# WORKERS' COMPENSATION APPEALS BOARD STATE OF CALIFORNIA

17	WOKKLK	STATE	STK 0124216, STK 0124214
			Case No.
Thomas	Beard	Applicant	DECLARATION OF READINESS TO PROCEED
	vs. aquin Mosquito & Associates	and Vecto  Defendants	NOTICE: "Any objection to the proceedings requested by a Declaration of Readiness to proceed shall be filed and served within ten (10) days after service of the Declaration. (Rule 10416)
and declarissues be to readefender	solve issues. 'dant to applica	olicant nalty of perjury the following effort There has no	requests that this case be set for hearing at  31 E. Channel St.  Stockton, CA. 95202  (Place)  at he or she is presently ready to proceed to hearing on the sto resolve these issues. Parties have been unable to been any acceptable response by the
Declara	nt requests: [x] Regula	ar Hearing [ ]	Conference Pre-trial [ ] Rating Pre-trial
	[ ]	(SE	E REVERSE SIDE FOR INSTRUCTIONS)
Employ Employ Doctor( filed an I expect for the I I have or require Adverse Copies	[x] Permanen [] Other ee [x] is (or) [] is not ee's condition follow is a served on herein to present where it is to present where it is to work with the served discovery and by WCAB Rules of exparties [x] have (or of this Declaration has expanded by work with the server is the parties [x] have (or of this Declaration has expanded by work with the server is the serve	ot presently receiving injury is ritnesses, including hours. Ind all medical repractices and Provided in the process of the pr	his date as shown below.
	Print or Type) Farant's signature	rrell, Frauk	Sp & Brown, David G.W. Belden
		Avenue Saci	ramento, CA 95816 Phone 916-442-5835
Type or	r print names and add	lresses of parties,	Date 04/14/97  SERVICE including attorneys and representatives served with a copy of
Keen	an & Associates	, 392 D Conn	ers Court, Chico,, CA 95929

## STATE OF CALIFORNIA DEPARTMENT OF INDUSTRIAL RELATIONS

## WORKERS' COMPENSATION APPEALS BOARD

SEE REVERSE SIDE FOR INSTRUCTIONS

THE PROPERTY OF CLAIM	CASE No. 876 124214
APPLICATION FOR ADJUDICATION OF CLAIM (PRINT OR TYPE NAMES AND ADDRESSES)	C. 102 1.0.
I/L/FIVED	
Mr. Thomas Beard	2937 Toyan Drive (INJURED EMPLOYEE'S ADDRESS AND ZIP CODE)
WORKERS DIVISION OF	
M r. Thomas Beard  JUN _ 1996  DIVISION OF  Social Security No.: 558-76-6159 KERS COMPENSATION	Stockton, CA 95203
-, 176	
(APPLICANT, IF OTHER THAN INJURED EMPLOYEE)	7759 S. Airport Way Stockton, CA 95206  (EMPLOYER'S ADDRESS AND ZIP CODE)  (EMPLOYER'S ADDRESS AND ZIP CODE)  392 D Conners Court  Chico CA 95929
San Joaquin Mosquito and Vector Control  (EMPLOYERSTATE IF SELF-INSURED)	Stockton, CA 95206  (EMPLOYER'S ADDRESS AND ZIP CODE)
	392 D Conners Court Chico,, CA 95929
Keenan & Associates (EMPLOYER'S INSURANCE CARRIER OR, IF SELF-INSURED, ADJUSTING AGENCY)	(INSURANCE CARRIER OR ADJUSTING AGENCY'S ADDRESS)
IT IS CLAIMED THAT:	
1. The injured employee, born 09/24/49 , while employee on CT 1/18/96 at Stockton, (ADDRESS)	oyed as a <u>control tech</u>
CT 1/18/96 at Stockton,	, CA (CITA (STATE) (ZIP CODE)
By the employer sustained injury arising out of and in the coun	rse of employment to
	to of employment to
left knee (STATE WHAT PARTS	OF BODY WERE INJURED)
2. The injury occurred as follows: Cummulative trai	MPLOYEE WAS DOING AT TIME OF INJURY AND HOW INJURY WAS RECEIVED)
3. Actual earnings at time of injury were: \$16.69 per	hour, maximum for 'I'D  R MONTHLY SALARY OF HOURLY RATE AND NUMBER OF HOURS WORKED PER WEEK)
(SEPARATELY STATE VALUE PER WEEK OR MONTH OF TIPS,	MEALS, LODGING OR OTHER ADVANTAGES REGULARLY RECEIVED)
4. The injury caused disability as follows: (SPECIFY LAST DAY OFF WORK DUE	TO THIS INJURY AND BEGINNING AND ENDING DATES OF ALL PERIODS OFF DUE TO THIS INJURY  (WEEKLY RATE) (DATE OF LAST PAYMENT)
5. Compensation was paid (NO) SOURCE (TOTAL PAID)	(WEEKLY RATE) (DATE OF LAST PAYMENT)
	disability benefits have been received since the date of injury
(NO)	
7. Medical treatment was received $\frac{Y}{(NS)}$ ongoing the Ferrilever or Insurance Company $\frac{Y}{(NS)}$ Other trees.	All treatment was furnished by (DATE OF LAST TREATMENT)
the Employer or Insurance Company $\frac{Y}{A}$ Other tro	eatment was provided or paid for by
	Did Medi-Cal pay for any health care
(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR M	MEDICAL CARE)  If for by employer or insurance company who treated or examined
	rior by employer or insurance company, which
for this injury are(STATE NAMES AND ADDRESSES OF SUCH E	DOCTORS AND NAMES OF HOSPITALS TO WHICH SUCH DOCTORS ADMITTED INJURED)
8. Other cases have been filed for industrial injuries by this emp	loyee as follows:
left knee, 1989, 6/22/95  SPECIFY CASE NUMB	ER AND CITY WHERE FILED)
9. This application is filed because of a disagreement regarding	natinty for. Temporary distributes machinery
Permanent disability indemnity X Reimburseme	ent for medical expense Medical treatment _X
Compensation at proper rate $X$ Rehabilitation $X$	Other (Specify) All benefits  AND APPLICANT REQUESTS A HEARING AND AWARD OF
THE SAME, AND FOR ALL OTHER APPROPRIATE BENEFITS PROVIDED BY LAW.  Dated at Sacramento (CITY), California, CITY)	ornia, 05/29/96 (DATE)
David G.W. Belden	(applicant's signature)
2315 Capitol Avenue Sacramento, CA 95816	David G.W. Belden for Applicant
Farrell, Fraulob & Brown 916-442-5835 DIA WCAB FORM 1 (REV 7/81)	84 32595

