

This packet contains instructions on how to fill in Optical Character Recognition (OCR) forms, examples of forms and is in the order in which forms / documents should be filed with the district office.

Use the table below to help identify the forms that you need to complete when filing a compromise and release. The table also shows the order in which the forms should be assembled. To help you find the correct document separator sheet, the product delivery unit, document type and document title are in brackets.

In this packet, you will see examples as filed by the applicant attorney for injured worker.

**Name of form**

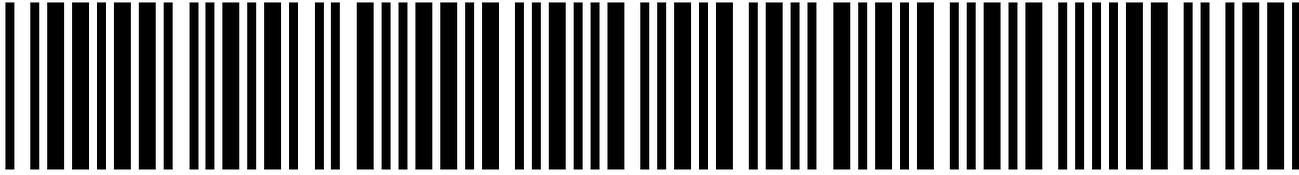
1	Document cover sheet
2	Document separator sheet [ADJ-LEGAL DOCS-COMPROMISE AND RELEASE]
3	Compromise and release form - may include addendum
4	Document separator sheet for QME report [ADJ-MEDICAL DOCS-QME REPORT]
5	QME report
6	Document separator sheet for proof of service [ADJ-LEGAL DOCS-PROOF OF SERVICE]
7	Proof of service

This packet is an example of how to fill in forms and the order in which they should be filed with the district office.

STATE OF CALIFORNIA  
DWC DISTRICT OFFICE

This example shows documents submitted by a represented injured worker.

DOCUMENT COVER SHEET



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

More than 15 Companion Cases

09/10/2008 **ENTER DATE YOU FILL IN DOCUMENT COVER SHEET.**  
Date:(MM/DD/YYYY)

SSN: **SOCIAL SECURITY NUMBER IS NOT REQUIRED.**

ADJ123456  
Case Number 1  Specific Injury  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: \_\_\_\_\_

**NO OTHER INFORMATION IS NEEDED WHEN CORRECT CASE NUMBER IS LISTED.**

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

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

ADJ  DEU  SIF  UEF  INT  RSU

**Companion Cases**

ADJ67890  
Case Number 2  Specific Injury  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 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

Example

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 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

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 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

Specific Injury

Case Number 5

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 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

DO NOT PRINT OR  
SUBMIT BLANK  
PAGES.

## District office codes for place of venue

<b>Legend</b>	
<b>Abbreviation</b>	<b>Office</b>
AHM	Anaheim
ANA	Santa Ana
BAK	Bakersfield
EUR	Eureka
FRE	Fresno
GOL	Goleta
LAO	Los Angeles
LBO	Long Beach
MDR	Marina del Rey
OAK	Oakland
OXN	Oxnard
POM	Pomona
RDG	Redding
RIV	Riverside
SAC	Sacramento
SAL	Salinas
SBR	San Bernardino
SDO	San Diego
SFO	San Francisco
SJO	San Jose
SLO	San Luis Obispo
SRO	Santa Rosa
STK	Stockton
VNO	Van Nuys

**Use this document to complete forms, but do not file this document with your forms.**

DO NOT PRINT OR  
SUBMIT THIS PAGE.

## Body Part Code List

The body part codes listed below are used to complete forms that require the listing of the part of the body that is in issue. Please do not file this document with your forms.

