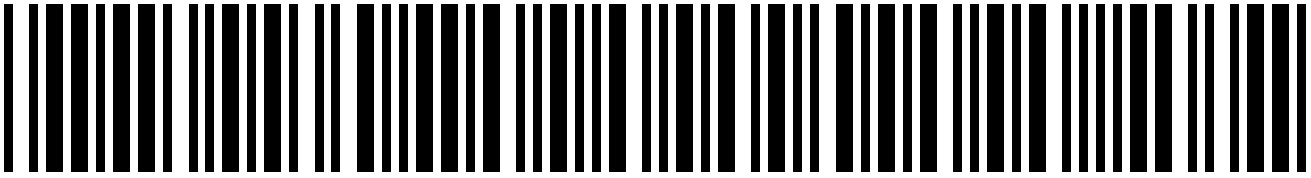
This packet is an example of the order in which documents should be filed. These are not examples of how to fill out forms/documents.

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

ADJ12345
Case Number 1

☐ Cumulative Injury

02/02/2004
(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:

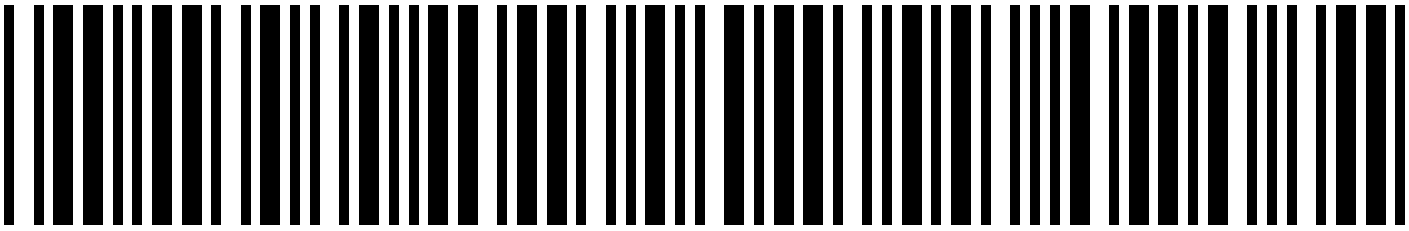
Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

DOCUMENT SEPARATOR SHEET



Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: PETITION TO TERMINATE LIABILITY FOR TEMPORARY DISABILITY INDEMNITY

Document Date: 07/30/2008
MM/DD/YYYY

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
PETITION TO TERMINATE LIABILITY FOR TEMPORARY DISABILITY INDEMNITY

Case Number 1

Case Number 2

Case Number3

Case Number 4

Case Number 5

Injured Worker (Completion of this section is required)

First Name

MI

Last Name

VS

Employer Information

☐ 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

DEFENDANTS ALLEGE that temporary disability was heretofore found by decision of a WCJ dated _____ that

temporary disability has been paid in the total sum of $ _____ for the period _____ to _____

that temporary disability terminated on _____

☐ (1) Applicant returned to work on said date.

☐ (2) Applicant was declared able to return to work on said date per report of Dr. _____

Dated _____

☐ (3) Applicant's condition is permanent and stationary as shown by the attached medical report(s).

☐ (4) Applicant's condition has reached maximum medical improvement as shown by the attached medical report(s).

☐ (5) Other _____

Defendants are informed and believe that applicant ☐ is presently working ☐ is not presently working Advances ☐ are ☐ are not

being made on permanent disability indemnity at the rate of $ _____ per week and will continue until

approximately _____.

Defendants request that the workers compensation administrative law judge make an order terminating liability for temporary disability indemnity unless the employee objects, and if the employee does object,that this petition be set for hearing.

All medical reports in petitioner's possession not previously served and filed herein, are attached hereto, served herewith.

(Insurer / Employer)

By _____

NOTE: Section 10466 of title 8 of the California Code of Regulation provides as follows: "IF WRITTEN OBJECTION IS NOT RECEIVED TO THE PETITION WITHIN FOURTEEN DAYS OF ITS PROPER FILING AND SERVICE THE WCJ MAY ORDER TEMPORARY DISABILITY COMPENSATION TERMINATED", in accordance with the facts as stated in the petition or in such other manner as may appear appropriate on the record.

DOCUMENT SEPARATOR SHEET

Product Delivery Unit ADJ

Document Type MEDICAL DOCS

Document Title ALL MEDICAL REPORTS

Document Date 01/24/2006
MM/DD/YYYY

Author MEDICAL PROVIDER NAME

Date of document following Document Separator Sheet

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

EAST BAY SPORTS MEDICINE AND ORTHOPAEDIC ASSOCIATES
A MEDICAL CORPORATION

Sports Medicine • Arthroscopy • General Orthopaedics
Trauma • Joint Replacement • Hand Surgery

[redacted]

January 24, 2006

SCIF
Attn: [redacted]

RE: [redacted]

EMP:
CLAIM #: [redacted]

Dear SCIF:

I had the opportunity, at the request of [redacted]
Medicine, to reevaluate [redacted] in the office today.

HISTORY:
He was last seen on 3/1/05. At that time, I had recommended a corticosteroid injection, however, apparently he did quite well on anti-inflammatories. Symptoms began to return and therefore he returned to [redacted] His pain is intermittent without clear precipitating factors. When he was last seen he was authorized for consultation only.

PHYSICAL EXAMINATION:
Examination shows 175 degrees of forward elevation of the shoulders bilaterally. External rotation is also symmetric at 60 degrees. Internal rotation on the left is to T8 and on the right T7. Secondary impingement signs are positive.

MRI SCAN:
He has had MRI evidence of partial thickness tearing of the rotator cuff with a bursal effusion.

X-RAYS:
He also had x-ray evidence of a type II to III acromion.

[redacted]

PLAN:
Today, I have discussed options with him. I have again recommended and performed an injection of local anesthetic and steroid into the subacromial space. If he does not have significant improvement with this, I would like to see him again.

Thank you for the opportunity to continue to participate in his care.

I declare under penalty of perjury that the information contained in this regard 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, I believe it to be true.

I have not violated California Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

Signed this 24th day of January, 2006 at Contra Costa County, California.

Sincerely,

[redacted]

MFS/dh
cc: [redacted]

DOCUMENT SEPARATOR SHEET

Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title PROOF OF SERVICE

Date of document following Document Separator Sheet

Document Date _____
MM/DD/YYYY

Author UNIFORM ASSIGNED NAME

Office Use Only

Received Date _____
MM/DD/YYYY

DWC-CA form 10232.2

Proof of Service
with
Petition to Terminate Liability for Temporary Disability Indemnity
and
Medical Reports