibuprofen and Birth Control Pills

ALLERGIES None Known

VITAL SIGNS Weight 145 pounds. Blood Pressure: 137/89. Pulse: 85/minute.

PHYSICAL EXAMINATION:

General Gait is antalgic. There are signs of mild discomfort while at rest. She appears to have moderate pain with movement

Right Knee Bruising is absent. Deformity of the knee is not present Iliotibial band palpation causes no pain. Joint effusion is present Movement of the knee causes pain. Range of motion is limited. Tenderness to palpation is present posteriorly.

DIAGNOSIS: 1. Knee effusion, Right (719 06) 2. Anterior Cruciate Ligament Sprain, Right (844 2).

MEDICAL DECISION MAKING: This is a follow up visit for this medical condition. Overall, the patient's condition remains unchanged. Current treatment includes medications, splint and a home exercise program. I've directed Tiffany to begin physical therapy at this time. I have prescribed the therapist to provide evaluation and treatment I expect the duration of this therapy to be two weeks. The frequency of therapy treatments should be three times a week RTC 1 week.

MEDICAL CAUSATION: Based on the available information, this appears to be a work-related condition.

WORK STATUS MODIFIED work duties.

WORK RESTRICTIONS: No squatting, kneeling or crawling. No climbing ladders. Wear splint/brace as directed. No prolonged standing or walking.

Dameron Hospital Occupational Health Services				(209) 461-3198
PATIENT NAME	SSN	BIRTH DATE	INJURY DATE	VISIT DATE
Tiffany Anderson	549-23-5133	08/22/1970	06/19/2008	6/20/2008
PRACTITIONER NAME				
Mike Dixon, PA-C	Donald Rossman, M.D.			

CHIEF COMPLAINT. Tiffany states that on June 19, 2008, while working for SJ Mosquito & Vector Control, she injured the right leg while she was climbing up and down the bed of the truck for two days.

HISTORY OF PRESENT ILLNESS. This is the initial visit for Tiffany Anderson, a 37 year-old Pesticide Applicator , whose primary complaint is pain, stiffness and swelling located in the right leg. She describes it as a "shooting" pain and "pressure". She considers it to be moderate. Tiffany says that it seems to be present on a constant basis and varies with her activity levels. She has noticed that it is made worse by walking. It is improved with nothing. She feels it is Rest 5/10 with activity 7/10. Her pain level is 5-7/10. She denies ever having a similar injury in the past. She states she has had a injury in the past, which was work-related. Tiffany states she had fell into a ditch full of pesticide and she ended up with a rash. She does not recall how long she was off of work because it was three years ago.

REVIEW OF SYSTEMS: General Health: Good. Constitutional: Negative for fever, malaise. Eyes: Negative for recent change in vision. Cardiovascular: Negative for chest pain, heart trouble. Respiratory: Negative for cough, shortness of breath, wheezing. Gastrointestinal: Negative for abdominal pain, diarrhea, heartburn, nausea. Genitourinary: Negative for kidney disease. Musculoskeletal. Negative for joint pain, joint stiffness, joint swelling. Neurological: Negative for headache. Psychiatric: Negative for anxiety, depression, difficulty sleeping. Hematologic: Negative for blood disorder, anemia.

PAST, FAMILY AND SOCIAL HISTORY. Major Surgery: None. Marital Status: She is currently not married. Employment Status. She is currently employed in a full time position. Other Employment. None.

CURRENT MEDICATIONS: Ibuprofen and Birth Control Pills

ALLERGIES: None Known

VITAL SIGNS: Weight: 145 pounds. Blood Pressure: 137/89 Sitting Pulse. 85/minute and Regular. Respirations 16/minute.

PHYSICAL EXAMINATION:

General: Gait is antalgic There are signs of mild discomfort while at rest. She appears to have moderate pain with movement

Right Knee: Bruising is absent Deformity of the knee is not present Iliotibial band palpation causes no pain. Joint effusion is present. Movement of the knee causes pain. Range of motion is limited Tenderness to palpation is present posteriorly

DIAGNOSIS: 1 Knee effusion, Right (719.06). 2 Anterior Cruciate Ligament Sprain, Right (844.2).

MEDICAL DECISION MAKING: This is the initial visit for this medical condition Current treatment includes medications, splint and a home exercise program RTC 2-3 days. Modified duty

PRESCRIPTIONS. Tiffany has been prescribed the following (RX1) Propoxyphene/APAP Dosage: 100 mg./650 mg. Dispense: 10 Instructions: One tablet every four hours as needed for pain Refills: None. She has been instructed in medication use and side effects. She has been instructed of the impact medication (Propoxyphene/APAP) has on driving and machine operation.

ALPINE ORTHOPAEDIC MEDICAL GROUP, INC.

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ANH X. LE, M.D.
ALAN T. KAWAGUCHI, M.D.
GARY M. ALIGRE, M.D.
VANESSA BEEMAN, PA-C

JAMES V. ROGHE, M.D.
1924-2001
EMERITUS
ROBERT M. HERMANN, M.D.
W. PAUL MOUCHON, M.D.

ANNE McGUNN, MS, FACHE
ADMINISTRATOR

August 07, 2008

Mike Dixon, P.A.
DAMERON INDUSTRIAL
525 West Acacia
Stockton, CA 95203

RE: Tiffany Anderson
DOI: 6/19/08
CLM: VE0700157

Dear Mr. Dixon:

I had the opportunity to see Ms. Anderson on August 7, 2008.

HISTORY
Ms. Anderson is a 37-year-old female with a chief complaint of right knee discomfort. The patient is employed as a vector control worker for San Joaquin County. Her job duties include repetitive, climbing, squatting, and walking. On June 19, 2008, she noted increasing right knee pain and swelling after climbing into a truck, walking on uneven terrain, and climbing two fences to avoid cows chasing her. She did not sustain an acute injury such as a fall or twisting her knee, but at the end of that day she noted increasing pain in her knee. Because of pain and swelling she was unable to continue working that day. She has not worked since this time No light duty is available. She has had some improvement taking Ibuprofen. She recently had an MRI of the knee. She is ambulatory without external supports.

Past Medical History:	She has no active medical problems. No history of cardiac disease, thyroid disease, or diabetes.
Current Medications:	Ibuprofen 2400 mg per day.
Allergies:	None to medications.
Review of Systems.	She has decreased hearing, urinary difficulty with starting urination, morning cough with shortness of breath, headaches, and anxiety.

ALPINE ORTHOPAEDIC MEDICAL GROUP, INC.

RE: Tiffany Anderson 2 **August 07, 2008**

PHYSICAL EXAMINATION
On physical examination about the right knee, she has mild effusion of her knee. Range of motion is guarded from 5-120 degrees. The ligaments are stable. She has a negative Lachman sign. She has 1+ patellofemoral crepitus; no prepatellar bursa.

X-RAYS
I reviewed the MRI and agree there appears to be a lateral meniscal tear. There is a large area of horizontal cleavage which appears to reach the joint surface on one view.

ASSESSMENT
Lateral meniscal tear of the right knee.

PLAN
I believe she has failed conservative treatment. She has had physical therapy as well as use of anti-inflammatories with continued pain and stiffness. The patient was given an arthroscopic booklet and I told her she is a candidate for arthroscopic surgery. Since she is only seen in consultation I have not given her a follow-up appointment. In the meantime she could perform sedentary work if available, avoiding climbing, squatting, and kneeling. Walking and standing should be limited to occasional. I would be happy to see he again if she is referred for further treatment.

Thank you for the opportunity to see your patient.

I have not violated Labor Code 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury. Dated 8/8/08, at San Joaquin County, CA.

Sincerely,

Gary T. Murata, M.D.

GTM/sh
Cc: AIMS
Post Office Box 269120
Sacramento, CA 95826

D: 08/07/08 T: 08/08/08

AIMS
ACCLAMATION INSURANCE MANAGEMENT SERVICES

AIMS Sacramento
Post Office Box 296120
Sacramento, California 95826
Telephone (916) 563-1900
Facsimile (916) 563-1919

Approval of Medical Authorization Request

Date 8-4-08

Dr Rossman
420 W Acacia St, Ste 2
Stockton, CA 95203

Sent via fax to 209-461-7529

RE	Injured Worker:	Tiffany Anderson
	Employer	Vector Control
	Date of Injury	6-19-08
	Claim Number	VE0700184
	Treatment Request	
	Date of Request	7-29-08
	Date of Receipt	7-29-08
	Type of Review	Prospective
	Disposition	Approved

Dear Dr Rossman:

After careful consideration approval is being extended as follows for the above captioned claim:

Consult with ortho surgeon

Approval is being extended with the following exceptions:

- Approved, but will be reimbursed at the appropriate reasonable rate for the procedure CPT code(s) listed.
- Full amount billed by all providers is not guaranteed for total reimbursement
- This authorization does not guarantee full payment for your service
- A recommended allowance will be based on what is accepted as fair and reasonable reimbursement for the same services and geographical area
- Add time for physical and occupational therapies is not approved

In order to expedite payment of these services, please attach a copy of this authorization letter to your billing, in addition to other required documents/reports If you have any questions regarding this approval please feel free to contact me at 916-563-1900 X 242

Sincerely,
Acclamation Insurance Management Services

Mackenzie Dawson
Claims Examiner

ACCLAMATION INSURANCE
MANAGEMENT SERVICES

07/08/2008

Tiffany Anderson
1416 Iris Drive #7
Lodi, CA 95242

Claim Number: VE0700184
Date of Injury: 06/19/2008
Employer: San Joaquin County VCD

NOTICE REGARDING TEMPORARY DISABILITY BENEFITS

Acclamation Insurance Management Services, Inc. is handling your workers' compensation claim on behalf of **San Joaquin County Mosquito Vector Control District**. This notice is to advise you of the status of temporary disability payments for your workers' compensation injury of **06/19/2008**.

Your first payment for temporary disability is being paid for the period of **06/20/2008 through 07/08/2008**. This benefit is not taxable and is paid to you for every day of a seven-day week while you are unable to work because of your injury. However, benefits are not paid for the first three days of disability unless you were hospitalized or you are disabled for more than 14 days.

Your weekly compensation rate is **$612.23** based on your earnings of **$918.34** per week You may receive less if you are earning partial wages.

An Application for Adjudication must be filed with the Workers' Compensation Appeals Board within one year of the date of injury if no benefits, compensation or medical treatment has been furnished. If you have been furnished benefits, compensation or medical treatment, an Application for Adjudication must be filed within one year after the date of the last payment or provision of benefits or within five years from the date of injury, whichever is later. Failure to meet these requirements could bar your rights to further compensation by operation of law.

The State of California requires that you be given the following information: *If you disagree with the decision, you may consult with a State Information and Assistance Officer at 1-800-736-7401 or call your local Information and Assistance Officer at 1-916-263-2741 You may also consult with and be represented by an attorney, and/or apply to have your case heard by the Workers' Compensation Appeals Board*

Please review the enclosed pamphlet for a full explanation of workers' compensation benefits. If you have any questions, call me at 916-563-1900.

Sincerely,

Mackenzie Dawson,
Examiner

Enc. TD Fact Sheet

PO Box 269120
Sacramento, CA 95826-9120
916/563-1900 Fax 916/563-1919
www.aims4claims.com
CAL LIC. 2772984

ACCLAMATION INSURANCE
MANAGEMENT SERVICES

07/11/2008

Tiffany Anderson
1416 Iris Drive #7
Lodi, CA 95242

Claim Number: VE0700184
Employee. Tiffany Anderson
Employer: San Joaquin County MVCD
Date of Injury. 06/19/2008

NOTICE OF DELAY IN DETERMINING LIABILITY FOR WORKERS' COMPENSATION BENEFITS

Dear Ms Anderson:

Acclamation Insurance Management Services, (AIMS) is handling your workers' compensation claim on behalf of your employer. At this time we are unable to determine whether you are eligible for workers' compensation benefits. In order to make a decision, we need to investigate liability or obtain additional factual and medical information regarding this injury. Your cooperation is required to complete this investigation in a timely manner. We will need your recorded statement and all medical records. Please complete the attached medical history and authorization and return to our office at you earliest opportunity. We will notify you of our decision on or before 10/08/2008.

For injuries which occur on or after January 1, 1990, there is a legal presumption before the Workers' Compensation Appeals Board that your claim is compensable if it is not denied within 90 days of your returning an Employee Claim Form to your employer. The presumption can be rebutted only with information that could not be discovered within the 90 day period

Notice pursuant to LC 5402(c): Within one working day after an employee files a claim form under LC 5401, the employer shall authorize the provisions of all treatment consistent with LC 5307 27 or the American College of Occupational and Environmental Medicine's guidelines for the alleged injury and shall continue to provide the treatment until the date that liability for the claim is accepted or denied. Until the date the claim is accepted or denied, liability for medical treatment shall be limited to ten thousand dollars ($10,000). If your claim is denied, we will seek reimbursement from your private health care insurance. As a result, your private insurance may contact you regarding your co-pay and/or deductible

Notice pursuant to LC 4062 1: Where the employee is not represented by an attorney the exclusive procedure for obtaining a medical legal exam is by panel QME Enclosed find IMC Form 106 "Request for a Qualified Medical Evaluator". Please complete this form and mail it to the Industrial Medical Council. You have 10 days from the issue date of this letter to request the panel. If you fail to act timely, we may request a panel. If you are represented by an attorney, LC 4062.1 does not apply If you have questions regarding the delay and investigation process for represented employees, please contact your attorney.

PO Box 269120
Sacramento, CA 95826-9120
916/563-1900 Fax 916/563-1919
www.aims4claims.com
CAL. LIC 2772984

7/23/08

Dear Mike Dixon,

Workman's comp does not want to pay me my salary for my time off until I see their doctor who at this time I do not have an appointment with. And they have up to 15 days to schedule me an appointment with a State Dr. of their choice. They are claiming that my injury was not work related. My employer has taken me off payroll. UNUM is a supplemental insurance offered to me. Can you please fill out this paperwork so I can have some financial means. I will need to go back to work weather I am capable or not because I will need to pay my bills. I will see you Tuesday at 2:00.