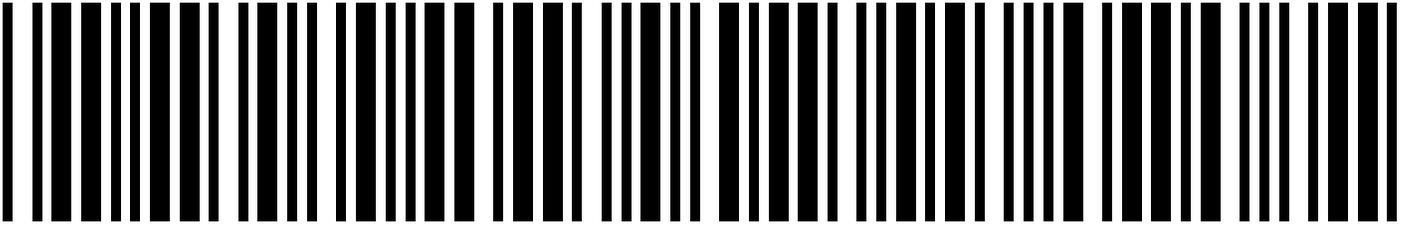
100	Head - not specified	500	Lower extremities - not specified
110	Brain	510	Legs - above ankles, not specified
120	Ear - not specified	511	Thigh femur
121	Ear - external	513	Knee Patella
124	Ear - internal including hearing	515	Lower leg tibia and fibula
130	Eye - including optic nerves and vision	518	Leg - multiple parts any combination of above parts
140	Face - not specified	519	Leg - not specified
141	Jaw - including chin and mandible	520	Ankle malleolus
144	Mouth - including lips, tongue, throat and taste	530	Foot not ankle or toe
145	Teeth	540	Toes
146	Nose - including nasal passages, sinus and smell	598	Lower extremities - multiple parts any combination of above parts
148	Face - multiple parts any combination of above parts	700	Multiple parts more than five major parts use only in fifth position of listing of body parts
149	Face - forehead, cheeks, eyelids	800	Body system - not specific
150	Scalp	801	Circulatory system - heart -other than heart attack, blood, arteries,veins, etc.
160	Skull	802	Circulatory system - Heart attack
198	Head - multiple injury any combination of above parts	810	Digestive system - stomach
200	Neck	820	Excretory system - kidneys, bladder, intestines, etc.
300	Upper extremities - not specified	830	Musculo-skeletal system - bones, joints, tendons, muscles, etc.
310	Arm - above wrist not specified	840	Nervous system - not specified
311	Arm - upper arm humerus	841	Nervous system - stress
313	Arm - elbow head of radius	842	Nervous system - Psychiatric/psych
315	Arm -forearm radius and ulna	850	Respiratory system - lungs, trachea, etc.
318	Arm - multiple parts any combination of above parts	860	Skin dermatitis, etc.
319	Arm - not specified	870	Reproductive systems
320	Wrist	880	Other body systems
330	Hand - not wrist or fingers	999	Unclassified - insufficient information to identify body parts
340	Fingers		
398	Upper extremities - multiple parts any combination of above parts		
400	Trunk - not specified		
410	Abdomen - including internal organs and groin		
411	Hernia		
420	Back - including back muscles, spine and spinal cord		
430	Chest - including ribs, breast bone and internal organs of the chest		
440	Hips - including pelvis, pelvic organs, tailbone, coccyx and buttocks		
450	Shoulders - scapula and clavicle		
498	Trunk - use for side; multiple parts any combination of above parts		

DO NOT PRINT OR  
SUBMIT THIS PAGE.

**Use this document to complete forms, but do not file this document with your forms.**

# Example

# DOCUMENT SEPARATOR SHEET



Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title COMPROMISE AND RELEASE

Document Date

09/10/2008

ENTER DATE YOU FILL IN DOCUMENT SEPARATOR SHEET.

MM/DD/YYYY

Author

UNIFORM ASSIGNED NAME

IF YOU ARE A CLAIMS ADMINISTRATOR,  
HEARING REPRESENTATIVE OR LAW FIRM  
USE YOUR UNIFORM ASSIGNED NAME.

---

## Office Use Only

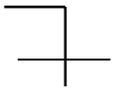
Received Date

\_\_\_\_\_

MM/DD/YYYY



**STATE OF CALIFORNIA  
DIVISION OF WORKERS' COMPENSATION  
WORKERS' COMPENSATION APPEALS BOARD  
COMPROMISE AND RELEASE**



ENTER ALL EAMS CASE  
NUMBERS THAT APPLIES.

ADJ123456

Case Number 1

Case Number 4

ADJ45678

Case Number 2

Case Number 5

Case Number 3

SSN (Numbers Only)

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

CHECK THE BOX THAT APPLIES.

- 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).)

OAK

PUT 3 LETTER CODE OF DISTRICT OFFICE OF  
WHERE HEARING WILL BE HELD.

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

**Employee (Completion of this section is required)**

JANE \_\_\_\_\_ MI  
First Name

DOE \_\_\_\_\_  
Last Name

345 MAIN ST \_\_\_\_\_  
Address/PO Box (Please leave blank spaces between numbers, names or words)

OAKLAND \_\_\_\_\_ CA \_\_\_\_\_ 94622 \_\_\_\_\_  
City State Zip Code

**Employer Information (Completion of this section is required)**

- Insured
- Self-Insured
- Legally Uninsured
- Uninsured

PREMIUM CRACKERS \_\_\_\_\_  
Employer Name (Please leave blank spaces between numbers, names or words)

660 E 7TH ST \_\_\_\_\_  
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

OAKLAND \_\_\_\_\_ CA \_\_\_\_\_ 95409 \_\_\_\_\_  
City State Zip Code

Example

**Applicant's Attorney or Authorized Representative:**

Law Firm/Attorney       Non Attorney Representative

JANE  
First Name

SMITH  
Last Name

568901  
Law Firm Number

PUT UAN OF LAW FIRM.

ABLE ATTORNEY ALAMEDA  
Law Firm Name

ENTER THE ADDRESS THAT IS IN EAMS DATABASE.

12345 FIRST ST  
Address/PO Box (Please leave blank spaces between numbers, names or words)

ALAMEDA  
City

CA  
State

94501  
Zip Code

**Defendant's Attorney or Authorized Representative:**

Law Firm/Attorney       Non Attorney Representative



JIM  
First Name

JONES  
Last Name

577889  
Law Firm Number

PUT UAN OF LAW FIRM.

