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.

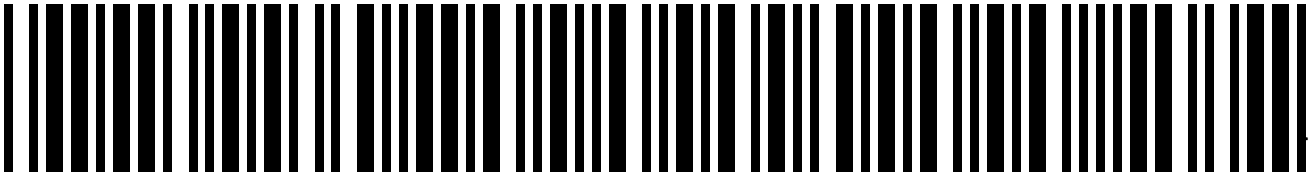
Use the table below to help identify the forms that you need to complete when filing the stipulations with request for award. The table also shows the order in which the forms should be assembled. To help you find the correct document separator sheet, the product delivery unit, document type and document 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 for stipulations with request for award **[ADJ-LEGAL DOCS-STIPULATIONS WITH REQUEST FOR AWARD]**
3	Stipulations with request for award
4	Document separator sheet for QME reports **[ADJ-MEDICAL DOCS-QME REPORTS]**
5	QME report
6	Document separator sheet for QME reports **[ADJ-MEDICAL DOCS-QME REPORTS]**
7	QME report
8	Document separator sheet for proof of service **[ADJ-LEGAL DOCS-PROOF OF SERVICE]**
9	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

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.

☐ Specific Injury

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)

Body Part 1: 420

Body Part 2: 100

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

Body Part 3:

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

☐ 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:

IF THERE ARE COMPANION CASES, ENTER THE CORRECT EAMS CASE NUMBER.

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 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: _____

DO NOT PRINT OR SUBMIT BLANK PAGES.

☐ 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: _____

District office codes for place of venue

Legend	
Abbreviation	**Office**
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

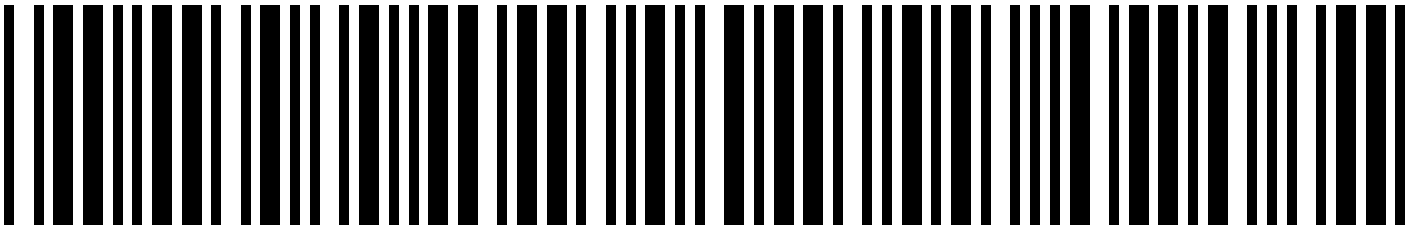
The body part codes listed below are used to complete forms that require the listing of the part of the body that is in issue. Please do not file this document with your forms.

100	Head - not specified
110	Brain
120	Ear - not specified
121	Ear - external
124	Ear - internal including hearing
130	Eye - including optic nerves and vision
140	Face - not specified
141	Jaw - including chin and mandible
144	Mouth - including lips, tongue, throat and taste
145	Teeth
146	Nose - including nasal passages, sinus and smell
148	Face - multiple parts any combination of above parts
149	Face - forehead, cheeks, eyelids
150	Scalp
160	Skull
198	Head - multiple injury any combination of above parts
200	Neck
300	Upper extremities - not specified
310	Arm - above wrist not specified
311	Arm - upper arm humerus
313	Arm - elbow head of radius
315	Arm -forearm radius and ulna
318	Arm - multiple parts any combination of above parts
319	Arm - not specified
320	Wrist
330	Hand - not wrist or fingers
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
500	Lower extremities - not specified
510	Legs - above ankles, not specified
511	Thigh femur
513	Knee Patella
515	Lower leg tibia and fibula
518	Leg - multiple parts any combination of above parts
519	Leg - not specified
520	Ankle malleolus
530	Foot not ankle or toe
540	Toes
598	Lower extremities - 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
800	Body system - not specific
801	Circulatory system - heart -other than heart attack, blood, arteries,veins, etc.
802	Circulatory system - Heart attack
810	Digestive system - stomach
820	Excretory system - kidneys, bladder, intestines, etc.
830	Musculo-skeletal system - bones, joints, tendons, muscles, etc.
840	Nervous system - not specified
841	Nervous system - stress
842	Nervous system - Psychiatric/psych
850	Respiratory system - lungs, trachea, etc.
860	Skin dermatitis, etc.
870	Reproductive systems
880	Other body systems
999	Unclassified - insufficient information to identify body parts

DO NOT PRINT OR SUBMIT THIS PAGE.