Sincerely,

Tiffany Anderson

209-333-1037

MRI Scheduled 7-28-08 @ 2:00

unum

CLAIM FOR INCOME PROTECTION BENEFITS
The Benefits Center, P.O. Box 100158
Columbia, SC 29202-3158
Pacific Time Zone Toll-free: 1-877-851-7637 Fax: 1-877-851-7624
All Other Time Zones Toll-free 1-800-858-8843 Fax: 1-800-447-2498

A. ATTENDING PHYSICIAN'S STATEMENT (PLEASE PRINT)

Name of Patient	Home Telephone Number	Date of Birth	Social Security Number
Anderson, Tiffany	209 333 1037	8-22-1970	549-23-5133

Employer Name/Address	Employer Telephone Number
SJ Mosquito + Vector 7759 S. Airport Way Stk, CA 95206	209 982-4675

Instructions. The following sections must be completed and signed by the attending physician. The purpose of this report is to assist us in making a disability determination. If this claim is related to a normal pregnancy, complete the normal pregnancy section. Otherwise, please complete all applicable sections of this form and provide copies of supporting reports, such as office notes, medical records, consultations and/or testing. In all situations, you must complete the signature block at the bottom of this form.

NORMAL PREGNANCY

a) Expected Delivery Date | b) Actual Delivery Date | c) Delivery Type ☐ Vaginal ☐ C-Section

Date First Unable to Work | Date Hospitalized

ALL OTHER CONDITIONS

Patient Information

a) Height Weight b) Date of first visit regarding current conditions? 6/20/08

c) Date patient ceased work because of condition? 6/20/08 d) Did you advise patient to cease work? ☐ Yes ☐ No If yes, when? released to modified duty only

e) Has the patient been treated for the same/similar condition in the past? ☐ Yes ☒ No If yes, when?

If yes, please describe

f) Is the patient's condition due to injury or sickness involving the patient's employment? ☒ Yes ☐ No ☐ Unknown

Diagnosis and Treatment

Primary Diagnosis ① Rt knee effusion, sprain ② medial meniscal tear

a) What is the primary diagnosis preventing your patient from working? Medial meniscal tear right knee

Please include Primary ICD-9 and/or DSM IV Multi-Axial Diagnoses and Codes

b) Date of last examination 7/22/08

c) Describe Reported Symptoms: see attached PR2

d) Describe Physical Findings (MRIs, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF etc.): MRI ordered 7/22/08

Other Conditions **(Please attach additional information as necessary)**

Are there other conditions that prevent your patient from working? If so, please list with information as follows

a) Secondary ICD-9s Diagnosis: Secondary ICD-9s Diagnosis: N/A

b) Describe Reported Symptoms

c) Describe Physical Findings (MRIs, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF etc.)

⊕ medial meniscal tear Ⓡ knee

Treatment

a) Describe the patient's current treatment program (include facilities name/address if applicable). Mod Duty, PT (Lodi PT, 631 So Ham Lane, Lodi, Ibuprofen

b) Medications (Please list all medications including dosage and frequency) Ibuprofen 800 MG 1 tab PO tid prn

c) Has patient been hospitalized? ☒ Yes ☐ No Date Hospitalized through

d) Was surgery performed? CPT 4 Code(s) N/A Date Surgery Performed

Name/Address of facility.

e) Is the patient still under your care? ☒ Yes ☐ No Final Date of Treatment

1185-02 (06/08)

Claimant Name: Social Security Number:

Other Providers: Please supply complete name, act information and specialty of any other treating physic or hospitals

Name	Specialty	Address	Phone #	Fax #	Treatment From	Treatment To
	N/A					

Physical Capabilities

a) Patient's ability to *(Please Check Number of Hours Per Workday and How Often)*

	Number of Hours	How Often
Sit	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☒8	☐ Continuously ☐ Intermittently
Stand	☐0 ☐1 ☒2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8	☐ Continuously ☐ Intermittently
Walk	☐0 ☒1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8	☐ Continuously ☐ Intermittently

b) Patient's ability to *(Please Check)*

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Climb	☒	☐	☐	☐
Twist/bend/stoop	☐	☒	☐	☐
Reach above shoulder level	☐	☐	☐	☒
Operate heavy machinery	☒	☐	☐	☐

c) Patient's ability to lift/carry *(Please Check)*

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Up to 10 lbs	☐	☒	☐	☐
11 to 20 lbs	☒	☐	☐	☐
21 to 50 lbs	☒	☐	☐	☐
51 to 100 lbs	☒	☐	☐	☐

d) Patient's ability to perform *(Please Check)*

	Never 0% R	Never 0% L	Occasionally 1-33% R	Occasionally 1-33% L	Frequently 34-66% R	Frequently 34-66% L	Continuously 67-100% R	Continuously 67-100% L
Fine Finger movements	☐	☐	☒	☒	☐	☐	☐	☐
Hand/eye coordinated movements	☐	☐	☒	☒	☐	☐	☐	☐
Pushing/Pulling	☐	☐	☐	☐	☐	☐	☐	☐

Dominant Hand ☑ Right ☐ Left

Psychological Features

Are there any cognitive deficits or psychiatric conditions that interfere with the patient's ability to perform his/her occupation? If so, please describe specifically how any identified condition prevents the patient from performing his/her occupation

Return to Work

a) When do you expect improvement in the patient's capabilities?

b) Have you advised patient to return to work? ☐ Yes ☐ No Expected Return to Work Date ☐ Full Time ☐ Part Time
If yes, please indicate any ongoing restrictions and limitations in the space provided below
If no, please indicate the restrictions and limitations that prevent the patient from returning to work in the space provided below

c) RESTRICTIONS (activities patient should not do)

d) LIMITATIONS (activities patient cannot do)
kneel, squat, crawl

FRAUD NOTICE Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.

Print or Type Name: DONALD L. ROSSMAN		Degree: MD	Medical Specialty: occ health
Street Address: DAMERON OCCUPATIONAL HEALTH SERVICES 525 W. ACACIA STREET • STOCKTON CA 95203			Telephone Number: (209) 461-3196
City	State	ZIP Code	Fax: (209)
Signature of Physician			Date: 7/29/08
SSN or Employer's ID Number	Are you, the physician, related to this patient? ☐ Yes ☐ No If yes, what is the relationship?		

1185-02 (08/08)

GENERAL

I hereby acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the AIG American General Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself by sending a written request to: AIG/American General Assurance Company/American General Indemnity, P.O. Box 1577, Neptune, NJ 07754-1577

I understand that my revocation of authorization will not affect uses and disclosure of my health information by the Recipient for purposes of claims administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my claim for benefits.

This authorization will be valid for 12 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

Signature of Insured or
Insured's Personal Representative

549-23-5133
Insured's Social Security Number

Description of Authority of Personal Representative
(if applicable)

Date

AMERICAN GENERAL

American General Assurance Company*
Schaumburg, Illinois
American General Indemnity Company*
Schaumburg, Illinois
Member companies of American International Group, Inc
Administrative Office: 3600 Route 66, PO. Box 1577, Neptune, NJ 07754-1577 *This company does not solicit business in New York.

BE SURE ALL QUESTIONS ARE ANSWERED

Spaced for Typewriter – Marks for Tabulator Appear on this Line

PATIENT'S NAME AND ADDRESS Jeffrey Anderson AGE

DIAGNOSIS AND CURRENT CONDITIONS

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? IF "YES" EXPLAIN YES ☒ NO ☐ Medial meniscal tear (R) knee

IS CONDITION DUE TO PREGNANCY? IF "YES" WHAT WAS APPROXIMATE DATE OF COMMENCEMENT OF PREGNANCY? YES ☐ NO ☒ DATE ____ YEAR

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN? DATE 6/20/08 YEAR

WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE 6/20/08 YEAR

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? IF "YES" STATE WHEN AND DESCRIBE YES ☐ NO ☑

N/A

NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE, IF ANY (Describe Fully) N/A DATE PERFORMED ____ YEAR

IF PERFORMED IN HOSPITAL, GIVE NAME OF HOSPITAL INPATIENT ☐ OUTPATIENT ☐

GIVE DATES OF OTHER MEDICAL (NON-SURGICAL) TREATMENT, IF ANY CHARGE PER CALL

Physical therapy (Code)

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? IF "NO" GIVE DATE YOUR SERVICES TERMINATED YES ☑ NO ☐ DATE ____ YEAR

TOTALLY DISABLED – UNABLE TO WORK? YES ☒ NO ☐ FROM 6.20.08 YEAR Thru ____ YEAR

HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED? FROM ____ YEAR Thru ____ YEAR

TO YOUR KNOWLEDGE DOES PATIENT HAVE OTHER HEALTH INSURANCE OR HEALTH PLAN COVERAGE? IF "YES" IDENTIFY Unum YES ☑ NO ☐

D. [signature] MD

DATE 7/29/08. SIGNATURE (ATTENDING PHYSICIAN) DEGREE TELEPHONE

DAMERON OCCUPATIONAL HEALTH SERVICES
STREET ADDRESS 525 W. ACACIA STREET • STOCKTON CA 95203 STATE OR PROVINCE ZIP CODE

VOOOOOO9-1022A (11/05

GENERAL

American General Assur_ ice Company*
Schaumburg, Illinois
American General Indemnity Company*
Schaumburg, Illinois
Member companies of American International Group, Inc.
Administrative Office: 3600 Route 66, P.O. Box 1577, Neptune, NJ 07754-1577 *This company does not solicit business in New York.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")
Authorization to Obtain and Disclose Information

T. Hany Anderson — Name of Patient/Insured (Please Print)

8-22-1970 — Date of Birth

I hereby authorize all of the people and organizations listed below to give American General Assurance Company, American General Indemnity, and the American General Life Companies LLC, (an affiliated service company), (collectively the "Companies"), and their authorized representatives, including agents and insurance support organizations, (collectively the "Recipient"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including; but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinement for physical and mental conditions; use of drugs or alcohol; communicable diseases including HIV or AIDS; and medical bills and Films.

I hereby authorize each of the entities listed below to provide the information outlined above:

- any physician or medical practitioner,
- any hospital, clinic or other health care facility;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other AIG American General company which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

Name	Address & Phone Number	Date Range of Treatment Requested
Dameron Health	420 W. Acacia Street	6-08

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for benefits under and/or the contestability of an insurance policy, and
- detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs

VALLEY MRI & FAMILY IMAGING CENTER

LODI MRI MEDICAL IMAGING CENTER

MAGNETIC RESONANCE IMAGING RIGHT KNEE

PATIENT: ANDERSON, TIFFANY K
DOB: 08/22/1970
MR#: 579139 0
DATE: 07/28/2008
REFERRING PHYSICIAN: DONALD ROSSMAN MD
(W/C NETWORK) MDIA

CLINICAL HISTORY: Job injury, now with pain and swelling.

SEQUENCES: Axial proton density with fat saturation, high-resolution coronal and sagittal proton density with fat saturation, axial proton density with fat saturation, sagittal inversion recovery, and coronal gradient echo

FINDINGS: **Lateral Compartment:** There is a fairly large horizontal tear seen in the anterior horn of the lateral meniscus extending to the mid horn, sparing the posterior horn, otherwise, negative.

Patellofemoral Compartment: Normal

Medial Compartment: Normal

Ligaments and Tendons: Intact, though with mild signal alterations consistent with previous anterior and posterior cruciate ligament sprains.

Miscellaneous: There is no effusion, bone edema, Baker's cyst, or loose body.

CONCLUSION: Anterior horn, medial meniscus tear

W Aubrey Federal M D

WF: Im - D/T Tue Jul 29 07 58:57 2008 #5816

This document has been electronically signed and approved by WILLIAM FEDERAL MD

546 E. Pine St • Stockton, CA 95204 • Phone (209) 467-1000 • Fax (209) 467-7335
801 S. Ham Lane, Suite R • Lodi, CA 95242 • Phone (209) 366-1000 • Fax (209) 366-1060

ORTHOPAEDIC MANUAL THERAPY
INDUSTRIAL REHABILITATION
SPORTS MEDICINE

LODI PHYSICAL THERAPY

631 South Ham Lane
Lodi, CA 95242
209 / 368-7433
FAX: 209 / 368-4219

Progress Report

Date: 7/14/08
To: Dr. Rossman
No. Visits Authorized: 6
No. Visits Completed: 6

Re: Tiffany Anderson
Diagnosis: (R) knee effusion & sprain/strain
DOI: 6/19/08

Patient Subjectively: Resolved ____ Improving X Unchanged ____ Worse ____

Objective/ Assessment: Swelling down to mild increase on (R). Strength (R) hams 4/5 pain, (R) quads 5/5. McMurray's + grind (-) for pain (R) knee. Tender c palpation of (R) medial gastroc and hamstring tendons.

Functional Goals	Status Update
(1) amb. s pain	met
(2) ↓ swelling to equal (L)	within 1-1.5 cm
(3) able to amb on uneven ground	not met
(4) (I) HEP & symptom management	50% met cont. new exercises

Patient Has Received Treatment Consisting Of.

- ___ Manual therapy
- X Therapeutic Exercises
- X Functional/ Therapeutic Activities
- X Self Care/Home Mgt Training
- ___ Gait Training
- X Therapeutic Modalities:
  - X E-Stim
  - X U.S.
  - X Ice/ Heat
  - ___ Traction

PLAN: Patient to continue current treatment program for 2 times per week for 4 weeks.
Recommend Discharge to ___ Home Program ___ Gym Program ___ Other
Reason For Discharge ____
Therapist Signature: [signature], PT

PLEASE COMPLETE AND SIGN THE PERSCRIPTION BELOW TO CONTINUE TREATMENT.
I certify/re-certify the need for these services furnished under this plan of treatment and while under my care.

Physician Signature X [signature], MD / Date: 7.15.08

CARE REHAB

Facsimile Cover Sheet
and Issuance Checklist

07

Please Fax to:
Tracy Cook
800-611-5733

Total Number of Pages _____

Fax To:

Care Rehab and Orthopaedic Products, Inc.
Billing Office
800-611-5733 (Toll-Free Fax)
866-667-2257 (Voice)

Fax From:

FAXED 7/8/08 FH

Facility Name: _____
Contact Name: DAMERON HOSPITAL OCCUPATIONAL INJURY CLINIC
Phone: (209) 461-3196 525 W. ACACIA ST.
Fax: (209) 461-[illegible] STOCKTON, CA 95203

Checklist:

Care Rehab needs the following information to completely process the patient's claim. Please indicate which items are included with this fax by checking the appropriate boxes:

☒ **Care Rehab's "Patient Information Form"**
...This form must be signed and dated by patient,but not filled out.