RESPONSIBLE ATTORNEY SAN LEANDRO  
Law Firm Name

ENTER THE ADDRESS THAT IS IN EAMS DATABASE.

45890 EIGHT ST  
Address/PO Box (Please leave blank spaces between numbers, names or words)

SAN LEANDRO  
City

CA  
State

97852  
Zip Code

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

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

PO BOX 458901  
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

SACRAMENTO  
City

CA  
State

95800  
Zip Code

Example

Claims Administrator Information (if known and if applicable)

PUT UAN OF CLAIMS ADMINISTRATOR.

SPRING CLAIMS MODESTO

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

PO BOX 123590

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

MODESTO

City

CA

State

93489

Zip Code

IT IS CLAIMED THAT:

1. The injured employee, born 08/08/1945, alleges that while employed as a(n)

(DATE OF BIRTH: MM/DD/YYYY)



STOCKER

(OCCUPATION AT THE TIME OF INJURY)

, sustained injury

arising out of and in the course of employment at the locations and during the dates listed below:

(State with specificity the date(s) of injury(ies) and what part(s) of body, conditions or systems are being settled.)

Specific Injury

ADJ123456

Case Number 1

Cumulative Injury

03/09/2002

(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 BACK

Body Part 2: 500 LOWER EXT

Body Part 3:

Body Part 4:

Other Body Parts:

The injury occurred at 660 EAST 7TH ST

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

MAY ENTER "ON JOB SITE OR WORK PLACE" OR ADDRESS.

OAKLAND

City

CA

State

95409

Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

Example

ADJ45678  
Case Number 2

Specific Injury

Cumulative Injury

05/30/2003  
(Start Date: MM/DD/YYYY)  
(If Specific Injury, use the start date as the specific date of injury)

01/01/2005  
(End Date: MM/DD/YYYY)

Body Part 1: 420 BACK      Body Part 2: 500 LOWER EXT      Body Part 3: \_\_\_\_\_

Body Part 4: \_\_\_\_\_      Other Body Parts: \_\_\_\_\_

The injury occurred at 660 E 7TH ST  
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

OAKLAND      CA      94501  
City      State      Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

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: \_\_\_\_\_

The injury occurred at \_\_\_\_\_  
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

\_\_\_\_\_  
City      State      Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

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: \_\_\_\_\_

The injury occurred at \_\_\_\_\_  
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

\_\_\_\_\_  
City      State      Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

Specific Injury

Case Number 5

Cumulative Injury

(Start Date: MM/DD/YYYY)  
(If Specific Injury, use the start date as the specific date of injury)

(End Date: MM/DD/YYYY)

Body Part 1: \_\_\_\_\_ Body Part 2: \_\_\_\_\_ Body Part 3: \_\_\_\_\_

Body Part 4: \_\_\_\_\_ Other Body Parts: \_\_\_\_\_

The injury occurred at \_\_\_\_\_  
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

\_\_\_\_\_  
City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

2. Upon approval of this compromise agreement by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge and payment in accordance with the provisions hereof, the employee releases and forever discharges the above-named employer(s) and insurance carrier(s) from all claims and causes of action, whether now known or ascertained or which may hereafter arise or develop as a result of the above-referenced injury(ies), including any and all liability of the employer(s) and the insurance carrier(s) and each of them to the dependents, heirs, executors, representatives, administrators or assigns of the employee. Execution of this form has no effect on claims that are not within the scope of the workers' compensation law or claims that are not subject to the exclusivity provisions of the workers' compensation law, unless otherwise expressly stated.

3. This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury set forth in Paragraph No. 1 and further explained in Paragraph No. 9 despite any language to the contrary elsewhere in this document or any addendum.

4. Unless otherwise expressly stated, approval of this agreement RELEASES ANY AND ALL CLAIMS OF APPLICANT'S DEPENDENTS TO DEATH BENEFITS RELATING TO THE INJURY OR INJURIES COVERED BY THIS COMPROMISE AGREEMENT. The parties have considered the release of these benefits in arriving at the sum in Paragraph 7. Any addendum duplicating this language pursuant to Sumner v WCAB (1983) 48 CCC 369 is unnecessary and shall not be attached.

5. Unless otherwise expressly ordered by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge, approval of this agreement does not release any claim applicant may have for vocational rehabilitation benefits or supplemental job displacement benefits.

6. The parties represent that the following facts are true: (If facts are disputed, state what each party contends under Paragraph No. 9.)

EARNINGS AT TIME OF INJURY \$ 2,500.00

ENTER DOLLAR AMOUNT WITHOUT COMMAS.  
IF INFORMATION IS NOT KNOWN, LEAVE BLANK.  
DO NOT ENTER N/A, NONE, ETC.

