PLAINTIFF'S EXHIBIT 17-D
DATE OF INJURY: 10/11/05

DOI: 10/11/05			Y=Yes, we have a copy N= No we do not have a copy		WC CLAIM #: VE060031		PROVIDER'S NAME AND LICENSE #: DR. DONALD ROSSMAN, CA#C35074
	Required Forms	Received Forms?					
	DWC-1	Y					
	DWC-1 ACK FORM	Y					
DATE OF SERVICE:		10/13/05	10/14/05	10/17/05	10/20/05	10/25/05	Tiffany Anderson: final discharge per work status report
	Required Forms						
	EMPLOYER'S FIRST REPORT OF INJURY	Y	N/A	N/A	N/A	N/A	
PROVIDER CASE #: 78225	PATIENT'S INITIAL VISIT FORM	Y	N/A	N/A	N/A	N/A	Tiffany Anderson: THERE ARE PR2S FOR 10/20 & 10/25/05, NOT THE "REGULAR" PROGRESS NOTES. NO OTHER PR2S ARE PRESENT FOR ANY DOS OR INJURIES; ALTHOUGH SOME DO HAVE DR'S INTERNAL PROGRESS NOTES
	CONSENT AND AUTHORIZATION TO RELEASE INFORMATION (PROVIDER'S FORM)	Y	N/A	N/A	N/A	N/A	
	CONSENT AND AUTHORIZE TO RELEASE INFORMATION TO EMPLOYER (EMPLOYERS FORM)	N	N	N	N	N	
	NURSE'S NOTES	Y	Y	Y	Y	Y	Tiffany Anderson: WE HAVE AN INITIAL REPORT AND AN AMENDED ONE; OUT ON 10/20/05, SICK DAY
	DOCTOR'S NOTES (TYPED)	Y	Y	Y	N	N	
	INJURY (RECHECK) WORKSHEET	Y	N/A	N/A	Y	Y	
Tiffany Anderson: MOST OF THE TIME THIS IS NOTED ON THE WORK STATUS REPORT	WORK STATUS REPORT WORKSHEET	Y	Y	Y	Y	Y	
	WORK STATUS REPORT	Y	Y	Y	Y	Y	
	DOCTOR'S FIRST REPORT OF INJURY	Y	N/A	N/A	N/A	N/A	Tiffany Anderson: LAB RESULTS ON 10/17/05 SHOW ABNORMALLY HIGH BASOPHIL AUTO 1.44.PLANTIFF WAS NOT MADE AWARE OF THIS, NOR WERE FOLLOW UP TESTS ORDERED.
	PR-2	N	N	N	Y	Y	
	FOLLOW UP APPOINTMENT INFORMATION	Y	Y	Y	Y	N/A	
	LAB RESULTS (IF APPLICABLE)	N/A	N/A	Y	N/A	N/A	
Tiffany Anderson: DATED 11/07/05	AIMS MILEAGE REIMBURSEMENT FORM	Y	Y	Y	Y	Y	
	CLAIMS-SUMMARY PAYMENTS	Y	Y	Y	Y	Y	
	AIMS FULLY RECOVERED LETTER	N/A	N/A	N/A	N/A	Y	

TIFFANY ANDERSON

SAN JOAQUIN COUNTY
MOSQUITO AND VECTOR CONTROL DISTRICT
Daily Timesheet

Name: T. Anderson   Veh. # 32   Veh. # ______
Employee No.: 306   In 26388   In ___:___
Date: 10-11-05 tues   Out 26263   Out ___:___
off at noon   125