☒ **Patient Data Sheet**
...i.e. face sheet, intake sheet, demographics, etc.

☒ **Patient Insurance Information**
...and include a copy of Patient's Insurance Card if possible.

☒ **Physician's Order**
...or name and phone number of referring physician.

Notes:

_____
_____
_____
_____

Thank You For Choosing Care Rehab

CARE REHAB

Patient Information Form

07

Please Fax to:
Tracy Cook
800-611-5733

Patient Information

Name: Tiffany Andersun

Address: _____

City: _____ State: ____ Zip: _____

Patient Relationship to Policy Holder.
☐ Self ☐ Spouse ☐ Child ☐ Other

SS #: _____

Birth Date ____/____/____

Home Phone (____) _____ - _____

Work Phone: (____) _____ - _____ Ext. _____

Health Insurance

Policy Effective Date: ____/

Insured Name: _____

Insurer: _____

Policy #: _____

Group #: _____

Phone: (____) _____ - _____

Billing Address _____

City: _____ State: ____ Zip: _____

Worker's Comp / Auto Insurance

☐ Work Comp ☐ Auto Carrier

Claim #: _____

Adjuster's Name _____

Phone (____) _____ - _____ Ext. _____

Employer: _____

Date of Injury. ____/____/____

Insurer _____

Billing Address: _____

City _____ State ____ Zip. _____

WORKERS COMPENSATION: RIGHT TO CHOOSE
The equipment I received is the equipment ordered by my authorized physician. I choose to use this particular equipment supplied by Care Rehab, Inc. I choose Care Rehab, Inc. as my provider and understand that I have this right if applicable under the worker's compensation law in the state of my residence. My insurance carrier may NOT CHANGE the equipment or provider without my prior knowledge and written approval. I choose Care Rehab, Inc. as the provider of any future supplies and accessories.

Attorney

Attorney Name _____

Law Firm _____

Address _____

City _____

State ____ Zip _____

Phone (____) _____ - _____ Ext _____

Self-Pay Patients

Amount. $ ___,___ ___

☐ Visa ☐ MasterCard ☐ Amex ☐ Diner's Club

Card #. _____ _____ _____ _____

Expiration Date. ____/____

☐ Payment by Check Check #: _____ ☐ Payment by Cash

Modality

☒ Care TENS®	☐ Starr Cervical Traction®
☐ Care Stim®	☐ Care Lumbar Traction®
☐ Care Select Stim®	
☐ Care Select Stim Plus®	☐ Acustim Adaptor®
☐ Care IFC Sport®	☐ Hand Switch
☐ Care IFC Plus®	☒ Electrodes & Supplies
☐ Care EMG®	☐ Other _____
☐ Care ETS®	CTNS
☐ Care High Volt®	Serial #. 148214

- DO NOT ISSUE E-STIM DEVICES TO PACEMAKER PATIENTS -

Physician

Prescribing Physician _____

NPI # _____

Phone (____) _____ - _____ Ext: _____

Diagnosis _____

ICD-9-CM. _____.____ _____.____ _____ _____

Clinician

Clinic _____

Phone. (____) _____ - _____

Physical Therapist _____

I have been instructed in the proper application, use and care of the above described unit. I may rent or purchase the system. I understand that I am responsible for the Care Rehab equipment and if for any reason, I do not return the unit directly to Care Rehab, Inc. I agree to pay the rental or purchase price. I authorize the release of any medical information necessary to process my claim and I agree to pay for all charges not covered by this authorization or not otherwise paid by my insurance company. I permit a copy of this authorization to be valid as the original. I, the undersigned, select Care Rehab, Inc. as my DME provider of choice and represent that I have insurance coverage and do hereby authorize my carrier to pay and assign directly to Care Rehab, Inc surgical and medical benefits, if any, otherwise payable to me for the services described. I understand that I am financially responsible for all charges, whether or not paid for by said insurance. I hereby authorize said assignee to release and obtain all information necessary.

X Patient's Signature _____ Date 7/8/08

Insured's Signature (If different from patient) _____ Date ____/____/____

✓ Please Enroll me

Please mail me fresh electrodes/batteries monthly if covered by my insurance.

Please initial below:

Initial: _____

Rev 8/2007

CARE REHAB®

Letter of Medical Necessity & Prescription

07

Please Fax to,
Tracy Cook
800-611-5733

The following information is required by your patients insurance company Please complete this entire form

Patient Information

Name Tiffany Anderson

SS #

DOB 6, 19, 08

Phone (_____) _____ - _____

Referring Clinic

Clinic

Phone (_____) _____ - _____

Physical Therapist

Modality

- ☒ Care TENS®
- ☐ Care Stim®
- ☐ Care Select Stim®
- ☐ Care Select Stim Plus®
- ☐ Care IFC Sport®
- ☐ Care IFC Plus®
- ☐ Care EMG®
- ☐ Care ETS®
- ☐ Care High Volt®
- ☐ Starr Cervical Traction®
- ☐ Care Lumbar Traction®
- ☐ Acustim Adapter®
- ☐ Hand Switch
- ☒ Electrodes & Supplies
- ☐ Other: CTNS

Serial #: 148214

- DO NOT ISSUE E-STIM DEVICES TO PACEMAKER PATIENTS -

Physician

Prescribing Physician

NPI #

Phone (_____) _____ - _____ Ext _____

Diagnosis and Device Duration

	Diagnosis	ICD-9-CM
Primary		
Secondary		

Recommended Device Duration: ☐ 6-9 Months ☐ Long Term ☐ Purchase ☐ Other ____ Months

Please provide the following information.

Is the above device prescribed to this patient for their physical therapy due to injuries sustained in either an automobile or work related accident? ☒ Yes ☐ No

Was surgery performed on the patient? (If "Yes", give dates and details) ☐ Yes ☒ No

Are these services to be rendered while patient remains under your care? ☒ Yes ☐ No

Is there a reasonable expectation that the prescribed device will result in significant improvement for the patient? (Please explain). ☒ Yes ☐ No

Statement of Medical Necessity

Care Rehab and Orthopaedic Products, Inc has supplied this modality as per the above prescription. I recommend this particular device for home use as part of this patient's physical therapy treatment.

- DO NOT SUBSTITUTE -

Physician's Signature D. Rinaudo MD Date: 7, 8, 08

Rev 5/2007

ORTHOPAEDIC MANUAL THERAPY
INDUSTRIAL REHABILITATION
SPORTS MEDICINE

LODI PHYSICAL THERAPY

631 South Ham Lane
Lodi, CA 95242
209 / 368-7433
FAX 209 / 368-4219

June 25, 2008

WORK COMP CLAIM: VE0700184
Donald Rossman, M. D.
Dameron Hospital, Rehab. Dept.
420 W. Acacia St
Stockton, Ca. 95203

INITIAL EVALUATION
Date of Eval: 06-25-08
Diag: Knee effusion/ACL Sprain, Right
Onset: 6-19-08

RE: **ANDERSON, Tiffany**

SUBJECTIVE: Thank you for your referral of Ms. Anderson to our clinic. She comes to us with complaint of right knee pain and swelling since climbing in/out of her truck for 2-days at work. She states that the swelling began the following morning and has persisted with activity but decreases with rest. At this time her symptoms are aggravated by standing greater than 15-minutes, walking greater than a quarter mile, keeping her knee bent while sitting in a chair, squatting, and going up stairs. Prior to injury she was able to work a full 8-hour day getting in/out of her trunk, walking on uneven surfaces, and able to walk for exercise when she gets home.

OBJECTIVE: Active range of motion of the knees is as follows:

Flexion	Bilaterally 135°
Extension	Right 0° leading to pain in the anterior knee Left: +2°

Manual muscle testing revealed mild weakness in the right knee and hip secondary to pain. Girth measurements revealed moderate swelling of the right knee. Both Anterior Drawer and varus and valgus special tests were performed and negative on the right. However, McMurray's special test and Grind special test were positive for pain in the right knee as well as tenderness with palpation along the anterior joint line.

ASSESSMENT/GOALS: Ms. Anderson presents with moderate swelling in the right knee, pain with rotational movements and decreased loading tolerance in the right knee. Goals are: 1. Patient able to recover full ROM of the right knee without pain in 3-weeks 2. Patient able to decrease swelling in the right knee to equal the left in 3-weeks 3. Patient able to perform a body weight squat with controlled symptoms in 6-weeks 4. Patient able to walk on uneven ground with controlled symptoms in 6-weeks.
5 Patient to be independent with home exercise program and symptoms management in 6-weeks.

TREATMENT PLAN: Therapeutic exercise, body mechanics training, soft tissue mobilization, stretching, ice, electrical stimulation, ultra sound, and to establish a home exercise program. She is to be seen 3 times a week for 2 weeks. Her rehab potential and prognosis are good. I will keep you apprised of this patient's progress.

DS/dt

Danielle Sartori, PT
DANIELLE SARTORI, D.P.T.

ORTHOPAEDIC MANUAL THERAPY
INDUSTRIAL REHABILITATION
SPORTS MEDICINE
"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge." This statement is made under penalty of perjury.
Date of report: 6-25-08
at San Joaquin County, California

LODI PHYSICAL THERAPY

631 South Ham Lane
Lodi, CA 95242
209 / 368-7433
FAX. 209 / 368-4219

June 25, 2008

WORK COMP CLAIM: VE0700184
Donald Rossman, M. D.
Dameron Hospital, Rehab. Dept.
420 W. Acacia St
Stockton, Ca. 95203

INITIAL EVALUATION
Date of Eval: 06-25-08
Diag: Knee effusion/ACL Sprain, Right
Onset: 6-19-08

RE: **ANDERSON, Tiffany**

SUBJECTIVE: Thank you for your referral of Ms. Anderson to our clinic. She comes to us with complaint of right knee pain and swelling since climbing in/out of her truck for 2-days at work. She states that the swelling began the following morning and has persisted with activity but decreases with rest. At this time her symptoms are aggravated by standing greater than 15-minutes, walking greater than a quarter mile, keeping her knee bent while sitting in a chair, squatting, and going up stairs. Prior to injury she was able to work-a full-8-hour-day getting in/out of her trunk, walking on uneven surfaces, and able to walk for exercise when she gets home.

OBJECTIVE: Active range of motion of the knees is as follows:

Flexion	Bilaterally 135°
Extension	Right 0° leading to pain in the anterior knee Left. +2°

Manual muscle testing revealed mild weakness in the right knee and hip secondary to pain. Girth measurements revealed moderate swelling of the right knee. Both Anterior Drawer and varus and valgus special tests were performed and negative on the right. However, McMurray's special test and Grind special test were positive for pain in the right knee as well as tenderness with palpation along the anterior joint line

ASSESSMENT/GOALS. Ms. Anderson presents with moderate swelling in the right knee, pain with rotational movements and decreased loading tolerance in the right knee. Goals are: 1. Patient able to recover full ROM of the right knee without pain in 3-weeks 2. Patient able to decrease swelling in the right knee to equal the left in 3-weeks 3. Patient able to perform a body weight squat with controlled symptoms in 6-weeks 4. Patient able to walk on uneven ground with controlled symptoms in 6-weeks.
5 Patient to be independent with home exercise program and symptoms management in 6-weeks.

TREATMENT PLAN. Therapeutic exercise, body mechanics training, soft tissue mobilization, stretching, ice, electrical stimulation, ultra sound, and to establish a home exercise program. She is to be seen 3 times a week for 2 weeks. Her rehab potential and prognosis are good. I will keep you apprised of this patient's progress.

DS/dt

Danielle Sartori, PT
DANIELLE SARTORI, D.P.T.

Procedure/Seq #: 00001
Account #: 00105715551
Patient Name: ANDERSON, TIFFANY

Birth date, Age: 08/22/1970
Ordering MD: HULL, INJURIES, MD
Adm DX1:
Reason for Study:

Admission Date: 06/20/2008
Patient Type/Bed: / DISC/DIS/ XRO
Medical Record #: 626041
Gender: F

Procedure Date: 06/20/2008

Procedure: RIGHT KNEE

Three views of the right knee demonstrate the soft tissues and osseous structures intact without any obvious fracture or dislocation seen. Joint space is maintained without any narrowing.

Electronically Signed 06/20/2008 04:32 PM
DAVID WONG, MD

D: /T. 06/20/2008 15:01:51/DI: 00004774/DN: 00004774

ANDERSON, TIFFANY
626041

ORIGINAL

DAMERON HOSPITAL
STOCKTON, CALIFORNIA 95203

RADIOLOGY

DAMERON HOSPITAL ASSOCIATION
Occupational Injury Clinic

[redacted]

6/16/2008 8:22 a.m.

Patient Name: / *Nombre de paciente*: Tiffany anderson	Sex: / *Sexo*: ☐ Male / *Masculino* ☒ Female / *Femenino*	Birthdate: / *Fecha de nacimiento*: 8-22-70
Street Address: / *Domicilio*: 1416 Iris Dr #7	Status: ☒ Married / *Casado*	Home Telephone No.: / *Telefono de casa*: 209-333-1037
City, State, Zip: / *Ciudad, Estado, Zip*: Lodi CA 95242		Social Security Number: / *Seguro Social*: 549-23-5133
Employer: / *Empleador*: SJCMVCD	☐ Single / *Soltero*	Job Title: / *Ocupacion*: PESTICIDE APPLICATI
Date of Injury: / *Fecha de accidente*: 6 19 08 Hour / *Hora* ☐ AM ☒ PM	Date last worked: / *Dia que trabajo ultimo*: 6-19-08	Have you been seen here before? / *Ha venido aqui antes?* ☒ YES/SI ☐ NO

Have you received treatment for this injury elsewhere? / *A recibido tratamiento para este accidente en otro lugar?* ☐ YES/SI ☒ NO — If yes, where? / *Si, Cuando?* — Date / *Feche*

Describe how the injury occurred: / *Como ocurrio el accidente*: Climbing onto off the back off a truck repeatedly.