TEMPORARY DISABILITY INDEMNITY PAID 1,450.00 Weekly Rate \$ 125.00

Period(s) Paid 02/01/2005 01/30/2007  
(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

PERMANENT DISABILITY INDEMNITY PAID \_\_\_\_\_ Weekly Rate \$ \_\_\_\_\_

Period(s) Paid \_\_\_\_\_ End date \_\_\_\_\_  
(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

TOTAL MEDICAL BILLS PAID \$ 5,500.00 Total Unpaid Medical Expense to be Paid By: \_\_\_\_\_

Unless otherwise specified herein, the employer will pay no medical expenses incurred after approval of this agreement.

7. The parties agree to settle the above claim(s) on account of the injury(ies) by the payment of the SUM OF

\$ 50,000.00  
Settlement Amount

The following amounts are to be deducted from the settlement amount:

\$ \_\_\_\_\_ for permanent disability advances through \_\_\_\_\_

\$ \_\_\_\_\_ for temporary disability indemnity overpayment, if any.

\$ \_\_\_\_\_ payable to \_\_\_\_\_

\$ 5,000.00 requested as applicant's attorney's fee.

LEAVING A BALANCE OF \$ 45,000.00 , after deducting the amounts set forth above and less further permanent disability advances made after the date set forth above. Interest under Labor Code section 5800 is included if the sums set forth herein are paid within 30 days after the date of approval of this agreement.

8. Liens not mentioned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary):

NO LIENS

9. The parties wish to settle these matters to avoid the costs, hazards and delays of further litigation, and agree that a serious dispute exists as to the following issues (initial only those that apply). ONLY ISSUES INITIALED BY THE APPLICANT OR HIS/HER REPRESENTATIVE AND DEFENDANTS OR THEIR REPRESENTATIVES ARE INCLUDED WITHIN THIS SETTLEMENT.

<u>Applicant</u>	<u>Defendant</u>	
_____	<u>Y</u>	earnings
_____	<u>Y</u>	temporary disability
_____	_____	jurisdiction
_____	_____	apportionment
_____	_____	employment
_____	<u>Y</u>	injury AOE/COE
_____	_____	serious and willful misconduct
_____	_____	discrimination (Labor Code §132a)
_____	_____	statute of limitations
_____	<u>Y</u>	future medical treatment
_____	_____	other _____
_____	_____	permanent disability _____
_____	_____	self-procured medical treatment, except as provided in Paragraph 7
_____	_____	vocational rehabilitation benefits/supplemental job displacement benefits

COMMENTS:

ENTER ADDITIONAL INFORMATION OR CONDITION IN THIS AREA.

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

10. It is agreed by all parties hereto that the filing of this document is the filing of an application, and that the workers' compensation administrative law judge may in its discretion set the matter for hearing as a regular application, reserving to the parties the right to put in issue any of the facts admitted herein and that if hearing is held with this document used as an application, the defendants shall have available to them all defenses that were available as of the date of filing of this document, and that the workers' compensation administrative law judge may thereafter either approve this Compromise and Release or disapprove it and issue Findings and Award after hearing has been held and the matter regularly submitted for decision.

**11. WARNING TO EMPLOYEE: SETTLEMENT OF YOUR WORKERS' COMPENSATION CLAIM BY COMPROMISE AND RELEASE MAY AFFECT OTHER BENEFITS YOU ARE RECEIVING TO WHICH YOU BECOME ENTITLED TO RECEIVE IN THE FUTURE FROM SOURCES OTHER THAN WORKERS' COMPENSATION, INCLUDING BUT NOT LIMITED TO SOCIAL SECURITY, MEDICARE AND LONG-TERM DISABILITY BENEFITS.**

**THE APPLICANT'S (EMPLOYEE'S) SIGNATURE MUST BE ATTESTED TO BY TWO DISINTERESTED PERSONS OR ACKNOWLEDGED BEFORE A NOTARY PUBLIC**

By signing this agreement, applicant (employee) acknowledges that he/she has read and understands this agreement and has had any questions he/she may have had about this agreement answered to his/her satisfaction.

**FILL IN DATE AND LOCATION.**

Witness the signature hereof this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ at \_\_\_\_\_

**WHEN DOCUMENT IS NOT NOTORIZED, TWO DISINTERESTED WITNESSES TO SIGN AND DATE THE FORM.**

**SIGN AND DATE THE FORM.**

Witness \_\_\_\_\_ (Date)

Applicant (Employee) \_\_\_\_\_ (Date)

Witness 2 \_\_\_\_\_ (Date)

Attorney for Applicant \_\_\_\_\_ (Date)

Interpreter \_\_\_\_\_ (Date)

Attorney for Defendant \_\_\_\_\_ (Date)

COMPLETE THIS SECTION  
IF NOTORIZED.