Time In	Time Out	Total Time	Location/Activity
7:00	7:30	:30	yard
7:55	8:05	:10	light trap #33
8:30	8:35	:5	light trap #74
8:50	9:05	:15	McDonald Isl - fell in ditch
9:30	10:00	:30	Yard shower & change clothes
10:30	11:15	:45	091N5E08001
11:20	11:30	:10	091N4E06003
11:50	12:00	:10	yard
12:00	12:30	:30	lunch
:	:	:	
:	:	:	
:	:	:	
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Hours Worked		Hours taken off						
Regular Time Worked	O.V.T. Hrs. Worked	Vacation Time	Sick Time	Family Time	Over-Time	Without Pay	Workers Comp.	Grand Total Hours
~~4:5~~ 50	___:___	~~3:0~~	___:___	___:___	3:0	___:___	___:___	8:___

17-0-2

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

loyee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabjador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* Tiffany Anderson Today's Date. *Fecha de Hoy.* ______
2. Home Address. *Dirección Residencial.* 1416 Iris Dr. #7
3. City. *Ciudad.* Lodi State. *Estado.* CA Zip. *Código Postal.* 95242
4. Date of Injury. *Fecha de la lesión (accidente).* 10-11-05 Time of Injury. *Hora en que ocurrió.* 9:00 a.m. ______ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* Mc Donald Island
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* rash midsection of body spreading to head. Soar throat
7. Social Security Number. *Número de Seguro Social del Empleado.* 549-23-5133
8. Signature of employee. *Firma del empleado.* [signature]

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* San Joaquin Co. Mosquito & Vector Control District
10. Address. *Dirección.* 7759 S. Airport Way Stockton CA 95206
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* 10-11-05
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* 10-13-05
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* 10-13-05
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* AIMS 770 E. Shaw Ave. Fresno CA 93710
15. Insurance Policy Number. *El número de la póliza de Seguro.* ______
16. Signature of employer representative. *Firma del representante del empleador.* Carol Akaland
17. Title. *Título.* Secretary
18. Telephone. *Teléfono.* 209 982-4675

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within <u>one working day</u> of receipt of the form from the employee.

ING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☒ Employer copy/*Copia del Empleador* ☐ Employee copy/ *Copia del Empleado* ☒ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

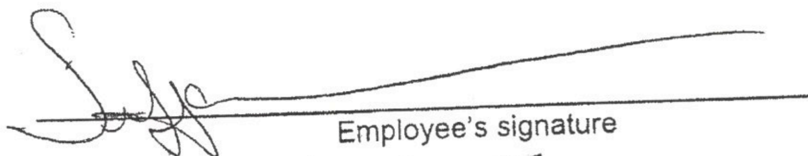
7/1/04 Rev.

17-D-3

SAN JOAQUIN COUNTY MOSQUITO AND
VECTOR CONTROL DISTRICT

To Whom It May Concern:

I Acknowledge That I Have Received DWC Form 1. "Employee's Claim For Workers' Compensation Benefits".



Employee's signature

DATE SIGNED 10-11-05

dwcfrm.doc 11/12/96

17-D-4

State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

*** AIMS WORKERS' COMPENSATION ***
P.O. Box 28904
Fresno, CA 93729-8904

OSHA CASE NO.
FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME: San Joaquin Co. Mosquito & Vector Control
1a. Policy Number:
2. MAILING ADDRESS: (Number, Street, City, Zip): 7759 S. Airport Way Stockton CA 95206
2a. Phone Number: 209 982-4675
3. LOCATION if different from Mailing Address (Number, Street, City and Zip):
3a. Location Code:
4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.: Mosquito Control
5. State unemployment insurance acct.no:
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☒ Other Gov't, Specify: Spec. Dist

Please do not use this column: CASE NUMBER / OWNERSHIP / INDUSTRY / OCCUPATION / SEX / AGE / DAILY HOURS / DAYS PER WEEK / WEEKLY HOURS / WEEKLY WAGE / COUNTY / NATURE OF INJURY / PART OF BODY / SOURCE / EVENT / SECONDARY SOURCE / EXTENT OF INJURY