Significant Diagnosis	Major Surgery	Medications	Drug Allergies
1	1 ———	1 IBprofin 800mg	1 None
2	2	2	2
3	3	3	3
4	4	4	4

Tetanus: — Vision: Rt 20/ Lt 20/ — Dominant Hand: Rt Lt

Subjective: ☐ dictated

Objective ☐ dictated

effusion (R) knee

Sprain (R) knee

Assesment: ☐ dictated

Orders: X-Ray — Lab — Injection

Results: knee — Mod duty

Treatments

Medications IBP — Dose 800 — Quantity

Medications Darvocet — Dose 10 — Quantity

Medications — Dose — Quantity

Physician Signature: [signature]

DAMERON HOSPITAL
Occupational Health Services

AUTHORIZATION FOR MEDICAL SERVICES

Date	Employee/Applicant Name
10-13-05	Tiffany Anderson
Company Name	**Telephone #**
Mosquito	
Company Authorization By	
Carol	

SERVICES REQUESTED

☐ Treatment of work-related illness or injury

If working for a temporary agency

Agency Name: _____

Telephone Number: _____

☐ Medical Examination:

☐ Pre-employment ☐ DOT - Initial ☐ DOT Recertification

☐ Other _____

☐ Drug Screen. ☐ DOT ☐ Non-DOT

☐ Breath Alcohol. ☐ DOT ☐ Non-DOT

☐ Pre-employment ☐ Random ☐ Reasonable Suspicion

☐ Post Accident ☐ Other

Special Instructions _____

_____

_____

_____

Appointment: **Date:**_____ / _____ / _____

Time:_____**AM/PM**

8635 124 (10/30/02)

Dameron Hospital Occupational Health Services
525 W. Acacia St., Stockton, CA 95203

WORK STATUS REPORT

Employee Name:	Anderson, Tiffany K	**Date of Visit:**	10/25/2005
Social Security No.:	549-23-5133	**Time In:** 07:25 am	**Time Out:** 07:55 am
Employer:	SJ Mosquito and Vector Control		
Date of Injury:	10/11/2005	**Guarantor:**	AIMS - Fresno 8046
Clinic Case Number:	78225	**Claim Number:**	Pending

CLINICAL STATUS

Diagnosis: Dermatitis, Contact Allergic

Since the last visit, this patient's condition has: Improved as expected

EVALUATION AND TREATMENT PLAN

Physical / Occupational Therapy:

Recommended Evaluation / Diagnostic Studies:

WORK STATUS

Work Status: Full work duties **From:** 10/25/2005 **To:** 10/25/2005

Work Restrictions:

Estimated return to full duty:

DISPOSITION

Disposition: Final Discharge, P&S, no residuals PR2 to follow

Next Scheduled Appointment:

"I have not violated Labor Code Section 139 3, and the contents of the report and bill are true and correct to the best of my knowledge This statement is made under penalty of perjury "

Signed,

Donald Rossman, (Original signature on file)

Doctor's Phone: (209) 461-3196 opt. 3
Doctor's Fax: (209) 461-7529
Case Coordinator Phone: (209) 461-3196 opt.1

DH-WSR 9/13/05

DAMERON HOSPITAL
OCCUPATIONAL INURY CLINIC

WORK STATUS REPORT - WORKSHEET

Employee Name: Anderson, Tiffany K Date of this Examination. 10/25/2005
Employer: SJ Mosquito and Vector Clinic Case Number: 78225

DIAGNOSIS:

CLINICAL STATUS: __Q1: Improved, as expected __Q2 Improving slowly __Q3: No significant change __Q4 Worse

PT/OT: __W1. Continue as prescribed __W2: 3x/wk - 2 week __W3:3x/wk – 1 week __W4. One visit __W5 Non-DHA PT

RECOMMENDED EVALUATION / DIAGNOSTIC STUDIES:
__E1: MRI __E2. CT Scan __E3 NCS __E4 Work Conditioning __E5 Epidurals __E6 Ergo Evaluation

REFERRAL / CONSULT:

__ R10: Orthopedist
__ R11. Ophthalmologist
__ R12. Neurosurgeon
__ R13: Hand Specialist
__ R14 General Surgeon
__ R15: Neurologist
__ R16: Psych
__ R17 Physiatrist
__ R18. ENT
__ R19 Dermatology
__ R20. Pain Mgmt
__ R21 Dentist
__ R22 Health Club
__ R23. Urology
__ R24 Acupuncture
__ R25 Podiatrist

WORK STATUS:
__ Full work duties
__ Modified work duties
__ Off balance of shift, modified work
__ Off balance of shift, full work duties
__ No work until next appt
__ Current WS until Specialist appt.

WORK RESTRICTIONS:

No lift / carry >.
__A09. 50#
__A10: 10-15#
__A11 30#
__A12. 5#

No prolonged
__A15 Stand/Walk
__A16 Sitting

Other Back/Neck
__A13: No frequent lift, bend, twist, stoop at waist
__A14. Limit twist / bend at neck
__A17 Desk / sedentary only

Lower Extremity
__A18 No crawl / kneel / squat
__A19: No climbing ladders
__A20 Use crutches as directed
__A21: Elevate as directed
__A22 Use cane as directed

Upper Extremity
__S10 Wear splint / sling as directed
__S11 No frequent / repetitive use of wrist / hand
__S12. No heavy pushing or pulling
__S13 No use of arm above shoulder
__S14 No forceful hand grasp
__S15 No use of injured body part

Miscellaneous
__S16 Limited use of injured body part
__S17 May advance work activities as tolerated
__S18 Keep dressing clean and dry
__S19 No operating company vehicles
__S20. No exposure to heat
__S21 No exposure to cold
__S22 No exposure to chemical, vapors, fumes
__S23 No welding
__S24. Avoid physical altercations
__S25. Avoid wearing latex gloves
__S27. Limit keyboarding 45 min/hr
__S28 Limit keyboarding: 4 hr/day

PR STATUS:

__ PR-1. Periodic Report
__ PR-2 Change in Work Status
__ PR-3 Change in Pt. Condition
__ PR-4 Change in Tx Plan
__ PR-5 Referral/Consult
__ PR-6. Surgery/Hospitalization
__ PR-7 Discharge
__ PR-8 Request by Adjuster
__ PR-9 Other _____

DISPOSITION:
__D1 Consult
__D5. Referral / Transfer of care
__D6 Non-occupational, refer to PMD
__D2: Final Discharge without residuals, PR-2 to follow
__D4 Final Discharge with residuals, PR-3 to follow
__D3: First Aid

Next scheduled appointment _____ Provider Initial: dlr

DWC Worksheet Revised 12

Dameron Hospital Occupational Health Services
525 W. Acacia St., Stockton, CA 95203

WORK STATUS REPORT

Employee Name:	Anderson, Tiffany K	**Date of Visit:**	10/20/2005
Social Security No.:	549-23-5133	**Time In:** 08:52 am	**Time Out:** 09:54 am
Employer:	SJ Mosquito and Vector Control		
Date of Injury:	10/11/2005	**Guarantor:**	AIMS - Fresno 8046
Clinic Case Number:	78225	**Claim Number:**	Pending

CLINICAL STATUS

Diagnosis: Dermatitis, Contact Allergic

Since the last visit, this patient's condition has:

EVALUATION AND TREATMENT PLAN

Physical / Occupational Therapy:

Recommended Evaluation / Diagnostic Studies:

WORK STATUS

Work Status: Off balance of shift; return to full w **From:** 10/20/2005 **To:** 10/25/2005

Work Restrictions:

Estimated return to full duty:

DISPOSITION

Disposition:

Next Scheduled Appointment: 07:20 am 10/25/2005

"I have not violated Labor Code Section 139 3, and the contents of the report and bill are true and correct to the best of my knowledge This statement is made under penalty of perjury "

Signed,
Donald Rossman, (Original signature on file)

Doctor's Phone: (209) 461-3196 opt 3
Doctor's Fax: (209) 461-7529
Case Coordinator Phone: (209) 461-3196 opt 1

DH-WSR 9/1

DAMERON HOSPITAL
OCCUPATIONAL INURY CLINIC

WORK STATUS REPORT - WORKSHEET

R

Employee Name: Anderson, Tiffany K Date of this Examination: 10/20/2005
Employer: SJ Mosquito and Vector Clinic Case Number: 78225

DIAGNOSIS: _____ _____

_____ _____

CLINICAL STATUS: __Q1 Improved, as expected __Q2: Improving slowly __Q3 No significant change __Q4. Worse

PT/OT: __W1 Continue as prescribed __W2: 3x/wk - 2 week __W3:3x/wk – 1 week __W4. One visit __W5: Non-DHA PT

RECOMMENDED EVALUATION / DIAGNOSTIC STUDIES:
__E1 MRI __E2 CT Scan __E3. NCS __E4 Work Conditioning __E5. Epidurals __E6. Ergo Evaluation

REFERRAL / CONSULT.

__ R10 Orthopedist
__ R11 Ophthalmologist
__ R12. Neurosurgeon
__ R13 Hand Specialist
__ R14: General Surgeon
__ R15 Neurologist
__ R16 Psych
__ R17 Physiatrist
__ R18 ENT
__ R19. Dermatology
__ R20 Pain Mgmt
__ R21: Dentist
__ R22. Health Club
__ R23 Urology
__ R24: Acupuncture
__ R25: Podiatrist

WORK STATUS:
__ Full work duties
__ Modified work duties
__ ~~Off balance of shift, modified work~~
__ Off balance of shift, full work duties
__ No work until next appt.
__ Current WS until Specialist appt.

WORK RESTRICTIONS: 10/24/05

No lift / carry >
__A09 50#
__A10 10-15#
__A11: 30#
__A12 5#

No prolonged
__A15 Stand/Walk
__A16 Sitting

Other Back/Neck
__A13 No frequent lift, bend, twist, stoop at waist
__A14 Limit twist / bend at neck
__A17. Desk / sedentary only

Lower Extremity
__A18 No crawl / kneel / squat
__A19 No climbing ladders
__A20 Use crutches as directed
__A21 Elevate as directed
__A22 Use cane as directed

Upper Extremity
__S10 Wear splint / sling as directed
__S11 No frequent / repetitive use of wrist / hand
__S12 No heavy pushing or pulling
__S13 No use of arm above shoulder
__S14 No forceful hand grasp
__S15 No use of injured body part

Miscellaneous
__S16. Limited use of injured body part
__S17: May advance work activities as tolerated
__S18 Keep dressing clean and dry
__S19. No operating company vehicles
__S20. No exposure to heat
__S21 No exposure to cold
__S22 No exposure to chemical, vapors, fumes
__S23. No welding
__S24 Avoid physical altercations
__S25. Avoid wearing latex gloves
__S27: Limit keyboarding: 45 min/hr
__S28. Limit keyboarding, 4 hr/day

PR STATUS.
__ PR-1 Periodic Report
__ PR-2: Change in Work Status
__ PR-3 Change in Pt Condition
__ PR-4 Change in Tx Plan
__ PR-5. Referral/Consult
__ PR-6 Surgery/Hospitalization
__ PR-7 Discharge
__ PR-8 Request by Adjuster
__ PR-9 Other. _____

DISPOSITION:
__D1 Consult
__D5 Referral / Transfer of care
__D6: Non-occupational, refer to PMD
__D2 Final Discharge without residuals, PR-2 to follow
__D4: Final Discharge with residuals, PR-3 to follow
__D3. First Aid

Next scheduled appointment: ~~[illegible]~~ TUES Provider Initial: AV

DFEA5 (Work h

Dameron Hospital Occupational Health Services
525 W. Acacia St., Stockton, CA 95203

WORK STATUS REPORT

Employee Name:	Anderson, Tiffany K	**Date of Visit:**	10/17/2005
Social Security No.:	549-23-5133	**Time In:** 07:48 am	**Time Out:** 08:32 am
Employer:	SJ Mosquito and Vector Control		
Date of Injury:	10/11/2005	**Guarantor:**	AIMS - Fresno 8046
Clinic Case Number:	78225	**Claim Number:**	Pending

CLINICAL STATUS

Diagnosis: Dermatitis, Contact Allergic

Since the last visit, this patient's condition has.

EVALUATION AND TREATMENT PLAN

Physical / Occupational Therapy:

Recommended Evaluation / Diagnostic Studies:

WORK STATUS

Work Status: Full work duties **From:** 10/17/2005 **To:** 10/20/2005

Work Restrictions:

Estimated return to full duty:

DISPOSITION

Disposition:

Next Scheduled Appointment: 3:00 pm 10/20/2005

"I have not violated Labor Code Section 139 3, and the contents of the report and bill are true and correct to the best of my knowledge This statement is made under penalty of perjury "

Signed,

Donald Rossman, (Original signature on file)

Doctor's Phone: (209) 461-3196 opt. 3
Doctor's Fax: (209) 461-7529
Case Coordinator Phone: (209) 461-3196 opt 1

DH-WSR 8/14/0?

DAMERON HOSPITAL
OCCUPATIONAL INURY CLINIC

WORK STATUS REPORT - WORKSHEET

R

Employee Name: Anderson, Tiffany K Date of this Examination: 10/17/2005
Employer: SJ Mosquito and Vector Clinic Case Number: 78225

DIAGNOSIS: _____ _____
_____ _____

CLINICAL STATUS: __Q1 Improved, as expected __Q2. Improving slowly __Q3. No significant change __Q4 Worse

PT/OT: __W1 Continue as prescribed __W2 3x/wk - 2 week __W3 3x/wk – 1 week __W4 One visit __W5· Non-DHA PT

RECOMMENDED EVALUATION / DIAGNOSTIC STUDIES·
__E1 MRI __E2 CT Scan __E3 NCS __E4 Work Conditioning __E5. Epidurals __E6. Ergo Evaluation

REFERRAL / CONSULT·

__ R10 Orthopedist	__ R14 General Surgeon	__ R18 ENT	__ R22. Health Club
__ R11 Ophthalmologist	__ R15 Neurologist	__ R19 Dermatology	__ R23· Urology
__ R12 Neurosurgeon	__ R16 Psych	__ R20· Pain Mgmt	__ R24. Acupuncture
__ R13· Hand Specialist	__ R17 Physiatrist	__ R21. Dentist	__ R25: Podiatrist

WORK STATUS: ✓ Full work duties __ Off balance of shift, modified work __ No work until next appt.
__ Modified work duties __ Off balance of shift, full work duties __ Current WS until Specialist appt

WORK RESTRICTIONS:

No lift / carry >
__A09 50#
__A10 10-15#
__A11 30#
__A12 5#

No prolonged·
__A15·Stand/Walk
__A16 Sitting

Other Back/Neck
__A13 No frequent lift, bend, twist, stoop at waist
__A14· Limit twist / bend at neck
__A17· Desk / sedentary only

Lower Extremity
__A18 No crawl / kneel / squat
__A19 No climbing ladders
__A20 Use crutches as directed
__A21 Elevate as directed
__A22 Use cane as directed

Upper Extremity
__S10 Wear splint / sling as directed
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__S12 No heavy pushing or pulling
__S13 No use of arm above shoulder
__S14 No forceful hand grasp
__S15 No use of injured body part

Miscellaneous
__S16· Limited use of injured body part
__S17· May advance work activities as tolerated
__S18 Keep dressing clean and dry
__S19· No operating company vehicles
__S20 No exposure to heat
__S21 No exposure to cold
__S22 No exposure to chemical, vapors, fumes
__S23. No welding
__S24 Avoid physical altercations
__S25 Avoid wearing latex gloves
__S27 Limit keyboarding 45 min/hr
__S28 Limit keyboarding 4 hr/day

PR STATUS.