## ACKNOWLEDGMENT

State of California  
County of \_\_\_\_\_)

On \_\_\_\_\_ before me, \_\_\_\_\_  
(insert name and title of the officer)

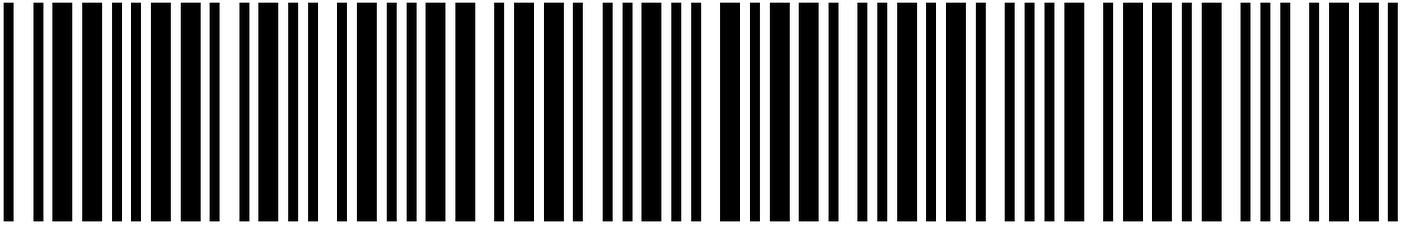
personally appeared \_\_\_\_\_,  
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are  
subscribed to the within instrument and acknowledged to me that he/she/they executed the same in  
his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the  
person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing  
paragraph is true and correct.

WITNESS my hand and official seal.

Signature \_\_\_\_\_ (Seal)

# DOCUMENT SEPARATOR SHEET



Product Delivery Unit ADJ

Document Type MEDICAL DOCS

Document Title QME REPORTS

Document Date 07/10/2007  
MM/DD/YYYY

ENTER DATE OF THE DOCUMENT FOLLOWING THE SEPARATOR SHEET.

Author JOHN PHYSICIAN MD

Example:  
**JOHN A SMITH MD**  
**JOHN A SMITH PT**  
Use only capital letters and no special characters e.g. / \ ' . " , : ; ( ) & !

---

## Office Use Only

Received Date \_\_\_\_\_  
MM/DD/YYYY

Example

LMC

07 100

[Redacted]

Board Eligible Orthopaedic Surgeon  
Qualified Medical Evaluator

000

[Redacted]

QUALIFIED MEDICAL EVALUATION

May 18, 2007

[Redacted]

RE:

DATE OF EVALUATION:

[Redacted]

May 18, 2007

EMPLOYER:

[Redacted]

DATE OF INJURY:

January 1, 2005

CLAIM NO.:

[Redacted]

FILE NO:

51012-0

35minutes were spent face to face with the patient in the evaluation process.

**FEE DISCLOSURE**

**ML 104-95:** This is an Unrepresented Qualified Medical Evaluation with Extraordinary Circumstances as a result of meeting the requirements of 4 complexity factors, which are listed below:

- 7 hour(s) of record review time
- 3 hour(s) of report preparation time
- 35 minutes of face to face time
- 10 1/2 total hours of combined time
- Four hours or more of any combination of 2 complexity factors (2 factors)
- Addressing issues of causation (1 factor)
- Addressing issues of apportionment when the physician addresses: (1 factor)
  - 3+ injuries to the SAME body system or region

Example

LHII

RE: [REDACTED]  
Page 2

07 100

**PROOF OF SERVICE:** All reports are accompanied by the HICFA form stapled to the first page of the report, along with a proof of service.

Thank you for the opportunity to evaluate [REDACTED] on Friday, May 18, 2007 in my [REDACTED] office.

The history and physical examination is not intended to be construed as a general or complete medical evaluation. It is intended for medical legal purposes only and focuses on those areas in question. No treatment relationship is established or implied.

This medical-legal evaluation is based only on the current information and records submitted. It is solely the treating physician's responsibility to determine the patient's differential diagnoses and subsequent needs for medical treatment. This would be inclusive of all psychiatric conditions, vascular diseases, neuromuscular disorders, central nervous system disorders, auto-immune diseases, internal medicine disorders and all tumors, benign or malignant, even if they are undiagnosed or currently occult.

It is noted seven inches of medical records were reviewed. It is also noted that the applicant has had previous industrial trauma therefore complex acts of apportionment, this should be an ML 104.

#### HISTORY OF INJURY

[REDACTED] is a [REDACTED] for [REDACTED]. She indicates she began working for this organization in 1986 and continues with her normal activities at the present time. The applicant is seen at this time in conjunction with a claim of cumulative trauma through January 1, 2005. [REDACTED] describes no specific industrial injury occurring at that time. She describes no worsening symptomatology occurring in 2005. She indicates that her back pain was "the same that I had for years". She further states "Over the years, it is worse and worse." She indicates she has been taking Celebrex "for years".