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy): 10-11-05
8. TIME INJURY/ILLNESS OCCURRED: 9:00 AM ___ PM
9. TIME EMPLOYEE BEGAN WORK: 7:00 AM ___ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy): ——
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy):
13. DATE RETURNED TO WORK (mm/dd/yy):
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy): 10-11-05
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy): 10-13-05
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning: Rash - legs - stomach area
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip): McDonald Island
20a. COUNTY: San Joaquin
21. ON EMPLOYER'S PREMISES? ☐ Yes ☒ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.: Field
23. Other Workers injured or ill in this event? ☐ Yes ☒ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold: dipper for sampling water
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.: checking flooded area for larva breeding - Slipped down into water - 4½ ft deep - bank gave away.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY: It was a 30 minute drive back to district yard with wet clothes, Something irritated my skin. Hugh rash This is spreading and a sore throat.
27. Name and address of physician (number, street, city, zip): Dameron Hospital 420 W. Acacia St Stockton
27a. Phone Number: 209 461-3196
28. Hospitalized as an inpatient overnight? ☒ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip):
28a. Phone Number:
29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2".

EMPLOYEE

30. EMPLOYEE NAME: Tiffany Anderson
31. SOCIAL SECURITY NUMBER: 549 23 5133
32. DATE OF BIRTH (mm/dd/yy): 8/22/70
33. HOME ADDRESS (Number, Street, City, Zip): 1416 Iris Dr Lodi CA 95242
33a. PHONE NUMBER: 209 333-1037
34. SEX: ☐ Male ☒ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers): Mosquito Control Technician I
36. DATE OF HIRE (mm/dd/yy): 4/19/04
37. EMPLOYEE USUALLY WORKS: 8 hours per day, 5 days per week, 40 total weekly hours
37a. EMPLOYMENT STATUS: ☒ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED: Salaries / Wages
38. GROSS WAGES/SALARY: $1492.54 per bi weekly
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☒ No

Completed By (type or print): Carol Aksland
Signature & Title: Carol Aksland - Secretary
Date (mm/dd/yy): 10/13/05

* Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

17-D-5

3 DWC- MISSING 10-13-05

8046

DAMERON HOSPITAL ASSOCIATION
Occupational Injury Clinic

Initial Visit

10/13/2005 7:49 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:**	**Home Telephone No.:** *Telefono de casa* 209-333-1037
City, State, Zip: *Ciudad, Estado, Zip* Lodi CA 95242	☐ Married *Casado*	Social Security Number: *Seguro Social* 549-23-5133
Employer: *Empleador* SJCMVC	☒ Single *Soltero*	**Job Title:** *Ocupacion* Tech I

Date of Injury: *Fecha de accidente* 10-11-05 Hour *Hora* 9:00 ☒ A.M. ☐ P.M. | **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 *Feche*

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. 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*

Objective: ☑ *dictated*

Pemolog 40 mg 1 hr

Assesment: ☑ *dictated*

benadryl 50 mg q6h #16

Orders: X-Ray ______ Lab ______ Injection ______

Results: ______ ______

Treatments: Medications ______ Dose ______ Quantity ______

Medications ______ Dose ______ Quantity ______

Medications ______ Dose ______ Quantity ______

Physician Signature: dlV

17-D-613

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION

NAME: Anderson, Tiffany K **DOS:** 10/13/2005 10-13-05

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: ______________________

17-D-7

10-13-05

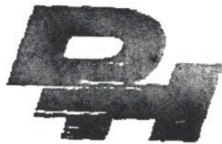
DAMERON HOSPITAL
Occupational Injury Clinic

