This packet is an example of the order in which documents should be filed. These are not examples of how to fill out forms/documents.

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET

Is this a new case? Yes ☑ No ☐ Companion Cases Exist ☐ Walkthrough Yes ☐ No ☑

More than 15 Companion Cases ☐

09/10/2008
Date:(MM/DD/YYYY)

SSN: 000-00-0000

☑ Specific Injury

Case Number 1

☐ Cumulative Injury

11/02/2007
(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: 420

Body Part 2: 100

Body Part 3:

Body Part 4:

Other Body Parts:

Please check unit to be filed on (check only one box)

☑ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ VOC ☐ INT ☐ RSU

Companion Cases

☐ 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:

DOCUMENT SEPARATOR SHEET

Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title APPLICATION FOR ADJUDICATION

Date of document following Document Separator Sheet

Document Date _____
MM/DD/YYYY

If you are the Claims Administrator or the Hearing Representative use your Uniform Assigned Name. For unrepresented Injured Worker and others, "Author" is the document author.

Author UNIFORM ASSIGNED NAME

Office Use Only

Received Date _____
MM/DD/YYYY

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
APPLICATION FOR ADJUDICATION OF CLAIM

☐ Amended Application

CASE No.

SSN (Numbers Only)

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

☐ Residence of employee (Labor Code section 5501.5(a)(1).)

☐ Location where injury occurred (Labor Code section 5501.5(a)(2).)

☐ Principal address of employee's attorney (Labor Code section 5501.5(a)(3).)

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

Injured Worker (Completion of this section is required)

First Name MI

Last Name

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

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

Applicant (If other than Injured Employee):

☐ Insurance Carrier ☐ Employer ☐ Lien Claimant

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

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

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Employer 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

IT IS CLAIMED THAT (Complete all relevant information):

1. The injured employee, born (DATE OF BIRTH: MM/DD/YYYY) while employed as a (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

☐ Specific Injury (DATE OF INJURY: MM/DD/YYYY)

suffered:

☐ Cumulative Injury which began on (Start Date: MM/DD/YYYY) and ended on (End Date: MM/DD/YYYY)

The injury occurred at

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

City State Zip Code

(State which parts of the body were injured)

Body Part 1: _____

Body Part 2: _____

Body Part 3: _____

Body Part 4: _____

Other Body Parts _____

2. The injury occurred as follows:

(EXPLAIN WHAT THE EMPLOYEE WAS DOING AT THE TIME OF INJURY AND HOW THE INJURY WAS RECEIVED)

3. Actual earnings at the time of injury:

Rate of Pay $ _____ ☐ Monthly ☐ Weekly ☐ Hourly

State value of tips, meals, lodging, or other advantages, regularly received $ _____ ☐ Monthly ☐ Weekly ☐ Hourly

Number of hours worked per week _____

4. The injury caused disability as follows:

Last day off work due to injury: _____ MM/DD/YYYY

First Period of Disability: Start Date _____ MM/DD/YYYY End Date _____ MM/DD/YYYY

Second Period of Disability: Start Date _____ MM/DD/YYYY End Date _____ MM/DD/YYYY

5. Compensation:

Compensation was paid: ☐ Yes ☐ No

Total paid _____

Weekly rate(s) _____

Date of last payment _____ MM/DD/YYYY

6. Has the employee received any unemployment insurance benefits and/or any unemployment compensation disability benefits (state disability) since the date of injury? ☐ Yes ☐ No

7. Medical treatment:

Medical treatment was received: ☐ Yes ☐ No

All treatment was furnished by the Employer or Insurance Carrier ☐ Yes ☐ No

Date of last treatment _____
MM/DD/YYYY

Other treatment was provided paid by: _____
(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

Did Medi-Cal pay for any health care related to this claim? ☐ Yes ☐ No

Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or examined for this injury, but that were not provided or paid for by the employer or insurance carrier:

_____
Name of Doctor/Hospital/Clinic 1 (Please leave blank spaces between numbers, names or words)

_____
Name of Doctor/Hospital/Clinic 2 (Please leave blank spaces between numbers, names or words)

8. Other cases have been filed for industrial injuries by this employee as follows:

_____ _____
Case Number 1 Case Number 3

_____ _____
Case Number 2 Case Number 4

9. This application is filed because of a disagreement regarding liability for:

☐ Temporary disability indemnity ☐ Permanent disability indemnity

☐ Reimbursement for medical expense ☐ Rehabilitation

☐ Medical treatment ☐ Supplemental Job Displacement/Return to Work

☐ Compensation at proper rate ☐ Other (Specify) _____

Is the Applicant Represented? ☐ Yes ☐ No **if "No", applicant is to sign and date below.**