__ PR-1 Periodic Report	__ PR-4 Change in Tx Plan	__ PR-7 Discharge
__ PR-2 Change in Work Status	__ PR-5 Referral/Consult	__ PR-8. Request by Adjuster
__ PR-3 Change in Pt Condition	__ PR-6 Surgery/Hospitalization	__ PR-9. Other· _____

DISPOSITION:
__D1 Consult
__D5 Referral / Transfer of care
__D6· Non-occupational, refer to PMD
__D2· Final Discharge without residuals, PR-2 to follow
__D4. Final Discharge with residuals, PR-3 to follow
__D3. First Aid

Next scheduled appointment· 1 hours. Provider Initial· dlv

✓ (1) V.S. incl. Temp.
(2) CBC.

Dameron Hospital Occupational Health Services
525 W. Acacia St., Stockton, CA 95203

WORK STATUS REPORT

Employee Name:	Anderson, Tiffany K	**Date of Visit:**	10/14/2005
Social Security No.:	549-23-5133	**Time In:** 09:50 am	**Time Out:** 10:30 am
Employer:	SJ Mosquito and Vector Control		
Date of Injury:	10/11/2005	**Guarantor:**	AIMS - Fresno 8046
Clinic Case Number:	78225	**Claim Number:**	Pending

CLINICAL STATUS

Diagnosis: Dermatitis, Contact Allergic

Since the last visit, this patient's condition has:

EVALUATION AND TREATMENT PLAN

Physical / Occupational Therapy:

Recommended Evaluation / Diagnostic Studies:

WORK STATUS

Work Status: Off balance of shift; return to full w **From:** 10/14/2005 **To:** 10/17/2005

10/15/05

Work Restrictions:

Estimated return to full duty:

DISPOSITION

Disposition:

Next Scheduled Appointment: 07:40 am 10/17/2005

"I have not violated Labor Code Section 139 3, and the contents of the report and bill are true and correct to the best of my knowledge This statement is made under penalty of perjury"

Signed,

Donald Rossman, (Original signature on file)

Doctor's Phone: (209) 461-3196 opt 3
Doctor's Fax: (209) 461-7529
Case Coordinator Phone: (209) 461-3196 opt.1

DH-WSR 8/1/02

DAMERON HOSPITAL
OCCUPATIONAL INURY CLINIC

R

WORK STATUS REPORT - WORKSHEET

ame Anderson, Tiffany K — Date of this Examination 10/14/2005
SJ Mosquito and Vector — Clinic Case Number 78225

DIAGNOSIS: _____ _____
_____ _____

CLINICAL STATUS: __Q1 Improved, as expected __Q2 Improving slowly __Q3 No significant change __Q4: Worse

PT/OT. __W1 Continue as prescribed __W2 3x/wk - 2 week __W3 3x/wk – 1 week __W4 One visit __W5 Non-DHA PT

RECOMMENDED EVALUATION / DIAGNOSTIC STUDIES:
__E1 MRI __E2 CT Scan __E3 NCS __E4 Work Conditioning __E5. Epidurals __E6. Ergo Evaluation

REFERRAL / CONSULT:

__ R10 Orthopedist	__ R14 General Surgeon	__ R18 ENT	__ R22. Health Club
__ R11 Ophthalmologist	__ R15 Neurologist	__ R19 Dermatology	__ R23: Urology
__ R12 Neurosurgeon	__ R16: Psych	__ R20 Pain Mgmt	__ R24: Acupuncture
__ R13 Hand Specialist	__ R17 Physiatrist	__ R21: Dentist	__ R25. Podiatrist

WORK STATUS:
__ ~~Full work duties~~
__ ~~Modified work duties~~
__ Off balance of shift, modified work
__ Off balance of shift, full work duties
__ No work until next appt.
__ Current WS until Specialist appt.

WORK RESTRICTIONS: ~~10~~ 10/15/05

No lift / carry >
__A09 50#
__A10 10-15#
__A11 30#
__A12 5#

No prolonged
__A15 Stand/Walk
__A16 Sitting

Other Back/Neck
__A13. No frequent lift, bend, twist, stoop at waist
__A14: Limit twist / bend at neck
__A17 Desk / sedentary only

Lower Extremity
__A18 No crawl / kneel / squat
__A19 No climbing ladders
__A20 Use crutches as directed
__A21 Elevate as directed
__A22 Use cane as directed

Upper Extremity
__S10 Wear splint / sling as directed
__S11 No frequent / repetitive use of wrist / hand
__S12 No heavy pushing or pulling
__S13 No use of arm above shoulder
__S14 No forceful hand grasp
__S15 No use of injured body part

Miscellaneous
__S16: Limited use of injured body part
__S17: May advance work activities as tolerated
__S18: Keep dressing clean and dry
__S19. No operating company vehicles
__S20 No exposure to heat
__S21: No exposure to cold
__S22: No exposure to chemical, vapors, fumes
__S23: No welding
__S24. Avoid physical altercations
__S25: Avoid wearing latex gloves
__S27. Limit keyboarding: 45 min/hr
__S28. Limit keyboarding: 4 hr/day

PR STATUS:

__ PR-1 Periodic Report	__ PR-4: Change in Tx Plan	__ PR-7 Discharge
__ PR-2 Change in Work Status	__ PR-5: Referral/Consult	__ PR-8 Request by Adjuster
__ PR-3 Change in Pt Condition	__ PR-6: Surgery/Hospitalization	__ PR-9 Other _____

DISPOSITION.
__D1 Consult
__D5 Referral / Transfer of care
__D6 Non-occupational, refer to PMD
__D2. Final Discharge without residuals, PR-2 to follow
__D4: Final Discharge with residuals, PR-3 to follow
__D3. First Aid

Next scheduled appointment Mon.

Provider Initial: dlv

W3 - TEMP

DAMERON HOSPITAL Occupational Health Services
420 West Acacia Street, Suite ..., Stockton, CA 95203 (209) 461-3196 Fax: (209) 461-3123

Follow Up Appointments

While you are recovering from your injury, we want to make your visits to our facility as convenient as possible with minimal waiting times. To help us achieve this goal, we ask that you please follow these basic guidelines:

1. **Please arrive to your appointment on time.**

2. **If possible, please do not bring children or more than one family member to your appointment.**

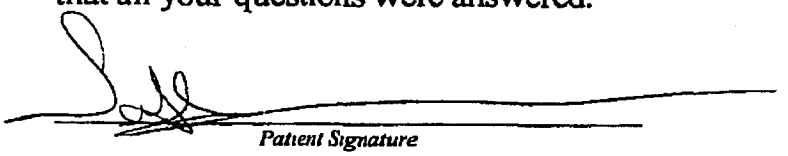
3. **If you need to change your appointment, please call us as soon as possible.**

4. **If you do not keep your appointment, we must assume that you have recovered from your injury and you will be returned to full work duties until you return for a follow up visit.**

Following these guidelines will avoid unnecessary delays for all of our patients and keep your waiting time to a minimum. Thank you for helping us to make your visits as pleasant and convenient as possible.

If you have *ANY* questions about these guidelines, please do not hesitate to ask.

Please sign below indicating that these guidelines were explained to you and that all your questions were answered.



Patient Signature

10/13/2005
Date

Name Anderson, Tiffany K

Case No 78225

Dameron Hospital Occupational Health Services
525 W. Acacia St., Stockton, CA 95203

WORK STATUS REPORT

Employee Name:	Anderson, Tiffany K	**Date of Visit:**	10/13/2005
Social Security No.:	549-23-5133	**Time In:** 07:49 am	**Time Out:** 09:49 am
Employer:	SJ Mosquito and Vector Control		
Date of Injury:	10/11/2005	**Guarantor:**	AIMS - Fresno 8046
Clinic Case Number:	78225	**Claim Number:**	Pending

CLINICAL STATUS

Diagnosis: Dermatitis, Contact Allergic

Since the last visit, this patient's condition has·

EVALUATION AND TREATMENT PLAN

Physical / Occupational Therapy:

Recommended Evaluation / Diagnostic Studies:

WORK STATUS

Work Status. Off balance of shift; return to full w **From:** 10/13/2005 **To:** 10/14/2005

Work Restrictions:

Estimated return to full duty:

DISPOSITION

Disposition:

Next Scheduled Appointment: 08:40 am 10/14/2005

"I have not violated Labor Code Section 139 3, and the contents of the report and bill are true and correct to the best of my knowledge This statement is made under penalty of perjury "

Signed,
Donald Rossman, *(Original signature on file)*

Doctor's Phone: (209) 461-3196 opt 3
Doctor's Fax: (209) 461-7529
Case Coordinator Phone: (209) 461-3196 opt 1

DH-WSR 8/15/05

DAMERON HOSPITAL
OCCUPATIONAL INURY CLINIC

only R

WORK STATUS REPORT - WORKSHEET

Employee Name: Anderson, Tiffany K Date of this Examination: 10/13/2005
Employer: SJ Mosquito and Vector Clinic Case Number: 78225

DIAGNOSIS: ✓ 492.9.

CLINICAL STATUS: __Q1· Improved, as expected __Q2. Improving slowly __Q3 No significant change __Q4. Worse

PT/OT: __W1: Continue as prescribed __W2: 3x/wk - 2 week __W3 3x/wk – 1 week __W4 One visit __W5 Non-DHA PT

RECOMMENDED EVALUATION / DIAGNOSTIC STUDIES:
__E1. MRI __E2 CT Scan __E3. NCS __E4. Work Conditioning __E5 Epidurals __E6 Ergo Evaluation

REFERRAL / CONSULT:

__ R10· Orthopedist	__ R14: General Surgeon	__ R18· ENT	__ R22 Health Club
__ R11· Ophthalmologist	__ R15· Neurologist	__ R19. Dermatology	__ R23. Urology
__ R12: Neurosurgeon	__ R16· Psych	__ R20. Pain Mgmt	__ R24 Acupuncture
__ R13· Hand Specialist	__ R17. Physiatrist	__ R21· Dentist	__ R25· Podiatrist

WORK STATUS: __ Full work duties __ Off balance of shift, modified work __ No work until next appt
__ Modified work duties ✓ Off balance of shift, full work duties __ Current WS until Specialist appt

WORK RESTRICTIONS: 10/14/05

No lift / carry >·
__A09. 50#
__A10· 10-15#
__A11 30#
__A12. 5#

No prolonged
__A15·Stand/Walk
__A16.Sitting

Other Back/Neck
__A13. No frequent lift, bend, twist, stoop at waist
__A14· Limit twist / bend at neck
__A17. Desk / sedentary only

Lower Extremity
__A18 No crawl / kneel / squat
__A19 No climbing ladders
__A20 Use crutches as directed
__A21 Elevate as directed
__A22 Use cane as directed

Upper Extremity
__S10 Wear splint / sling as directed
__S11 No frequent / repetitive use of wrist / hand
__S12 No heavy pushing or pulling
__S13 No use of arm above shoulder
__S14 No forceful hand grasp
__S15 No use of injured body part

Miscellaneous
__S16· Limited use of injured body part
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__S19 No operating company vehicles
__S20· No exposure to heat
__S21 No exposure to cold
__S22 No exposure to chemical, vapors, fumes
__S23 No welding
__S24 Avoid physical altercations
__S25 Avoid wearing latex gloves
__S27 Limit keyboarding 45 min/hr
__S28 Limit keyboarding 4 hr/day

PR STATUS:

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__ PR-2· Change in Work Status	__ PR-5 Referral/Consult	__ PR-8 Request by Adjuster
__ PR-3 Change in Pt Condition	__ PR-6 Surgery/Hospitalization	__ PR-9 Other _____

DISPOSITION.
__D1· Consult
__D5 Referral / Transfer of care
__D6 Non-occupational, refer to PMD
__D2 Final Discharge without residuals, PR-2 to follow
__D4 Final Discharge with residuals, PR-3 to follow
__D3 First Aid

Next scheduled appointment: 1 day. Provider initial: d/r

✓ Kenalog 1cc IM.

Occupational Injury Clinic

Injury Worksheet

Patient
Anderson, Tiffany K
1416 Iris Dr #7
Lodi, CA 95242-

PHONE (209) 333-1037

Employer
SJ Mosquito and Vector Control
7759 S Airport Way

Stockton, CA 95206-

CONTACT
PHONE / FAX (209) 982-4675x / (209) 982-0120

Guarantor
AIMS - Fresno 8046
PO Box 28100

Fresno, CA 93729-

PHONE / FAX (559) 227-9891 / (559) 227-1579

Sex: F **DOB** : 08/22/1970 **Age** 35 **SSN#** : 549-23-5133
Occupation : Tech I
Department
Injury Location :
Patient History :

Date/Hour of Injury : 10/11/2005 at 09 00 am
Case Number : 78225
Claim Number : Pending

Check In Instructions

Date/Time of Visit : 10/13/2005 at 07 49 am

Chart Up _____ _____ am / pm
Patient Back _____:_____ am / pm
Discharged _____ _____ am / pm

Results in Stolas: *Date* _____ *Initials* _____

Page OHS staff @ 929-2541 BEFORE proceeding

DRUG AND ALCOHOL TESTING
* None

OTHER INSTRUCTIONS
* Company may request DOT UDS & BAT
* Lab Quest, Test #35304N, Client #76337

TREATMENT AUTHORIZATION
1 John Stroh
2 Carol Aksland
3 Ed Lucchesi

Service Procedures

Ord	Compl	Service Procedures / Service Instructions		Charge
_____	_____	84483	DOT Panel (co req) - At company request	13 50
_____	_____	84460	Urine Drug Screen Collection - OIC (co req) - At company request	20.00
_____	_____	84178	MRO - DOT (co req) - At company request	10.00
_____	_____	84542	Breath Alcohol Test - OIC (co req) - At company request	20 00
_____	_____	84461	Urine Drug Screen Collection - ER	20.00
_____	_____	84543	Breath Alcohol Test - After Hours	20 00

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION

NAME: Anderson, Tiffany K **DOS:** 10/13/2005
DOB: 8/22/1970

CONSENT

I hereby authorize the Dameron Hospital occupational Health Department to:

- ☑ Obtain a complete medical history and physical examination including any required medical tests
- ☑ Provide medical treatment for a work-related injury
- ☐ Obtain a urine specimen and/or breath sample for drug and/or alcohol testing

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I hereby authorize the Dameron Hospital Occupational Health Department to furnish to an agent, designee or representative of ***SJ Mosquito and Vector Control*** the results of my medical evaluation and/or treatment including past or present records pertaining to employment history, medical history, test results, urine drug and/or breath alcohol test results, services rendered or treatment provided to me.

