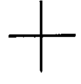
STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
STIPULATIONS WITH REQUEST FOR AWARD



ADJ7010682
Case No.

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

549-23-5133
SSN (Numbers Only)

RECEIVED
MAR 08 2011
DIVISION OF WORKERS COMPENSATION STOCKTON OFFICE

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	CA	95242
City	State	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	CA	95206
City	State	Zip Code