Her past medical history is significant for a specific industrial trauma occurring March 9, 2002. At that time, she indicates that she was lifting file boxes when her back "snapped". She indicates she was seen by her family physician and later was referred for an MRI scan which was positive for a disc herniation at the L4-5 level. She had applied for workers' compensation and was referred to Dr. [REDACTED], a neurosurgeon. Surgery was performed by Dr. [REDACTED] on June 3, 1992 for diagnosis

# Example

RE: [REDACTED]  
Page 3

of herniated intervertebral disc at L5-S1 level. She underwent an L4-5 laminectomy and discectomy procedure. She did note initial improvement after that surgery. She was deemed permanent and stationary by Dr. [REDACTED] as of April 29, 1999 and was awarded a 24% permanent disability in conjunction with her back injury. The applicant states that she began developing gradual increasing symptomatology and underwent a repeat MRI scan and was recommended by Dr. [REDACTED] to undergo further surgery. On January 17, 2000, the applicant underwent a bilateral L4-5 laminectomy, nerve root decompression and posterior interbody fusion. She indicated that she did improve although she continued to have back pain. She has continued to treat with Dr. [REDACTED] who sees her at yearly intervals.

She was deemed permanent and stationary in regard to her second operative procedure as of April 18, 2002. He was referred by the insurance carrier to Dr. [REDACTED] a spine surgeon who examined her on December 30, 2003. At that time, she was in constant pain. She was noted to have right buttock numbness with numbness into the right third and fourth toes. Dr. [REDACTED] recommended further nonoperative management. [REDACTED] states that she continues under the care of Dr. [REDACTED] who sees her at yearly intervals.

#### CURRENT COMPLAINTS

The applicant describes pain in her lower back which is almost constant. She states that she will have pain daily. She states that the use of nonsteroidal anti-inflammatory medications ( Celebrex) diminished the discomfort. She further indicated sitting for more than fifteen to thirty minutes a day is painful; standing more than fifteen to thirty minutes is painful. She indicates that lying down diminishes her pain. causes pain of the lower back at the lumbosacral junction. She states that the right side of the lower back is more symptomatic than the left side. She describes decreased sensation over the anterior aspect of the right thigh with prolonged sitting. She describes sensation of "numbish" feeling in the third and fourth toes of the right foot.

#### REVIEW OF MEDICAL RECORDS

January 22, 1993 Progress Report from [REDACTED], M.D. Has an injury March 9, 1992. Dr. [REDACTED] notes "It is my opinion that [REDACTED] is postoperative laminectomy and discectomy. I believe her condition is improved. "

November 8, 1993 from [REDACTED], M.D. It is my impression that [REDACTED] is able to perform her job duties without limitations.

Example

L M I E

RE: [REDACTED]  
Page 4

07.100  
000

November 20, 1998 MRI scan of the lumbar spine. Interpreted by Gregory Henzie, M.D. Impression: surgical changes on the right at L4-5, disc desiccation at L3-4, disc desiccation at L2-3.

February 3, 1999 signed by [REDACTED] M.D. At the time of her appointment, the patient complained of moderate to severe lower back pain and right leg pain and numbness. Dr. [REDACTED] recommended authorization to proceed with a posterior lumbar interbody fusion using threaded fusion cages.

August 4, 1999 Progress Report from Dr. [REDACTED]. The patient states that she is continuing to have constant lower back pain of severe intensity which increases with activity. [REDACTED] is suffering from degenerative disc disease at the L4-5 level.

January 17, 2000 Operative Report signed by [REDACTED], M.D. Procedure bilateral L4-5 laminectomy, facetectomy nerve root decompression with posterior interbody fusion. The patient is a 51-year-old female who underwent prior laminectomy discectomy in 1992 with recurrent back pain.

June 5, 2001 [REDACTED] M.D. diagnoses lumbar disc disease.

Treating Physician's Consultation Report signed by Dr. [REDACTED] dated April 18, 2002 notes date of injury March 9, 1992.

Deposition of [REDACTED] dated June 21, 2005. Question: Are you currently working? Answer: Yes. Question: When were you hired at [REDACTED]? Answer: November 18, 1986. Question: Did you file a claim of cumulative trauma? Answer: Yes. Question: February 15, 2004? Answer: Yes, though I am thinking this is 2005. Question: How did you sustain injury? Answer: By lifting boxes. Question: Did you sustain an injury in 1992; is that what you are referring to? Answer: Yes. Question: Did you receive an Award of Permanent Disability for 24%? Answer: Yes. Question: How many surgeries have you had in your back? Answer: There was one in June of 1992, a second one in January of 2000. Question: So you went back to work full time after the 2000 surgery? Have you lost any time from work due to your complaints of pain to your back? Answer: No. Question: Do you understand this as to Republic Indemnity because of the stipulations the only rights you have are to continue medical care? Answer: I understand.

December 30, 2003 Initial consultation performed by [REDACTED], M.D. [REDACTED] is a [REDACTED] complaining of lower back pain. Plain films today

# Example

LME

RE: [REDACTED]  
Page 5

demonstrate ray cage PLIF in place, essentially a complete laminectomy of L4 and much of L5 has been performed. Assessment: 1) possible pseudoarthrosis L4-5; 2) possible symptomatic adjacent disc degeneration lumbar spine. Dr. Neuberger recommended further nonoperative management.