USE

I understand that this medical information will be used for the purpose of determining my ability to perform the essential functions of my job with ***SJ Mosquito and Vector Control***.

RESTRICTIONS

I understand that ***SJ Mosquito and Vector Control*** may use these medical records only for employment-related purposes and that they may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

DURATION

This authorization is effective immediately and shall remain in effect for one year from **10/13/2005**

ADDITIONAL COPY

I understand that I have a right to receive a copy of this form and that a copy of this document is as valid as the original

I would like a copy of this form ☐ Yes ☑ No Received. ☐ Yes ☐ No Initial _____

SIGNATURE

_____
Employee signature

_____
Witness Signature

Date: 10/13/200

Non-DOT Drug Screens Only
List current meds: ☐ None
Rx: _____
_____
OTC: _____

Occupational Injury Clinic

Recheck Worksheet

Patient	Employer	Guarantor
Anderson, Tiffany K 1416 Iris Dr #7 Lodi, CA 95242	SJ Mosquito and Vector Control 7759 S Airport Way Stockton, CA 95206	AIMS - Fresno 8046 PO Box 28100 Fresno, CA 93729
Phone (209) 333-1037	Contact : John Stroh Phone (209) 982-4675 x Fax : (209) 982-0120	Phone (559) 227-9891 Fax : (559) 227-1579

Sex	Female	**DOB** : 08/22/1970	**Age:** 35	**Date/Hour of Injury**	: 10/11/2005 at 09:00 am
Social Security #	: 549-23-5133			**Last Work Date**	:
Occupation	: Tech I			**Case Number**	: 78225
Department	:			**Claim Number**	: Pending

Date/Time of Visit : 10/25/2005 at 07 25 am

Check In Instructions

Page OHS staff @ 929-2541 BEFORE proceeding

DRUG AND ALCOHOL TESTING
* None

OTHER INSTRUCTIONS
* Company may request DOT UDS & BAT
* Lab Quest, Test #35304N, Client #76337

TREATMENT AUTHORIZATION
1 John Stroh
2 Carol Aksland
3 Ed Lucchesi

Provider's Notes

☑ Dictation Complete

dlv

420 W. Acacia Street , STE # 2 Linacia 1st Floor, Stockton, CA 95204
Phone (209) 461-3196 Fax: (209) 461-7520

Occupational Injury Clinic

Recheck Worksheet

Patient	Employer	Guarantor
Anderson, Tiffany K 1416 Iris Dr #7 Lodi, CA 95242	SJ Mosquito and Vector Control 7759 S Airport Way Stockton, CA 95206	AIMS - Fresno 8046 PO Box 28100 Fresno, CA 93729
Phone: (209) 333-1037	Contact : John Stroh Phone : (209) 982-4675 x Fax : (209) 982-0120	Phone (559) 227-9891 Fax : (559) 227-1579

Sex: Female	**DOB :**	08/22/1970	**Age:** 35	**Date/Hour of Injury :**	10/11/2005 at 09.00 am
Social Security # :		549-23-5133		**Last Work Date :**	
Occupation :		Tech I		**Case Number :**	78225
Department :				**Claim Number :**	Pending

Date/Time of Visit : 10/20/2005 at 08.52 am

Check In Instructions

Page OHS staff @ 929-2541 BEFORE proceeding

DRUG AND ALCOHOL TESTING
* None

OTHER INSTRUCTIONS
* Company may request: DOT UDS & BAT
* Lab Quest, Test #35304N, Client #76337

TREATMENT AUTHORIZATION
1 John Stroh
2 Carol Aksland
3 Ed Lucchesi

Provider's Notes

☑ Dictation Complete

Occupational Injury Clinic
420 W Acacia Street , STE # 2 Linacia 1st Floor
Stockton, CA 95204

DATE	10/17/2005		
PATIENT	Anderson, Tiffany K	DATE OF INJURY .	10/11/2005
EMPLOYER	SJ Mosquito and Vector Control	SOC. SEC #	· 549-23-5133
CASE #	76225	CLAIM #	· VE060031

SUBJECTIVE·

The patient's rash is improving. She is no longer having symptoms pruritic. She is having some "flu symptoms" at this time. She may have had a fever last evening, general malaise, denies sore throat, no respiratory symptoms, slight nausea.

OBJECTIVE.

She is alert, in no acute distress She is well hydrated. Ears, nose and throat. There is mild pharyngeal erythema. Neck Supple, no adenopathy. Lungs: Clear without wheeze, rales, rhonchi Breath sounds equal Heart· Regular rhythm without murmur. Heart sounds normal. Abdomen Soft and nontender without organomegaly or mass. Skin· There are a faint scattered erythematous small macules at the back. There are no inguinal nodes.

ASSESSMENT

1 Probable allergic reaction
2 Rule out viral syndrome

PLAN
Followup in three days

DR/bjg

D 10/17/2005
T 10/28/2005

I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury

Occupational Injury Clinic
420 W. Acacia Street , STE # 2 Linacia 1st Floor
Stockton, CA 95204

DATE	10/14/2005		
PATIENT	Anderson, Tiffany K	DATE OF INJURY	10/11/2005
EMPLOYER	SJ Mosquito and Vector Control	SOC SEC.#	549-23-5133
CASE #	78225	CLAIM #	VE060031

SUBJECTIVE·

The patient is much better, has no pruritus Her skin rash is improved. No respiratory difficulties or chest pain She was complaining of some drowsiness this morning, actually missed her appointment as she was quite drowsy secondary to Benadryl

OBJECTIVE

On examination, she is alert in no acute distress. Throat is clear Neck is without adenopathy Lungs are clear without wheeze, rales, rhonchi. Breath sounds equal. Heart: Regular rhythm without murmur. Heart sounds normal.

ASSESSMENT

Allergic skin reaction, contact

The patient's symptoms are resolving She is to continue her Benadryl in the evening and she will follow up if her symptoms increase, otherwise, she will follow up on Monday October 17

DR/bjg

D 11/01/2005
T 11/14/2005

I have not violated Labor Code Section 139 3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury

Occupational Injury Clinic
420 W. Acacia Street , STE # 2 Linacia 1st Floor
Stockton, CA 95204

DATE	10/13/2005		
PATIENT	Anderson, Tiffany K	DATE OF INJURY	10/11/2005
EMPLOYER	SJ Mosquito and Vector Control	SOC. SEC #	549-23-5133
CASE #	78225	CLAIM #	VE060031

SUBJECTIVE.

The patient continues to complain of primarily malaise at this point. She notes that she has had similar symptoms in the winters in the past on a rather recurrent basis, although more generally more marked symptomatology than she is experiencing. She is no longer having pruritus. She is not having any generalized headaches or sore throat at this time. She has no chest or respiratory symptoms, however, she is complaining of some nausea.

OBJECTIVE.

The ears, nose and throat are clear Her neck is supple. There is no adenopathy. Lungs are clear. Heart Regular rhythm without murmur. Heart sounds normal. Abdomen is soft, nontender without organomegaly Skin. There is a very faint erythematous macular rash over the upper back

ASSESSMENT.

Possible contact allergy Given her persistent symptoms and the character of the rash, viral exanthem is certainly a possibility. She did have a CBC on her last visit which was essentially normal white count. I will continue to observe her here, however, she is to see her private medical doctor hopefully today for evaluation.

DR/bjg

D 10/13/2005
T 10/27/2005

I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge This statement is made under penalty of perjury

Occupational Injury Clinic
[redacted]0 W Acacia Street , STE # 2 Linacia 1st Flo[redacted]
Stockton, CA 95204-

DOCTOR' S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

STATE OF CALIFORNIA

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's worker's compensation insurance carrier or the self insured employer Failure to file a timely doctor's report may result in assessment of a civil penalty In case of diagnosed or suspected pesticide poisoning send a copy of this report to Division of Labor Statistics and Research, P O Box 420603 San Francisco, CA 94142-0603 and notify your local health officer by telephone within 24-hours

1 INSURED NAME AND ADDRESS AIMS - Fresno 8046 PO Box 28100, Fresno, CA 93729		PLEASE DO NOT USE THIS COLUMN
2 EMPLOYER NAME SJ Mosquito and Vector Control		Case no
3 Address No and Street: 7759 S Airport Way; City: Stockton; Zip: 95206		Industry
4 Nature of Business (e g , food manufacturing, building construction, retailer of women's clothes)		County
5 PATIENT NAME: Anderson, Tiffany K 6 Sex: [ ] Male [X] Female 7 Date of Birth: Mo Day Year 08/22/1970		Age
8 Address No and Street: 1416 Iris Dr #7; City: Lodi; Zip: 95242 9 Telephone Number: (209) 333-1037		Hazard
10 Occupation (Specific Job title): Tech I 11 Social Security Number: 549-23-5133		Disease
12 Injured at No and Street: WORK PLACE; City: STOCKTON County: SAN JOAQUIN		Hospitalization
13 Date and hour of injury or onset of illness: Mo Day Yr 10/11/2005; Hour 09 00 am 14 Date Last Worked Mo Day Yr		Occupation
15 Date and hour of first examination or treatment: Mo Day Yr 10/13/2005; Hour 16 Have you (or your office) previously treated patient? [ ] Yes [X] No		Return Date/Code

Patient please complete this portion, if able to do so Otherwise, doctor please complete Immediately Inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code

17 **DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED** (Give specific object, machinery or chemical Use reverse side if more space is required)
SEE ATTACHED DICTATION

18 **SUBJECTIVE COMPLAINTS (Describe fully Use the reverse side if more space is required)**
SEE ATTACHED DICTATION

19 **OBJECTIVE FINDINGS** (Use reverse side if more space is required)
A Physical examination
SEE ATTACHED DICTATION

B X-ray and laboratory results (State if none pending)

20 **DIAGNOSIS** (If occupational illness, specify etiologic agent and duration of exposure) Chemical or toxic compounds involved? [ ] Yes [X] No ICD-9
692 9 Dermatitis, Contact Allergic

21 Are your findings and diagnosis consistent with patient's account of injury or onset of illness? [X] Yes [ ] No
If "no" please explain

22 Is there any other current condition that will impede or delay patient's recovery? [ ] Yes [X] No
If "yes" please explain

23 **TREATMENT RENDERED** (Use reverse side if more space is required)
SEE ATTACHED DICTATION

If further treatment required specify treatment — Estimated duration

24 If Hospitalized as inpatient, give hospital name and location — Date admitted Mo Day Yr — Estimated stay

25 **WORK STATUS** Is patient able to perform usual work? [ ] Yes [X] No
If no", patient can return to Mo Day Yr
Regular work _____
Modified work 10/13/2005 Specify restrictions _____

I have not violated Labor Code 139 3 and the contents of the report and bill are true and correct to the best of my knowledge This statement is made under penalty of perjury

Doctor's signature _____ Date _____ CA License Number C35074
Doctor name and degree (Please type) Donald Rossman, M D IRS Number _____
Case # 78225 Telephone Number _____

ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR PURPOSE OF OBTAINING OR DENYING WORKERS' COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY

DAMERON HOSPITAL CLINICAL LABORATORY
525 West Acacia Street Stockton California 95203
Laboratory Directors: J.L. Dickerson,M.D. R.D. Lawrence,M.D.

NAME: ANDERSON,TIFFANY K
SEX: F AGE: 35Y DOB: 08/22/1970
DR: HULL,INJURIES,
COPY TO DR: ROSSMAN,DONALD L MD

LOC: OCC Injury Clinic
ID: 08599110015
MR: 626041

ACC M4535 COLLECT 10/17/2005 08:25 RECEIPT 10/17/2005 11 51 ORD DR: ROSSMAN,DONALD L MD

	ABN LOW	NORMAL	ABN HIGH			
CBC						
WBC Count		6.2			[4.5-11.0]	10^3/uL
RBC Count		4.62			[3.80-5.30]	10^6/uL
Hemoglobin		13.7			[11.7-16.1]	g/dL
Hematocrit		40.1			[37.0-47 0]	%
MCV		87			[73-100]	fL
MCH		29.7			[26.0-35 0]	pg/Erc
MCHC		34.2			[31.0-36.0]	gHb/dL
PLT Count		231			[150-450]	10^3/uL
RDW-CV		13.4			[11.0-16 0]	%
Differential						
Abs Neutrophil Auto		4.2			[2.2-7.6]	10^3/uL
Abs Lymphocyte Auto		1.4			[1.0-3.8]	10^3/uL
Abs Monocyte Auto		0.3			[0.1-0.9]	10^3/uL
Abs Eosinophil Auto		0.1			[0.00-0.40]	10^3/uL
Abs Basophil Auto		0.1			[0.0-0.1]	10^3/uL
Neutrophil Auto		68			[55-75]	%
Lymphocyte Auto		23			[20-35]	%
Monocyte Auto		6			[2-8]	%
Eosinophil Auto		1 71			[1-4]	%
Basophil Auto			1.44	H	[0-1]	%

dlv

END OF REPORT

NAME ANDERSON,TIFFANY K
LOC OCC Injury Clinic

10/17/2005 12.10

PHYSICIAN / CLIENT REPORT
PAGE: 1

DAMERON HOSPITAL ASSOCIATION
Occupational Injury Clinic

Initial Visit

$40.46

10/13/2005 7:49 a.m.