If "Yes", applicant's representative is to complete the following and is to sign and date below

☐ Law Firm/Attorney ☐ Non-Attorney Representative

Law Firm or Company Name (If Applicable)

Law Firm Number (If Applicable)

Attorney/Rep First Name MI

Attorney/Rep Last Name

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

City State Zip Code

Applicant Attorney/Representative Signature Applicant Signature

Dated at _____, California
City

Date _____
MM/DD/YYYY

DOCUMENT SEPARATOR SHEET

Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: 4906(g) DECLARATION

Document Date: 04/16/2008
MM/DD/YYYY

If you are the Claims Administrator or the Hearing Representative use your Uniform Assigned Name. For unrepresented Injured Worker and others, "Author" is the document author.

Author: UNIFORM ASSIGNED NAME

Office Use Only

Received Date
MM/DD/YYYY

DWC-CA form 10232.2

ANTHONY G. RATTO
MELINEH AVANESIAN
ALANA DUNNIGAN
LAWYERS

JUAN J. SPENCER
HEARING REPRESENTATIVE

INFO@RATTOLAW.COM

RATTO LAW FIRM

A PROFESSIONAL CORPORATION

385 GRAND AVENUE, SUITE 201
OAKLAND, CA 94610
(510) 444-4600
FAX (510) 444-3604

SAN FRANCISCO
2601 MISSION STREET, SUITE 202
(415) 695-3101

COMPLIANCE WITH LABOR CODE §4906(g)

EMPLOYEE: [redacted]

EMPLOYER: [redacted]

CASE NO/DATE OF INJURY: 11/2/07

Pursuant to the requirements set forth in Labor Code §4906(g), I declare as follows:

I have not violated Labor Code §139.3.

I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

A photostatic copy of this declaration shall be as valid as the original.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

DATED: 4/16/21

X [redacted]

DATED: _____

[redacted]

APPLICANT'S ATTORNEY

DOCUMENT SEPARATOR SHEET

Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title DWC-1 CLAIM FORM

Document Date 04/16/2008
MM/DD/YYYY

If you are the Claims Administrator or the Hearing Representative use your Uniform Assigned Name. For unrepresented Injured Worker and others, "Author" is the document author.

Author UNIFORM ASSIGNED/INJURED WORKER'S NAME

Office Use Only

Received Date
MM/DD/YYYY

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

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

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

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

Complete the "**Employee**" section and give the form to your employer. Keep the copy marked "**Employee's Temporary Receipt**" until you receive the dated copy from your employer. You may call the Division of Workers' Compensation at **1-800-736-7401** if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the back 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 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.

PETICION DEL EMPLEADO PARA BENEFICIOS DE COMPENSACIÓN DEL TRABAJADOR

Si Ud. se ha lesionado o se ha enfermado a causa de su trabajo, Ud. tiene derecho a recibir beneficios de compensación al trabajador.

*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 fechada de su empleador. Si Ud. necesita ayuda para completar esta forma o para obtener sus beneficios, Ud. puede hablar con la División de Compensación al Trabajador llamando al* **1-800-736-7401**. *En la parte de atrás de esta forma se encuentra una explicación de los beneficios de compensación al trabajador.*

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

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 "felonía".

Employee: ***Empleado:***

1. Name. *Nombre.* [redacted] Today's Date. *Fecha de hoy.* 4/16/08
2. Home Address. *Dirección Residencial.* [redacted]
3. City. *Ciudad.* [redacted] State. *Estado.* CA Zip. *Código Postal.* [redacted]
4. Date of Injury. *Fecha de la lesión (accidente).* 11/2/07 Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar donde ocurrió el accidente.* [redacted]
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* + sleep apnea
7. Social Security Number. *Número de Seguro Social del Empleado.* [redacted]
8. Signature of employee. *Firma del empleado.* X [redacted]

Employer - complete this section and give the employee a copy immediately as a receipt.
Empleador - complete esta sección y déle inmediatamente una copia al empleado como recibo.