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

#### EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

If you are injured or become ill because of your job, you are entitled to workers' compensation benefits.

Complete the "Employee" section and give the form to you employer. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from your employer. You may contact the State's Office of Benefit Assistance and Enforcement at 1-800-735-7401 if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the reverse of this form.

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

Any person who makes of causes to be made any knowingly faise or fraudulent material statement or material representation for the purpose of obtaining or cenying workers compensation banatits or payments is quirty of felony.

**April** 1995

50

Postmark or Date

6/3/9

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

### RECLAMO DEL EMPLEADO PARA BENEFICIOS DE COMPENSACIÓN DEL TRABAJADOR

Si Ud. se ha lesionado o se ha enfermado en/o a causa de su trabajo. Ud. tiene derecho a recibir beneficios de compensación altrabajador.

Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Emplezdo" hasta que Ud. reciba la copia fechaca de su empleador. Si Ud. necesita ayuda para completar esta forma o para obtener sus beneficios, póngase en contacto con la Oficina Estatal de Asistencia para Beneficios y Ejecución de las Leyes Pertinentes llamando al 1-800-736-7401. Al dorso de esta forma se encuentra una explicación de los beneficios de compensación altrabajador.

Ud. también debería haber recibido de su empleador un folieto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerios.

Toda equella persona que con conocimiento haça o ceuse que se produzca cualquier declaración o representación material faisa o fraudulenta con el fin de optener o negar beneficios o pagos de corpensacion a trabajadotes lesionados es culpabla de un criman mayor felonia.

RESPONSABILIDAD

Diiginal (CCD2 Del Empleadi)

DWC FOIRE 1 (FEV. 4/93)

Employee: Emp	lezdo:		Today's Date. Fecha de Ho <u>\$/29/96</u>			
1. Name. Nombre.	Thomas Be	eard				
	''	-1 2037 Tovan Dr	1 Ve			
2. 1.0	Charleton		State. Estado. CA Zip. Código Posta 5203			
3. City. Ciuczo.	STOCKLOH,	7 /3 0 /06	Time of injury. Hora en que ocurrió a.m p.m.			
4. Date of Injury	. Fecha de la lesión (a	ccidenteCT 1/18/96	Time of injury. Hora en que ocurrió a.m p.m.			
5. Address/plac	e where injury happen	ed. Dirección/lugar dande ocu	rrió el accidente			
	on, CA					
Fell w	nile inspecti	ng ditch for mosq	parte del cuerpo a seciada. left knee			
7 Cinneture of	emninyee Firma delem	ocseici				
P 354 937 Postal Service eceipt for Cer Insurance Coverage	tified Mail	give the employee a copy if the inmediatamente una copor.	immediately as a feeding at the size of th			
not use for Internation	nal Mail (See reverse)	ta en que el empleador su	po por primera vez de la lesión o accidente			
in MCILIN I	45guito + l'ette	y see. Fecha en que se le entregó al empleado la petición.				
759 S. Aug	n+ 10001	;	volvió la petición completada al empleador.			
tox /ton. (	A 95206	cha en que el empleado de	VONTO IS PERIOR COMP.			
estage	S ir or adjusting agency. Nombre y dirección de la compañía de seguros o agencia administradora					
rtified Fee		·				
edal Delivery Fee			. Firma del representante del empleador.			
stricted Delivery Fee		15. Tele	15. Telephone. Teléfono			
etum Receipt Showing to		form and provide copies	Empleador: Se requiere que Ud. feche esta forma y que prové copias a su compañía de seguros y empleado, dependiente			
turn Receipt Showing to Whom, te, & Addressee's Address		andent or representative	representante que haya presentado esta petición dentro del plaz de un dia habil desde el momento de haber sido recibida la form			
OTAL Postage & Fees	S	y of receipt of completed	complete del empleado.  EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE			
in Data		SION OF LIKELLITY	EL FISIKAR ESTA FUEIKA NU SIGNIFICA ACTIONIO			

SION OF LIABILITY