Patient Name *Nombre de paciente* Tiffany Anderson	**Sex** ☐ Male *Masculino* ☒ Female *Femenino*	**Birthdate:** *Fecha de nacimiento* 8-22-70	
Street Address: *Domicilio* 1416 Iris Dr. #7	**Status.** ☐ Married *Casado* ☒ Single *Soltero*	**Home Telephone No.:** *Telefono de casa* 209-333-1037	
City, State, Zip. *Ciudad Estado Zip* Lodi CA 95242		**Social Security Number:** *Seguro Social* 549-23-5133	
Employer: *Empleador* SJCMVC		**Job Title:** *Ocupacion* Tech I	
Date of Injury *Fecha de accidente* 10-11-05 **Hour** *Hora* 9 00 ☒ AM ☐ PM	**Date last worked:** *Dia que trabajo ultimo* 10-13-05	**Have you been seen here before?** *Ha venido aqui antes?* ☒ YES/*Si* ☐ NO	
Have you received treatment for this injury elsewhere? *A recibido tratamiento para este accidente en otro lugar?* ☐ YES/*Si* ☒ NO	If yes, where? *Si, Cuando?*	Date *Fecha*	

Describe how the injury occurred *Como ocurrio el accidente* Checking a mosquito breeding source and the bank of the ditch gave way I fell into a four 1/2 Ft ditch filled with water.

SUMMARY OF DIAGNOSIS AND CONDITIONS

Significant Diagnosis	Major Surgery	Medications	Drug Allergies
1 DENIES	1 DENIES	1 XANAX	1 NKA
2	2	2	2
3	3	3	3
4	4	4	4

Tetanus: | **Vision.** Rt 20/ Lt 20/ | **Dominant Hand:** (Rt) Lt

PROVIDER NOTES

Subjective: ☑ *dictated*

Objective ☑ *dictated*

Penicillin 240 u, IM

Assesment: ☑ *dictated*

Bactrim 50 mg q6h #16

Orders. X-Ray _____ Lab _____ Injection _____

Results: _____ _____

Treatments.

Medications _____ Dose _____ Quantity _____

Medications _____ Dose _____ Quantity _____

Medications _____ Dose _____ Quantity _____

Physician Signature. _____

DAMERON HOSPITAL
Occupational Injury Clinic

Name: Anderson, Tiffany K **Date:** 10/13/2005
SSN: 549-23-5133 **Case No.:** 78225 **Employer:** SJ Mosquito and Vector Control

VITAL SIGNS AND NURSES NOTES

Date	Time	Blood Pressure	Pulse	Resp.	Temp.	Notes	Initials
10/13/05	0154	120/82	76	16	97.9	CC/35Y/O FEMALE C/O RASH ON BODY NO DIFFICULT BREATH C/O FATIGUES —	P.Hamel
10/13/05	0935					INJECTION PER DR ROSSMAN 40mg KENALOG IM. LOT 5F0 6515 APP 07 —	P.Hamel
10/14/05	1005					Rash remains	
10/14/05	1025	157/75	73	16	97.3	REV V/S PER DR. ROSSMAN	JP
10/17/05	0755					Rev rash - almost gone - Engel	
10/17/05	0815	117/84	64	16	97.8	V.S per Dr Rossman	for
10/20/05	0900	118/82	76	16	97.8	REV RASH: IMPROVING C/O FLU LIKE SYMPTOMS	JP
10/25/05		140				Improved	
10/25	0750	139/99 130/90	70	16	97.7	V.S per Dr Rossman - Engel	

Dameron Hospital Occupational Health Services
525 W. Acacia St., Stockton, CA 95203

WORK STATUS REPORT

Employee Name:	Anderson, Tiffany K	**Date of Visit:**	06/21/2004
Social Security No.:	549-23-5133	**Time In:** 09:20 am	**Time Out:** 10:09 am
Employer:	SJ Mosquito and Vector Control		
Date of Injury:	06/07/2004	**Guarantor:**	Gregory B Bragg and
Clinic Case Number:	56808	**Claim Number:**	Pending

CLINICAL STATUS

Diagnosis: Dermatitis, Contact Irritant

Since the last visit, this patient's condition has Improved as expected

EVALUATION AND TREATMENT PLAN

Physical / Occupational Therapy:

Recommended Evaluation / Diagnostic Studies:

WORK STATUS

Work Status: Full work duties **From:** 06/21/2004 **To:** 06/21/2004

Work Restrictions:

Estimated return to full duty:

DISPOSITION

Disposition: Final Discharge, P&S, no residuals PR2 to follow

Next Scheduled Appointment:

Note Missed appointments without 24 hours advance notice will be charged a $25 fee

"I have not violated Labor Code Section 139 3, and the contents of the report and bill are true and correct to the best of my knowledge This statement is made under penalty of perjury"

Signed,
Corky Hull, MD (Original signature on file)

Doctor's Phone: (209) 461-3196 opt. 3
Doctor's Fax: (209) 461-7529
Case Coordinator Phone: (209) 461-3196 opt 1

DFWSR 8/1/03

DAMERON HOSPITAL
OCCUPATIONAL INURY CLINIC

WORK STATUS REPORT - WORKSHEET

Employee Name Anderson, Tiffany K Date of this Examination 06/21/2004
Employer SJ Mosquito and Vector Clinic Case Number 56808

DIAGNOSIS

CLINICAL STATUS __Q1 Improved, as expected __Q2 Improving slowly __Q3 No significant change __Q4 Worse

PT/OT. __W1 Continue as prescribed __W2 3x/wk - 2 week __W3 3x/wk – 1 week __W4 One visit __W5 Non-DHA PT

RECOMMENDED EVALUATION / DIAGNOSTIC STUDIES
__E1 MRI __E2 CT Scan __E3 NCS __E4 Work Conditioning __E5 Epidurals __E6 Ergo Evaluation

REFERRAL / CONSULT.

__ R10 Orthopedist
__ R11 Ophthalmologist
__ R12 Neurosurgeon
__ R13 Hand Specialist
__ R14 General Surgeon
__ R15 Neurologist
__ R16 Psych
__ R17 Physiatrist
__ R18 ENT
__ R19 Dermatology
__ R20 Pain Mgmt
__ R21 Dentist
__ R22 Health Club
__ R23 Urology
__ R24 Acupuncture
__ R25 Podiatrist

WORK STATUS
__ Full work duties
__ Modified work duties
__ Off balance of shift, modified work
__ Off balance of shift, full work duties
__ No work until next appt
__ Current WS until Specialist appt

WORK RESTRICTIONS.

No lift / carry >
__A09 50#
__A10 10-15#
__A11 30#
__A12 5#

No prolonged
__A15 Stand/Walk
__A16 Sitting

Other Back/Neck
__A13. No frequent lift, bend, twist, stoop at waist
__A14 Limit twist / bend at neck
__A17 Desk / sedentary only

Lower Extremity
__A18 No crawl / kneel / squat
__A19 No climbing ladders
__A20 Use crutches as directed
__A21 Elevate as directed
__A22 Use cane as directed

Upper Extremity
__S10 Wear splint / sling as directed
__S11 No frequent / repetitive use of wrist / hand
__S12 No heavy pushing or pulling
__S13 No use of arm above shoulder
__S14 No forceful hand grasp
__S15 No use of injured body part

Miscellaneous
__S16 Limited use of injured body part
__S17 May advance work activities as tolerated
__S18 Keep dressing clean and dry
__S19 No operating company vehicles
__S20 No exposure to heat
__S21 No exposure to cold
__S22 No exposure to chemical, vapors, fumes
__S23 No welding
__S24 Avoid physical altercations
__S25 Avoid wearing latex gloves
__S27 Limit keyboarding 45 min/hr
__S28 Limit keyboarding 4 hr/day

PR STATUS

__ PR-1 Periodic Report
__ PR-2 Change in Work Status
__ PR-3 Change in Pt Condition
__ PR-4 Change in Tx Plan
__ PR-5 Referral/Consult
__ PR-6 Surgery/Hospitalization
__ PR-7 Discharge
__ PR-8 Request by Adjuster
__ PR-9 Other _____

DISPOSITION
__D1 Consult
__D5 Referral / Transfer of care
__D6 Non-occupational, refer to PMD
__D2 Final Discharge without residuals, PR-2 to follow
__D4 Final Discharge with residuals, PR-3 to follow
__D3 First Aid

Next scheduled appointment _____ Provider Initial _____

Dameron Hospital Occupational Health Services
525 W. Acacia St, Stockton, CA 95203

WORK STATUS REPORT

Employee Name:	Anderson, Tiffany K	**Date of Visit:**	06/09/2004
Social Security No.:	549-23-5133	**Time In:** 07:55 am	**Time Out:** 08:45 am
Employer:	SJ Mosquito and Vector Control		
Date of Injury:	06/07/2004	**Guarantor:**	Gregory B Bragg and
Clinic Case Number:	56808	**Claim Number:**	Pending

CLINICAL STATUS

Diagnosis: Dermatitis, Contact Irritant

Since the last visit, this patient's condition has

EVALUATION AND TREATMENT PLAN

Physical / Occupational Therapy:

Recommended Evaluation / Diagnostic Studies:

WORK STATUS

Work Status: Full work duties **From:** 06/09/2004 **To:** 06/18/2004

Work Restrictions:

Estimated return to full duty:

DISPOSITION

Disposition:

Next Scheduled Appointment: 07:40 am 06/18/2004

Note Missed appointments without 24 hours advance notice will be charged a $25 fee.

"I have not violated Labor Code Section 139 3, and the contents of the report and bill are true and correct to the best of my knowledge This statement is made under penalty of perjury"

Signed,

Corky Hull, MD (Original signature on file)

Doctor's Phone: (209) 461-3196 opt 3
Doctor's Fax: (209) 461-7529
Case Coordinator Phone: (209) 461-3196 opt 1

DH-WSR 8/14/02

DAMERON HOSPITAL
OCCUPATIONAL INURY CLINIC

WORK STATUS REPORT - WORKSHEET

Employee Name: Anderson, Tiffany K Date of this Examination: 06/09/2004
Employer: SJ Mosquito and Vector Clinic Case Number: 56808

DIAGNOSIS: contact dermatitis

CLINICAL STATUS: __Q1 Improved, as expected __Q2. Improving slowly __Q3. No significant change __Q4· Worse

PT/OT: __W1 Continue as prescribed __W2 3x/wk - 2 week __W3 3x/wk – 1 week __W4· One visit __W5 Non-DHA PT

RECOMMENDED EVALUATION / DIAGNOSTIC STUDIES.
__E1· MRI __E2 CT Scan __E3 NCS __E4· Work Conditioning __E5. Epidurals __E6. Ergo Evaluation

REFERRAL / CONSULT:

__ R10 Orthopedist
__ R11· Ophthalmologist
__ R12· Neurosurgeon
__ R13 Hand Specialist
__ R14 General Surgeon
__ R15 Neurologist
__ R16 Psych
__ R17. Physiatrist
__ R18: ENT
__ R19. Dermatology
__ R20. Pain Mgmt
__ R21: Dentist
__ R22. Health Club
__ R23· Urology
__ R24· Acupuncture
__ R25. Podiatrist

WORK STATUS:
X Full work duties
__ Modified work duties
__ Off balance of shift, modified work
__ Off balance of shift, full work duties
__ No work until next appt.
__ Current WS until Specialist appt

WORK RESTRICTIONS:

No lift / carry >
__A09 50#
__A10 10-15#
__A11 30#
__A12 5#

No prolonged
__A15 Stand/Walk
__A16.Sitting

Other Back/Neck
__A13. No frequent lift, bend, twist, stoop at waist
__A14· Limit twist / bend at neck
__A17 Desk / sedentary only

Lower Extremity
__A18 No crawl / kneel / squat
__A19 No climbing ladders
__A20 Use crutches as directed
__A21 Elevate as directed
__A22 Use cane as directed

Upper Extremity
__S10 Wear splint / sling as directed
__S11 No frequent / repetitive use of wrist / hand
__S12 No heavy pushing or pulling
__S13 No use of arm above shoulder
__S14 No forceful hand grasp
__S15 No use of injured body part

Miscellaneous
__S16· Limited use of injured body part
__S17· May advance work activities as tolerated
__S18 Keep dressing clean and dry
__S19· No operating company vehicles
__S20. No exposure to heat
__S21· No exposure to cold
__S22 No exposure to chemical, vapors, fumes
__S23 No welding
__S24 Avoid physical altercations
__S25 Avoid wearing latex gloves
__S27· Limit keyboarding. 45 min/hr
__S28 Limit keyboarding 4 hr/day

PR STATUS:

__ PR-1 Periodic Report
__ PR-2 Change in Work Status
__ PR-3 Change in Pt Condition
__ PR-4· Change in Tx Plan
__ PR-5 Referral/Consult
__ PR-6. Surgery/Hospitalization
__ PR-7. Discharge
__ PR-8· Request by Adjuster
__ PR-9· Other _____

DISPOSITION·
__D1 Consult
__D2. Final Discharge without residuals, PR-2 to follow
__D5 Referral / Transfer of care
__D4· Final Discharge with residuals, PR-3 to follow
__D6 Non-occupational, refer to PMD
X D3: First Aid

Next scheduled appointment: 1 week

Provider Initial·

6-18-04

DFWH Workshop Report

Occupational Injury Clinic

Injury Worksheet

Patient

Anderson, Tiffany K
1830 S Hutchins Apt304
Lodi, CA 95240-

PHONE (209) 333-9249

Employer

SJ Mosquito and Vector Control
7759 S Airport Way

Stockton, CA 95206-

CONTACT
PHONE / FAX (209) 982-4675x / (209) 982-0120

Guarantor

Gregory B Bragg and Associates-Roseville
PO Box 619058

Roseville, CA 95661-9058

PHONE / FAX (800) 422-7244 / (916) 783-0335

Sex. F **DOB** : 08/22/1970 **Age** : 33 **SSN#** : 549-23-5133
Occupation : Tech
Department :
Injury Location :
Patient History :

Date/Hour of Injury : 06/07/2004 at 12 00 pm
Case Number : 56808
Claim Number : Pending

Check In Instructions

Date/Time of Visit : 06/09/2004 at 07.55 am

Drug/Alcohol Testing:
--DOT BAT at company request
--DOT UDS at company request
----Quest, Test #35304N, Client #76337
--Page OHS @ 929-2541 before discharge!