9. Name of employer. *Nombre del empleador.*
10. Address. *Dirección.*
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.*
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.*
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.*
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.*
15. Insurance Policy Number. *El número de la póliza del Seguro.*
16. Signature of employer representative. *Firma del representante del empleador.*
17. Title. *Título.* 18. Telephone. *Teléfono.*

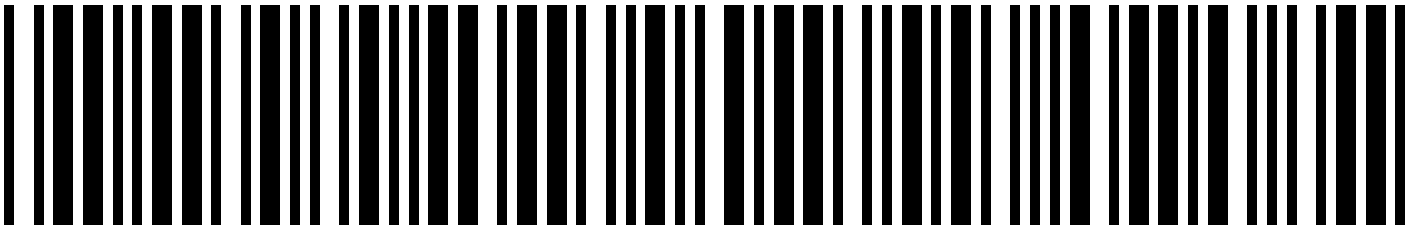
mployer: You are required to date this form and provide copies to your surer or claim administrator and to the employee, dependent or presentative who filed the claim within **one working day** of receipt of the rm from the employee.

SIGNING 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

DOCUMENT SEPARATOR SHEET



Product Delivery Unit: ADJ

Document Type: MISC

Document Title: TYPED OR WRITTEN LETTER

Document Date: 04/16/2008
MM/DD/YYYY

Author: UNIFORM ASSIGNED NAME

Office Use Only

Received Date
MM/DD/YYYY

DWC-CA form 10232.2

State of California
Department of Industrial Relations
Division of Workers' Compensation

FEE DISCLOSURE STATEMENT

If you choose to be represented by an attorney, your attorney's fees will be deducted from your benefits. The fee will be approved by the Workers' Compensation Appeals Board, with consideration given to the: (1) responsibility assumed by the attorney; (2) care exercised in representing you; (3) time involved; and, (4) results obtained.

Attorney's fees normally range from 9% to 12% of the benefits awarded. However a fee of 15% may be charged if the case is complicated and time consuming. If your attorney has also represented you before the Rehabilitation Unit, there may also be a fee allowed for this representation.

There are certain circumstances where your employer (or his/her insurer) may be liable to pay your attorneys' fees. For example, if employer disputes a permanent disability evaluation obtained when you were not represented by an attorney, your employer may, be liable for any attorney fees you incur because of the dispute.

If at anytime you no longer wish to be represented by the attorney, you may withdraw from representation by notifying the attorney. If you withdraw from representation, the fee amount found by a workers' compensation judge to be the fair value of any work the attorney did in your case will be deducted from your award.

An Information and Assistance Officer may be able to answer your questions concerning your workers' compensation benefits at no charge to you. He/She may be able to resolve your problems without the need for litigation.

Call this toll-free number: 1-800-736-7401

Employee's Signature [redacted] Date: 9/16/08

Employee's Name [redacted]

Attorney's Signature [redacted] Date: _____

Attorney's Name [redacted]
Address [redacted]

Phone No. [redacted]

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 felony.

DOCUMENT SEPARATOR SHEET

Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title DECLARATION OF READINESS TO PROCEED

Date of document following Document Separator Sheet

Document Date _____
MM/DD/YYYY

If you are the Claims Administrator or the Hearing Representative use your Uniform Assigned Name. For unrepresented Injured Worker and others, "Author" is the document author.

Author UNIFORM ASSIGNED NAME

Office Use Only

Received Date _____
MM/DD/YYYY

DWC-CA form 10232.2

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
DECLARATION OF READINESS TO PROCEED

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.

Case No.

Applicant

First Name MI

Last Name

VS

Employer Information

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

Declarants: Please designate your role (Please Select Only One)

☐ Employee ☐ Applicant ☐ Defendant ☐ Lien Claimant

Declarant requests: (Please Select Only One)

☐ Mandatory Settlement Conference ☐ Status Conference ☐ Rating MSC* ☐ Priority Conference

At the present time the principal issues are: (Check all that apply)

☐ Compensation Rate ☐ Rehabilitation/SJDB ☐ Temporary Disability ☐ Self-Procured Medical Treatment
☐ Permanent Disability ☐ Future Medical Treatment ☐ AOE/COE ☐ Discovery
☐ Employment ☐ Other _____

Declarant relies on the report(s) of:

Doctors (s) _____ date _____
MM/DD/YYYY

*For a Rating MSC, all ratable medical reports, including treating physician, QME and AME reports, must be filed with this Declaration of Readiness, unless they have been previously filed. A Rating MSC will be set only where the issues are limited to permanent disability and the need for future medical treatment.