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

VITAL SIGNS AND NURSES NOTES

Date	Time	Blood Pressure	Pulse	Resp.	Temp.	Notes	Initials
10/13/05	0754	120/82	76	16	97.9	CC/35Y/O FEMALE C/O RASH ON BODY NO DIFFICULTY BREATH C/O FATIGUE –	P.Hamer
10/13/05	0935	—				INJECTION PER DR. ROSSMAN. 40mg KENALOG RUQ IM. LOT. 5F0 6575 APR 07 –	P.Hamer
10/14/05	1005					Rash remains	C Bushnell
10/14/05	1025	157/75	73	16	97.3	REV V/S PER DR. ROSSMAN	J.B
10/17/05	0755	—				Rev rash – almost gone –	E.Najera
10/17/05	0815	117/84	64	16	97.8	V.S per Dr Rossman	E.Najera
10/20/05	0900	118/82	76	16	97.8	REV RASH: IMPROVING C/O FLU LIKE SYMPTOMS	J.B
10/25/05	740					Improved	C Bushnell
10/25	0750	139/99 130/90	70	16	97.7	V.S. per Dr Rossman –	E.Najera

17-D-8



DAMERON HOSPITAL
Occupational Health Services

AUTHORIZATION FOR MEDICAL SERVICES

Date 10-13-05	Employee/Applicant Name Tiffany Anderson
Company Name Mosquito	Telephone #
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)

17-D-9

Occupational Injury Clinic

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

DATE : 10/13/2005
PATIENT : Anderson, Tiffany K
EMPLOYER : SJ Mosquito and Vector Control
CASE # : 78225

DATE OF INJURY : 10/11/2005
SOC. SEC.# : 549-23-5133
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.

17-D-10

Occupational Injury Clinic

10-13-2005

Injury 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- CONTACT:	AIMS - Fresno 8046 PO Box 28100 Fresno, CA 93729-
PHONE: (209) 333-1037	PHONE / FAX: (209) 982-4675x / (209) 982-0120	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

Page OHS staff @ 929-2541 BEFORE proceeding

Chart Up ____:____ am / pm

Patient Back ____:____ am / pm

Discharged ____:____ am / pm

DRUG AND ALCOHOL TESTING

* None

Results in Stolas: *Date* __________ *Initials* ________

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

17-D-11

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: ✓ 692.9.

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
__ **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 10/14/05
__ 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: 1 day.   Provider Initial: dlr

✓ Kenalog kc IM.

17-D-12

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

WORK STATUS REPORT

Employee Name: Anderson, Tiffany K
Social Security No.: 549-23-5133
Employer: SJ Mosquito and Vector Control
Date of Injury: 10/11/2005
Clinic Case Number: 78225
Date of Visit: 10/13/2005
Time In: 07:49 am **Time Out:** 09:49 am
Guarantor: AIMS - Fresno 8046
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 10-14-05 **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 4/1/02

17-D-13

10-13-05

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Occupational Injury Clinic
20 W. Acacia Street, STE # 2 Linacia 1st Flo
Stockton, CA 95204-

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

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

8. Address — No. and Street: 1416 Iris Dr #7 — City: Lodi — Zip: 95242
9. Telephone Number: (209) 333-1037

10. Occupation (Specific job title): Tech I
11. Social Security Number: 549-23-5133

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

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.:

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

PLEASE DO NOT USE THIS COLUMN: Case no / Industry / County / Age / Hazard / Disease / Hospitalization / Occupation / 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

17-D-14

DAMERON HOSPITAL Occupational Health Services
420 West Acacia Street, Suite [illegible], 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

17-D-15

SAN JOAQUIN COUNTY
MOSQUITO AND VECTOR CONTROL DISTRICT
Daily Timesheet

Name: Tiffany Anderson Veh. # 32 Veh. # ____
Employee No.: 306 In ___:___ In ___:___
Date: 10-13-05 Out ___:___ Out ___:___

Time In	Time Out	Total Time	Location/Activity
7:00	8:30	1:30	yard-maps
:	:	:	
:	:	:	
:	:	:	
:	:	:	
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Hours Worked		Hours taken off						
Regular Time Worked	O.V.T. Hrs. Worked	Vacation Time	Sick Time	Family Time	Over-Time	Without Pay	Workers Comp.	Grand Total Hours
1:5	:	:	:	:	:	:	6:3	:

17-D-16