October 7, 2005 Examination performed by [REDACTED]. The patient presents today stating that she had another episode where she had what she felt was palpitations and ended up in the emergency room. Assessment: 1) continued intermittent palpitations; 2) hypertension; 3) history of ulcerative colitis; 4) history of hyper cholesterolemia.; 5) mild diabetes mellitus; 6) chronic lower back pain; 7) exogenous obesity.

January 10, 2000 X-rays lumbar spine interpreted by [REDACTED], M.D. Impression: Osteoporosis and mild degenerative changes as above.

June 9, 1996 Neurosurgical consultation performed by [REDACTED] M.D. Impression: Lumbar spinal stenosis L4-5 with right sided L4 compressive neuropathy. As a result of the lifting incident March 9, 1992, [REDACTED] has had persistent pain in the right lower extremity which is aggravated by walking and hyperextension of the lower back.

July 19, 1993 Progress Report [REDACTED] M.D. notes [REDACTED] condition became permanent and stationary as of April 29, 1993.

December 3, 1993 Examination performed by [REDACTED] M.D. Requested surgery by Dr. [REDACTED] is posterior lumbar interbody fusion using threaded fusion cages at L4-5.

Operative Report dated June 3, 1992 signed by [REDACTED]. Operation right L4-5 laminectomy, discectomy with partial facetectomy, nerve root decompression microsurgical technique. Postoperative diagnosis: 1) Herniated intervertebral disc L4-5.

#### PHYSICAL EXAMINATION

Physical examination reveals a well-developed, well-nourished [REDACTED]. Height is 5'9", weight is 200 pounds. She ambulates with a normal gait pattern. She sits comfortably during her interview. She is able to get up and unassisted.

Example

LME

RE: [REDACTED]  
Page 6

07 100

Mid thigh circumference is measured at 20" bilaterally. Thigh circumference is measured as 15" bilaterally.

000

She has normal sensation to pinprick in both extremities.

Straight leg raising is negative bilaterally. Straight leg raising does cause her referred lower back pain. Sciatic stresses was negative bilaterally. Extensor hallucis longus motor strength is normal and symmetrical in both extremities. She has normal sensation of pinprick in both extremities. Deep tendon reflexes are intact in both extremities.

She is able to toe walk, heel walk and squat. She describes no pain of those nerve roots.

Sitting straight leg raising is negative 90 degrees bilaterally. in a prone position shows a 2-1/2" incisional scar consistent with two previous lower back procedures. She has localized pain in the lower back at the lumbosacral junction to palpation.

..Lumbar range of motion is measured with dual inclinometers and is listed on Figure 15-10 accompanying this dictation.

#### DIAGNOSTIC IMPRESSION

1. Chronic lumbosacral strain with right lower extremity radiculitis.
2. Status post lumbar surgery, times two .
  - a. Right L4 laminectomy and discectomy and partial facetectomy and nerve root decompression (Surgery June 3, 1992)
  - b. Bilateral L4-5 laminectomy facetectomy for nerve root decompression and posterior interbody fusion (Surgery January 17, 2000)

#### DISCUSSION

The applicant was seen for orthopaedic examination in conjunction of related trauma occurring in 1992. At that time, she was diagnosed as having a disc herniation at the L4-5 level for which she underwent surgery. She did not initial improvement in symptomatology, however, she had recurrent of symptoms and underwent further surgery for a fusion procedure at the L4-5 level performed in the year 2000. She did

# Example

LME

RE: [REDACTED]  
Page 7

07 1 00

have improvement after the fusion although she continues to have episodic back pain. She had undergone a second opinion consultation with a spine surgeon in 2003. At that time, no further surgery was recommended. There has been no recent change in her symptomatology as compared with her current symptoms and review of prior medical records.

She continues to be permanent and stationary and was ordered to become permanent and stationary as of April 18, 2002. She does have persistence of back complaints consistent with her initial injury and subsequent surgeries. There is no indication of new or further trauma occurring on a cumulative trauma basis through January 1, 2005. Her current symptomatology would be consistent with a natural sequelae of her initial trauma and subsequent surgeries.

She will continue to require medical treatment which could include nonsteroidal anti-inflammatory medications, narcotic analgesics for flare ups and symptomatology as well as possible installation of corticosteroids or physical therapy modalities for flare ups of symptomatology.

For reasons therefore, future medical care should be granted on an as needed basis.

#### SUBJECTIVE FACTORS OF DISABILITY

The applicant describes frequent episodes of lower back of slight intensity becoming occasionally moderate with increased activity levels.

#### OBJECTIVE FACTORS OF DISABILITY

The applicant has localized tenderness over the lower back. She describes paresthesias in the right lower extremity. She has undergone prior back surgery for disc abnormalities at the L4-5 level resulting in a fusion at the L4-5 level. She is also noted to have some symptomatic adjacent disc degeneration of the lumbar spine as noted in the medical records.

#### WORK PRECLUSIONS

The patient would be restricted from heavy work activities in conjunction with her back symptomatology.