Declarant states under penalty that he or she is presently ready to proceed to hearing on the issues below and has made the following specific, genuine, good faith efforts to resolve the dispute(s) listed below:

Unless a status or priority conference is requested, I have completed discovery on the issues listed above, and all medical reports in my possession or control have been filed and served as required by the rules promulgated by the Court Administrator.

Copies of this Declaration have been served this date as shown on the attached proof of service.

Declarant's Signature _____

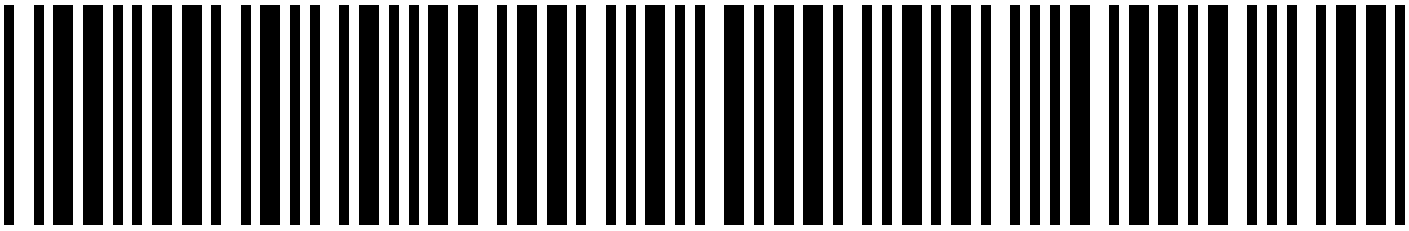
Name and Law Firm (Print or Type)

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

Phone Number

Date _____ MM/DD/YYYY

DOCUMENT SEPARATOR SHEET



Product Delivery Unit: ADJ

Document Type: MEDICAL DOCS

Document Title: ALL MEDICAL REPORTS

Document Date: 09/26/2006
MM/DD/YYYY

Author: KENDRICK E LEE MD

Office Use Only

Received Date
MM/DD/YYYY

DWC-CA form 10232.2

Kendrick E. Lee, M.D.
Surgery and Microsurgery of the Hand
Webster Orthopaedic Medical Group
80 Grand Avenue, Suite 400
Oakland, CA 94612-3725
510 238 1200 Fax 510 663 1543

Hand Surgery Consultation Report

[redacted]

Patient: [redacted]
Date of birth: November 27, 1942
Employer: [redacted]
Date of Injury: August 19, 2005
Claim number: [redacted]
Date of examination: August 28, 2006
Date of report: September 29, 2006

Dear [redacted]

Thank you for asking me to examine [redacted] for hand surgery consultation.

Chief complaint:
right thumb base pain

History:
[redacted] right handed woman. At the time of her injury she was employed as a espresso bar barista by the Nordstrom Rack store in San Leandro. She had worked there beginning about 1997.

She presents a 4 page history of her right thumb pain. She states that in 1999 she had the gradual onset of right thumb base pain. She reported this in 1999, and was initially treated at Occupational Medicine Associates in San Leandro. "They told me I had arthritis". Treatment included ibuprofen splinting and therapy treatment. "I never got better". She continued at the espresso bar for another year or two, and then the department was closed. She left Nordstrom for about a year, and worked "freelance"

drafting and other work.

She then returned to Nordstrom, working in the men's department beginning about 2002 or 2003. The symptoms persisted. She was subsequently treated at Kaiser for plantar fasciitis. She also asked about her hand and she was told about tendonitis, and she was told that that was work related.

She returned to the worker's comp system, and was treated at Concentra beginning in August 2005. She had additional medication, got another splint, and had therapy at Concentra and Cornerstone. There was temporary improvement with therapy for a couple of days.

In February 2006, she saw [redacted] for what sounds like evaluation. She is not sure what the result of the evaluation was.