Chart Up ____:____ am / pm
Patient Back ____:____ am / pm
Discharged ____:____ am / pm

Results in Stolas: *Date* _____ *Initials* _____

Work Status
--Modified duty available

--New injuries must have written or verbal auth
from one of the following contacts
----1 John Stroh
----2 Carol Aksland
----3 Eddie Lucchesi

Service Procedures

Ord	Compl		Service Procedures / Service Instructions	Charge
____	____	84483	DOT Panel (co req) - At company request	13 50
____	____	84460	Urine Drug Screen Collection - OIC (co req) - At company request	20 00
____	____	84178	MRO - DOT (co req) - At company request	10 00
____	____	84542	Breath Alcohol Test - OIC (co req) - At company request	20 00
____	____	84461	Urine Drug Screen Collection - ER	20 00
____	____	84543	Breath Alcohol Test - After Hours	20 00

Occupational Injury Clinic

Injury Worksheet

Patient

Anderson, Tiffany K
1830 S Hutchins Apt304
Lodi, CA 95240-

PHONE (209) 333-9249

Employer

SJ Mosquito and Vector Control
7759 S Airport Way

Stockton, CA 95206-

CONTACT
PHONE / FAX (209) 982-4675x / (209) 982-0120

Guarantor

Gregory B Bragg and Associates-Roseville
PO Box 619058

Roseville, CA 95661-9058

PHONE / FAX (800) 422-7244 / (916) 783 0335

Sex. F	**DOB** : 08/22/1970	**Age** : 33	**SSN#** : 549-23-5133	**Date/Hour of Injury** :	06/07/2004 at 12.00 pm
Occupation	: Tech			**Case Number** :	56808
Department	:			**Claim Number** :	Pending
Injury Location	:				
Patient History	:				

Check Out Instructions

Reporting Instructions:
--Autofax work status to employer

--Verbal results to
----1 John Stroh
----2 Carol Aksland
----3 Eddie Lucchesi

Special Instructions.
--None

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION

NAME: Anderson, Tiffany K **DOS:** 06/09/2004
DOB: 8/22/1970

CONSENT

I hereby authorize the Dameron Hospital occupational Health Department to:

- ☐ Obtain a complete medical history and physical examination including any required medical tests
- ☐ Provide medical treatment for a work-related injury
- ☐ Obtain a urine specimen and/or breath sample for drug and/or alcohol testing

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I hereby authorize the Dameron Hospital Occupational Health Department to furnish to an agent, designee or representative of ***SJ Mosquito and Vector Control*** the results of my medical evaluation and/or treatment including past or present records pertaining to employment history, medical history, test results, urine drug and/or breath alcohol test results, services rendered or treatment provided to me.

USE

I understand that this medical information will be used for the purpose of determining my ability to perform the essential functions of my job with ***SJ Mosquito and Vector Control.***

RESTRICTIONS

I understand that ***SJ Mosquito and Vector Control*** may use these medical records only for employment-related purposes and that they may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

DURATION

This authorization is effective immediately and shall remain in effect for one year from **6/ 9/2004**

ADDITIONAL COPY

I understand that I have a right to receive a copy of this form and that a copy of this document is as valid as the original.

I would like a copy of this form ☐ Yes ☐ No Received: ☐ Yes ☐ No Initial _____

SIGNATURE

Employee Signature

Witness Signature

Date: 6/ 9/2004

Non-DOT Drug Screens Only

List current meds· ☐ None

Rx:_____

_____

OTC:_____

Occupational Injury Clinic
420 W. Acacia Street , STE # 2 Linacia 1st Floor
Stockton, CA 95204

DATE	06/21/2004		
PATIENT	Anderson, Tiffany K	DATE OF INJURY	: 06/07/2004
EMPLOYER	SJ Mosquito and Vector Control	SOC. SEC.#	: 549-23-5133
CASE #	56808	CLAIM #	: V04023776

SUBJECTIVE:

Follow up contact dermatitis.

OBJECTIVE:

Alert, no acute distress. No rash seen.

ASSESSMENT.

Contact dermatitis.

PLAN.

1 Discharge from care without residual

DR/hf

D 06/21/04
T 06/22/04

I have not violated Labor Code Section 139 3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury

Occupational Injury Clinic
420 W Acacia Street , STE # 2 Linacia 1st Floor
Stockton, CA 95204

DATE	06/09/2004		
PATIENT	Anderson, Tiffany K	DATE OF INJURY	06/07/2004
EMPLOYER	SJ Mosquito and Vector Control	SOC SEC #	549-23-5133
CASE #	56808	CLAIM #	Pending

SUBJECTIVE

She works for SJ Mosquito and Vector Control. She was out in brush and developed a rash, possible contact dermatitis from the brush She experienced a light itching in the last couple of days of her upper legs and buttocks and neck

OBJECTIVE

She is in no acute distress. Past medical history is unremarkable Currently taking no medications No drug allergies Currently she is not pregnant Last menstrual period was 6/4/04 Vital signs are within normal limits There is a faint macular papular type rash, kind of pink There is no streaking of the posterior aspect of the lower legs and there are some patches around her neck

ASSESSMENT

Contact dermatitis

PLAN

1 _____ cream 0 1% apply b i d 30 grams
2 We will give her Prednisone dose pack she is to take for 6 days and taper the dose Start with 60 mg and reduce the dose within 6 days to 10 mg and discontinue #21 10 mg Prednisone tablets dispensed
3 Return to clinic prn

DR/ds

D 6/9/04
T 6/10/04

I have not violated Labor Code Section 139 3 and the contents of the report and bill are true and correct to the best of my knowledge This statement is made under penalty of perjury

Occupational Injury Clinic
420 W Acacia Street , STE # 2 Linacia 1st F
Stockton, CA 95204-

DOCTOR' S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

STATE OF CALIFORNIA

Within 5 days of your initial examination, for every occupational injury or illness send two copies of this report to the employer's worker's compensation insurance carrier or the self-insured employer Failure to file a timely doctor s report may result in assessment of a civil penalty In case of diagnosed or suspected pesticide poisoning send a copy of this report to Division of Labor Statistics and Research P O Box 420603, San Francisco CA 94142-0603 and notify your local health officer by telephone within 24-hours

1 INSURED NAME AND ADDRESS
Gregory B Bragg and Associates-Roseville 8115 PO Box 619058, Roseville, CA 95661-9058

PLEASE DO NOT USE THIS COLUMN
Case no
Industry
County

2 EMPLOYER NAME
SJ Mosquito and Vector Control

3 Address — No and Street: 7759 S Airport Way — City: Stockton — Zip: 95206

4 Nature of Business (e g food manufacturing building construction retailer of women s clothes)

5 PATIENT NAME
Anderson, Tiffany K

6 Sex [ ] Male [X] Female

7 Date of Birth Mo Day Year: 08/22/1970

Age

8 Address — No and Street: 1830 S Hutchins Apt304 — City: Lodi — Zip: 95240

9 Telephone Number: (209) 333-9249

Hazard

10 Occupation (Specific Job title): Tech

11 Social Security Number: 549-23-5133

Disease

12 Injured at — No and Street: WORK PLACE — City: STOCKTON — County: SAN JOAQUIN

Hospitalization

13 Date and hour of injury or onset of illness — Mo Day Yr: 06/07/2004 — Hour: 12 00 pm

14 Date Last Worked Mo Day Yr

Occupation

15 Date and hour of first examination or treatment — Mo Day Yr: 06/09/2004 — Hour

16 Have you (or your office) previously treated patient? [ ] Yes [X] No

Return Date/Code

Patient please complete this portion, *if able to do so* Otherwise doctor please complete immediately Inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code

17 DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED (Give specific object machinery or chemical Use reverse side if more space is required)
SEE ATTACHED DICTATION

18 SUBJECTIVE COMPLAINTS (Describe fully Use the reverse side if more space is required)
SEE ATTACHED DICTATION

19 OBJECTIVE FINDINGS (Use reverse side if more space is required)
A Physical examination
SEE ATTACHED DICTATION

B X ray and laboratory results (State if none pending)

20 DIAGNOSIS (If occupational illness specify etiologic agent and duration of exposure) Chemical or toxic compounds involved? [ ] Yes [Y] No ICD-9
692 0 Dermatitis, Contact Irritant

21 Are your findings and diagnosis consistent with patient s account of injury or onset of illness? [X] Yes [ ] No
If no please explain

22 Is there any other current condition that will impede or delay patient s recovery? [ ] Yes [X] No
If yes please explain

23 TREATMENT RENDERED (Use reverse side if more space is required)
SEE ATTACHED DICTATION

If further treatment required specify treatment

24 If Hospitalized as inpatient give hospital name and location — Date admitted Mo Day Yr — Estimated duration Estimated stay

25 WORK STATUS If no patient can return to — Is patient able to perform usual work? [X] Yes [ ] No
Mo Day Yr
Regular work 06/09/2004
Modified work — Specify restrictions

I have not violated Labor Code 139 3 and the contents of the report and bill are true and correct to the best of my knowledge This statement is made under penalty of perjury

Doctor s signature — Date 06/09/2004 — CA License Number C35074

Doctor name and degree (Please type) Donald Rossman, M D — IRS Number

Case # 56808 — Telephone Number

ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR PURPOSE OF OBTAINING OR DENYING WORKERS' COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY

8115

DAMERON HOSPITAL ASSOCIATION
Occupational Injury Clinic **Initial Visit** 6/ 9/2004 7:55 a.m.

Patient Name: *Nombre de paciente* Tiffany Anderson	**Sex:** *Sexo* ☐ Male *Masculino* ☒ Female *Femenino*		**Birthdate:** *Fecha de nacimiento* 8-22-70
Street Address: *Domicilio* 1830 S. Hutchins #304	**Status.**	**Home Telephone No.:** *Telefono de casa* 209-333-9249	
City, State, Zip: *Ciudad, Estado, Zip* Lodi CA 95240	☐ Married *Casado*	**Social Security Number:** *Seguro Social* 549-23-5133	
Employer: *Empleador* S.J. County mosquito & vector control	☒ Single *Soltero*	**Job Title:** *Ocupacion* Tech	
Date of Injury. *Fecha de accidente* 6/7/04 **Hour** *Hora* ☐ AM ☒ PM	**Date last worked:** *Dia que trabajo ultimo*	**Have you been seen here before?** *Ha venido aqui antes?* ☐ YES/SI ☒ NO	

Have you received treatment for this injury elsewhere? *A recibido tratamiento para este accidente en otro lugar?* ☐ YES/SI ☒ NO **If yes, where?** *Si, Cuando?* **Date** *Feche*

Describe how the injury occurred· *Como ocurrio el accidente* walking through brush poison Oak

SUMMARY OF DIAGNOSIS AND CONDITIONS

Significant Diagnosis	Major Surgery	Medications	Drug Allergies
1 rash itching	1 ⊖	1 ⊖	1 NKDA
2	2	2	2
3	3	3	3
4	4	4	4

Tetanus: ? **Vision:** Rt 20/ Lt 20/ **Dominant Hand:** (Rt) Lt

PROVIDER NOTES

Subjective: ☐ *dictated* LAST M.P. 6/2/04 [illegible]

Objective: ☐ *dictated* contact dermatitis

Assesment: ☐ *dictated*

Orders: X-Ray ______ Lab ______ Injection ______

Results· ______ ______

Treatments: Medications TAC 0.1% cream Dose ______ Quantity ______

Medications [illegible] Dose #21 Quantity ______

Medications ______ Dose ______ Quantity ______

Physician Signature ______

DAMERON HOSPITAL
Occupational Injury Clinic

Name:	Anderson, Tiffany K			**Date:**	6/ 9/2004
SSN:	549-23-5133	**Case No.:**	56808	**Employer:**	SJ Mosquito and Vector Control

VITAL SIGNS AND NURSES NOTES

Date	Time	Blood Pressure	Pulse	Resp.	Temp.	Notes	Initials
6/9/04	0805	128/74	72	14	95.9	itchy @ L ley pt stepped on something	[illegible]
6/21/04	1008	——	——	——	98.6	rev/rash. Better	[illegible]

COMPEX LEGAL SERVICES

AFFIDAVIT - (Pursuant to Cal Evidence Code 1561)

C50913-K

I hereby declare under penalty of perjury that the following statements are true to the best of my knowledge and belief I am over the age of 18 and the duly authorized custodian of records for

DAMERON OCCUPATIONAL HEALTH SERVICES
525 WEST ACACIA, STOCKTON, CA 95203

and have the authority to certify that the records made available to COMPEX LEGAL SERVICES for reproducing are all of the records under my custody and control, described and called for in the SUBPOENA/Authorization served with this declaration in the matter relating to said individual or thing pertaining to

RECORDS OF: ANDERSON, TIFFANY
AKA:
DATE OF BIRTH: 08/22/70
SOCIAL SECURITY#: 549-23-5133

HOW ORIGINAL RECORDS WERE PREPARED

- [x] HANDWRITTEN NOTES
- [x] TYPED/DATA ENTERED
- [x] TRANSCRIBED
- [x] OTHER printed

TYPE OF RECORDS PRODUCED

- [x] MEDICAL
- [ ] BILLING
- [ ] FILMS
- [ ] INSURANCE
- [ ] EMPLOYMENT
- [ ] PAYROLL
- [ ] SCHOLASTIC
- [ ] OTHER _____

Said records were prepared by personnel of the business in the ordinary course of business at or near the time of the act, condition, or event I have delivered all of the records/items requested with the following exception(s)

_____

_____

_____

Patricia Soloria — CUSTODIAN NAME (PLEASE PRINT)

Him — DEPARTMENT

Patricia Soloria — SIGNATURE OF CUSTODIAN

11-4-11 — DATE

I AM THE ATTORNEY'S REPRESENTATIVE AND I STATE THAT I MADE TRUE COPIES OF ALL THE ORIGINAL RECORDS DELIVERED TO ME BY THE CUSTODIAN OF RECORDS OF THE ABOVE LOCATION

I DECLARE UNDER PENALTY OF PERJURY & UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE FOREGOING IS TRUE AND CORRECT.

11-4 — DATE

_____ — SIGNATURE

John Mocl — PRINT NAME

PURSUANT TO BUSINESS & PROFESSIONS CODE SECTION 22462, I WILL MAINTAIN THE INTEGRITY & CONFIDENTIALITY OF ANY AND ALL INFORMATION OBTAINED, AND DISTRIBUTE THE RECORDS COPIED BY COMPEX LEGAL SERVICES TO THE AUTHORIZED PERSON OR ENTITIES