# Example

RE: [REDACTED]  
Page 8

### IMPAIRMENT

The applicant's injury and subsequent disability was preexistent to the AMA Impairment rating. For completeness, the impairment as per the Guides of the Evaluation of Permanent Impairment, of American Medical Association is included in this report. As per page 384, Table 15-3, the applicant will have a DRE Lumbar Category IV 23% of impairment of the whole person pending loss of motion segment due to successful or unsuccessful attempt at surgical arthrodesis.

### CAUSATION

The applicant sustained industrial trauma in 1992 necessitating surgery. She had increasing symptomatology for which she underwent further surgery in the year 2000. The progression of symptomatology will be considered on the basis of her initial industrial trauma of 1992. Her current symptomatology would also be considered on the basis of natural progression of symptomatology due to the industrial trauma and two subsequent surgeries. In addition, she does have some degenerative changes at adjacent disc level which would also be the sequelae of her initial trauma and subsequent fusion procedure.

### APPORTIONMENT

Apportionment to preexisting or nonindustrial causation is not indicated.

### FUTURE MEDICAL CARE

As I outlined in the report, the patient has persistent back symptomatology and will, in all probability, require further medical management for use of nonsteroidal anti-inflammatory medications as well as possible physical therapy modalities, installation of corticosteroids or narcotic analgesics for flare up of symptoms.

Future medical care should be done on an as needed basis.

### VOCATIONAL REHABILITATION

The patient has been able to continue with her normal duties and therefore would not be considered a Qualified Injured Worker for the purposes of vocational training.

Example

LHC

RE: [REDACTED]  
Page 9

07. 100

RECOMMENDATIONS

None.

000

Thank you for the opportunity to evaluate this patient. If I may be of additional assistance, please do not hesitate to contact me.

ATTESTATION

I, David M. Broderick, M.D., personally took the patient's history, reviewed the medical records, performed the physical examination, and dictated this report. All of the opinions expressed in the report are mine.

I hereby declare under penalty of perjury that I have not violated Labor Code Section 139.3 and have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage, dividend, discount or other consideration for any referral for examination or evaluation by a physician.

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 that I have indicated I 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.

Sincerely yours,

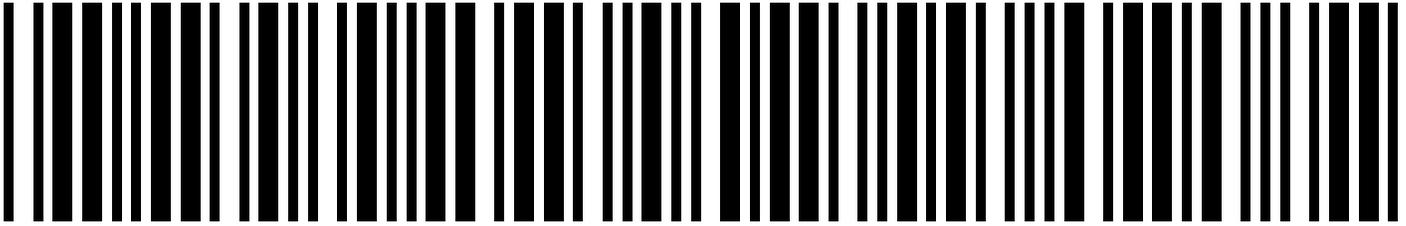
[REDACTED]

M.D.  
Board Eligible Orthopaedic Surgeon

Signed this 10<sup>th</sup> day of June 2007 in [REDACTED] County in the State of California.

Example

# DOCUMENT SEPARATOR SHEET



Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title PROOF OF SERVICE

Document Date 09/10/2008

MM/DD/YYYY

ENTER DATE YOU FILL IN DOCUMENT SEPARATOR SHEET.

Author UNIFORM ASSIGNED NAME

IF YOU ARE A CLAIMS ADMINISTRATOR,  
HEARING REPRESENTATIVE OR LAW FIRM  
USE YOUR UNIFORM ASSIGNED NAME.

---

## Office Use Only

Received Date \_\_\_\_\_  
MM/DD/YYYY

Case Name: [REDACTED]  
Case No.: [REDACTED]  
Our File No.: [REDACTED]

PROOF OF SERVICE

I certify and declare as follows:

I am over the age of 18 years, and not a party to the within  
action. My business address is [REDACTED] Suite [REDACTED]  
Oakland, California 94621, which is located in the county where the  
mailing described below took place. On the date listed below, I served  
the following documents: Compromise and Release and  
Original Medical Reports (see attached list) by placing a true copy  
thereof enclosed in a sealed envelope and served in the manner and/or  
manners described below to each of the parties herein and addressed as  
stated below:

United States Postal Service, U.S. Mail, with First Class  
postage prepaid and deposited in sealed envelope at Oakland,  
California. I am readily familiar with the business practice  
at my place of business for collection and processing of  
correspondence for mailing with the United States Postal  
Service. Correspondence so collected and processed is  
deposited with the U.S. Postal Service that same day in the  
ordinary course of business.

Facsimile Transmission

Hand-Delivery:

[REDACTED]

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

Executed on 9/10/08 [REDACTED]