



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



ADJ7010682
 Case No.

Date of Injury 03/26/2009
 MM/DD/YYYY

549-23-5133
 SSN (Numbers Only)



Venue Choice is based upon: (Completion of this section is required)

- County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)
- County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)
- County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

STK

Select 3 Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Applicant (Completion of this section is required)

TIFFANY
 First Name

MI

ANDERSON
 Last Name

2 N AVENA AVENUE
 Address/PO Box (Please leave blank spaces between numbers, names or words)

LODI
 City

CA
 State

95242
 Zip Code

Employer #1 Information (Completion of this section is required)

- Insured
- Self-Insured
- Legally Uninsured
- Uninsured

SAN JOAQUIN COUNTY MOSQUITO AND VECTOR CONTROL DISTRICT
 Employer Name (Please leave blank spaces between numbers, names or words)

7759 S AIRPORT WAY
 Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

STOCKTON
 City

CA
 State

95206
 Zip Code



Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)

PERMISSIBLY SELF INSURED

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)



PO BOX 269120

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

SACRAMENTO
City

CA
State

95826
Zip Code

Claims Administrator Information (if known and if applicable)



AIMS INSURANCE

Name (Please leave blank spaces between numbers, names or words)

PO BOX 269120

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

SACRAMENTO
City

CA
State

95826
Zip Code

Employer #2 Information (Completion of this section is required)

Insured

Self-Insured

Legally Uninsured

Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Insurance Carrier Information

(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code



Claims Administrator Information (if known and if applicable)



Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Employer #3 Information (Completion of this section is required)

Insured Self-Insured Legally Uninsured Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code



**Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)**

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code



Employer #4 Information (Completion of this section is required)

Insured

Self-Insured

Legally Uninsured

Uninsured



Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

**Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)**

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

The parties hereto stipulate to the issuance of an Award and/or Order, based upon the following facts, and waive the requirements of Labor Code section 5313:



1. TIFFANY

Employees First Name

ANDERSON

Employees Last Name

birth date 08/22/1970
MM/DD/YYYY

while employed at STOCKTON CONTROL DISTRICT CA
State

as a(n) TECHNICIAN I Occupation, Group in



More than 4 Companion Cases

Specific Injury

ADJ7070682

03/26/2009

Case Number 1

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

RIGHT

Body Part 1: 513 KNEE Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

Specific Injury

Case Number 2

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

Specific Injury

Case Number 3

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

Specific Injury

Case Number 4

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

by the employer(s) and their insurer(s) listed above and who sustained injury(ies) arising out of and in the course of employment to

RIGHT KNEE

(Please list all body parts injured)

2. The injury (ies) caused temporary disability for the period _____ through _____

MM/DD/YYYY

_____ for which indemnity has been paid at \$ _____ per week.

MM/DD/YYYY

Indemnity Paid

2(a). The injury(ies) caused additional temporary disability for the period _____

MM/DD/YYYY

through _____ at the rate of \$ _____ in the amount of \$ _____

MM/DD/YYYY

Rate

Indemnity Paid

3. The injury(ies) caused permanent disability of 2 % for which indemnity is payable at \$ 230.00

Indemnity Rate

per week beginning 09/08/2010 in the sum of \$ 1,380.00, less credit for such payments

MM/DD/YYYY

previously made. And a life pension of \$ _____ per week thereafter.

Life Pension

Labor Code §4658(d) adjustment:

Increase rate to \$ _____ as of _____

MM/DD/YYYY

or, \$1,173.00, less credit

Decrease rate to \$ 195.50 as of 09/08/2010

MM/DD/YYYY

of \$2,225.42, leaving

Not Applicable

defendant a total indemnity credit of \$1,052.42.

An informal rating has / has not (Select one) been previously issued in case no(s) _____

4. There is is Not a need for medical treatment to cure or relieve from the effects of said injury (ies).

5. Medical-legal expenses and/or liens are payable by defendant as follows:

FUTURE MEDICAL TREATMENT TO APPLICANT'S RIGHT KNEE ONLY

6. Applicant's attorney requests a fee of \$ 207.00

Fees to be commuted as follows:

7. Liens Against compensation are payable as follows:

NONE KNOWN.

8. Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

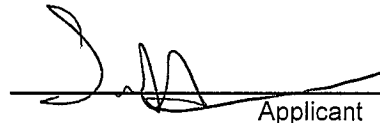
9. Other stipulations:

SEE ATTACHED ADDENDUM INCORPORATED HEREIN.

+

Dated

12-23-10
MM/DD/YYYY


Applicant

Applicant's Attorney or Authorized Representative:

Law Firm/Attorney

Non Attorney Representative

+

RONALD
First Name

STEIN
Last Name

4813094
Firm Number

RONALD STEIN STOCKTON
Law Firm name

4521 QUAIL LAKES DRIVE
Address/PO Box (Please leave blank spaces between numbers, names or words)

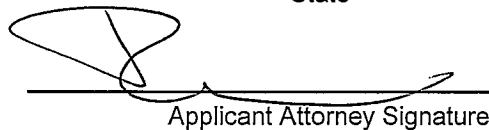
STOCKTON
City

CA
State

95207
Zip Code

Dated

12/23/10
MM/DD/YYYY


Applicant Attorney Signature

+

Defendant's Attorney or Authorized Representative:

Law Firm/Attorney Non Attorney Representative

ERIC

First Name

HELPHREY

Last Name

5185268

Firm Number

STOCKWELL HARRIS SACRAMENTO

Law Firm Name

1545 RIVER PARK DRIVE SUITE 330

Address/PO Box (Please leave blank spaces between numbers, names or words)

SACRAMENTO

City

CA

State

95815

Zip Code

Dated

MM/DD/YYYY

Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

Law Firm/Attorney Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Dated

MM/DD/YYYY

Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

Law Firm/Attorney

Non Attorney Representative



First Name _____

Last Name _____

Firm Number _____

Law Firm Name _____

Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____

State _____

Zip Code _____

Dated _____

MM/DD/YYYY

Defense Attorney Signature

Interpreter Licence Number:

Interpreter Name

Interpreter License Number



RE: ANDERSON, TIFFANY VS. SAN JOAQUIN COUNTY MVCD
WCAB: ADJ7004227; ADJ7004221

**ADDENDUM TO STIPULATIONS WITH REQUEST
FOR AWARD – PARAGRAPH 9**

Permanent disability is based on Panel QME Dr. Tabaddor dated June 8, 2010, August 20, 2010 and September 7, 2010 at 4% permanent disability. This settlement resolves any and all claims for temporary disability (medical, TPD, TTD, wage loss, or any other form of TD) through the date of the award. This settlement resolves any and all claims of penalty(s), filed or not, including but not limited to Labor Code Sections 4650 and 5814 related to untimely payment and/or alleged failure to pay TD, PD, medical-legal or medical treatment, mileage/transportation, out-of-pocket expenses, home care/housekeeping or any other benefit. Any previously submitted claims for benefits need to be resubmitted with time as specified by the labor code to pay. The parties stipulate that there are no other claims or issues for workers' compensation benefits at this time. The parties stipulate no interest will be owing on accrued sums if payment is made within 30 days of this award.

Defendant entitled to a future indemnity credit of \$4,571.42, less permanent disability payout of \$1,173.00 (ADJ7010682, date of injury: 3/26/09), leaving a total indemnity credit of \$1,052.42 against the case cited herein, as well as ADJ7010682 (date of injury: March 26, 2009). The applicant dismisses any claims or rights to workers' compensation benefits regarding the third right knee claim on or about July 2, 2009 (ADJ7004221). Defendant enjoys a future indemnity claim asserted in either ADJ7004227 (date of injury: June 19, 2008) or ADJ7010682 (date of injury: March 26, 2009). The attorney fees of \$ 621.00 will be paid in addition to the sums outlined herein.