Symptoms have not improved. The patient currently complains of right thumb base pain with pinching, such as a clothespin pinch. The pains occur everyday with activities of daily living, episodes can last "all night long". Using a Q tip hurts. Hair care hurts. The symptoms are relieved by rest, or "plunging my hand in a bucket of ice". Ibuprofen helps the pain also for a few hours. She denies numbness, tingling in the right or left, and there are no left hand symptoms.

She has remained at work. She now works doing freelance drafting.

[redacted] is now seen for hand surgery consultation.

Past Medical History:
Prior history of upper extremity complaints or injuries; none
Ongoing medical conditions; none
Prior surgery; gallbladder 2000, tonsils in childhood
Current medications; none
Allergies to medications; ASA causes GI irritation
Tobacco use; none
Alcohol use; none
Regular primary physician;Kaiser

Family and Social History:
Single, no children. She has a cat. She does some drawing for pleasure. She walks for exercise. She does not participate in any sports.

Review of systems:

The patient has had visual "floaters". She has ringing in the ears with aspirin. She denies ongoing symptoms of headache, hearing loss, persistent sore throat, shortness of breath, chest pain, abnormal cough, abdominal pain, blood or burning with urination, blood in bowel movements, menstrual disorders, current pregnancy, or unexplained weight loss.

Records reviewed: (9/29/2006, 15 minutes)

Four-page letter from the patient, setting forth in great detail her duties as a barista, the medical course, the symptoms. Also detailing work as a sales associate.

52 page file of records
4/27/2006, panel QME report [redacted] Diagnosis chronic right thumb tendinitis. Permanent and stationary "at least by October 1, 2005". Future medical treatment includes hand therapy, Dr. visits three or four times a year. Night splints. Medication.

Records from Concentra medical center.
9/14/2005, radial styloid tenosynovitis, resolved.. Arthritis, right thumb carpal metacarpal and metacarpal phalangeal, non-industrial. Released from care at maximum medical improvement, no permanent disability. [redacted]

9/2/2005, right hand metacarpal pharyngeal tenosynovitis. Medication, therapy, activity modification.

8/24/2005, physical therapy visits.

8/19/2005, doctors first report, [redacted]

8/19/2005, [redacted] eQuervain's tenosynovitis, thumb spica splint, ibuprofen, modified duty.

Reports from Occupational Medicine Associates, [redacted]
4/8/1999, right thumb arthritis. Regular work beginning 4/8/1999.
3/23/1999, right thumb arthritis.
Physical therapy notes, from 3/10/1999 to 3/23/1999.
3/8/1999, doctors first report, [redacted] right thumb overuse and arthritis. Use splints.

Physical examination:
[redacted] ppears her stated 5 foot 4 1/2 inch height and 198 lb. weight.

On record review, I note the diagnosis by the more recent treaters and on the QME report was tenosynovitis and chronic thumb tendonitis. Thumb CMC arthritis is an age related condition, which can be aggravated by work exposure. There may be need to ask for QME re evaluation regarding apportionment of the thumb CMC arthritis, which appears to be the ongoing condition.

The nature of the condition was discussed. Treatment options were discussed, and include activity modification, ergonomic changes, medication, splinting, therapy, steroid injection, and ultimately surgery. In fact, she has had all of these except for injection and surgery. She has had non specialist physical therapy splinting, but had not had hand therapy or custom thumb CMC splinting. Symptoms persist, and now impact daily living activities.

I advised a limited course of therapy, with focus on teaching activity modification, and custom short oppenens splinting.

She is scheduled for follow up October 9, 2006. Further treatment might be needed, based upon her symptoms.

I hereby declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that the contents of this report are true to the best of my information and belief. I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true. In compliance with Labor Code Section 5703 (A)(1), I, Kendrick E. Lee, the consulting physician, declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage dividend, discount, or other consideration whether in the form of money or otherwise as compensation or inducement for any referred examination or evaluation.

Signed September 29, 2006 in Alameda County, California.

Sincerely,

[redacted]

[redacted]

DOCUMENT SEPARATOR SHEET

Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title PROOF OF SERVICE

Document Date _____
MM/DD/YYYY

Date of document following Document Separator Sheet

If you are the Claims Administrator or the Hearing Representative use your Uniform Assigned Name. For unrepresented Injured Worker and others, "Author" is the document author.

Author UNIFORM ASSIGNED NAME

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DWC-CA form 10232.2

PROOF OF SERVICE OF

APPLICATION FOR ADJUDICATION OF CLAIM WITH SUPPORTING DOCUMENTS

AND

DECLARATION OF READINESS TO PROCEED WITH SUPPORTING DOCUMENTS