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

DOCUMENT SEPARATOR SHEET



Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: STIPULATIONS WITH REQUEST FOR AWARD

Document Date: 10/31/2008
MM/DD/YYYY

DATE OF DOCUMENT FOLLOWING DOCUMENT SEPARATOR SHEET

Author: UNIFORM ASSIGNED NAME

IF YOU ARE A CLAIMS ADMINISTRATOR, HEARING REPRESENTATIVE OR LAW FIRM USE YOUR UNIFORM ASSIGNED NAME. FOR UNREPRESENTED INJURED WORKERS AND OTHERS ENTER YOUR NAME.

Office Use Only

Received Date
MM/DD/YYYY

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

ADJ1235697
Case No.

Date of Injury 03/19/2005
MM/DD/YYYY

SOCIAL SECURITY NUMBER IS NOT REQUIRED.

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).)
- [x] 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. SEE PAGE 7 OF DOCUMENT COVER SHEET FOR LISTING OF DISTRICT OFFICE CODES.

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

Applicant (Completion of this section is required)

JANE
First Name

MI

DOE
Last Name

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

OAKLAND
City

CA
State

95609
Zip Code

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

- [x] 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
City

CA
State

95409
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

Claims Administrator Information (if known and if applicable)

ENTER THE UNIFORM ASSIGNED NAME OF THE CLAIMS ADMINISTRATOR.

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

ENTER THE ADDRESS THAT IS IN UNIFORM ASSIGNED NAME DATABASE.

PO BOX 13490
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

MODESTO — City
CA — State
93489 — 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. JANE
Employees First Name

DOE ,
Employees Last Name

birth date 08/08/1945 ,
MM/DD/YYYY

while employed at OAKLAND , CA
State

as a(n) STOCKER , in
Occupation Group

☐ More than 4 Companion Cases

☐ Specific Injury

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)

Body Part 1: _____ 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

HEAD AND LOWER EXTREMITY

(Please list all body parts injured)

2. The injury (ies) caused temporary disability for the period 03/19/2005 (MM/DD/YYYY) through 06/30/2006 (MM/DD/YYYY) for which indemnity has been paid at $ 125.00 (Indemnity Paid) per week.

2(a).The injury(ies) caused additional temporary disability for the period _____ (MM/DD/YYYY) through _____ (MM/DD/YYYY) at the rate of $ _____ (Rate) in the amount of $ _____ (Indemnity Paid)

3. The injury(ies) caused permanent disability of 25 % for which indemnity is payable at $ 150.00 (Indemnity Rate) per week beginning 07/15/2006 (MM/DD/YYYY) in the sum of $ 2,500.00 , less credit for such payments previously made. ☐ And a life pension of $_____ (Life Pension) per week thereafter.

Labor Code §4658(d) adjustment:

☐ Increase rate to $ _____ as of _____ (MM/DD/YYYY)

☐ Decrease rate to $ _____ as of _____ (MM/DD/YYYY)

☐ Not Applicable

FILL IN ALL INFORMATION. IF INFORMATION IS NOT KNOWN OR APPLICABLE, THEN LEAVE BLANK.

An informal rating ☑ has / ☐ has not (Select one) been previously issued in case no(s) ADJ1235697 .

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:

ABC MEDICAL SERVICES IN THE AMOUNT OF 3500.00

6. Applicant's attorney requests a fee of $ 5,000.00

☐ Fees to be commuted as follows:

FILL IN ALL INFORMATION. IF INFORMATION IS NOT KNOWN OR APPLICABLE, THEN LEAVE BLANK.

7. Liens Against compensation are payable as follows:

FILL IN ALL INFORMATION. IF INFORMATION IS NOT KNOWN OR APPLICABLE, THEN LEAVE BLANK.

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

9.Other stipulations:

Dated 10/31/2008 DATE THE FORM.
MM/DD/YYYY

INJURED WORKER SIGNS THE FORM.
Applicant

Applicant's Attorney or Authorized Representative:

☑ Law Firm/Attorney ☐ Non Attorney Representative

JANE
First Name

SMITH
Last Name

5891
Firm Number

ABLE ATTORNEY ALAMEDA
Law Firm name

PUT UAN OF LAW FIRM IF INJURED WORKER IS REPRESENTED.

14890 HORIZONTAL ST
Address/PO Box (Please leave blank spaces between numbers, names or words)

ENTER THE ADDRESS THAT IS IN THE UAN DATABASE.

ALAMEDA
City

CA
State

95400
Zip Code

Dated 10/31/2008 DATE THE FORM.
MM/DD/YYYY

APPLICANT ATTORNEY SIGNS FORM.
Applicant Attorney Signature

Defendant's Attorney or Authorized Representative:

☑ Law Firm/Attorney ☐ Non Attorney Representative

IF YOU ARE A CLAIMS ADMINISTRATOR, THE CLAIMS EXAMINER WILL DATE AND SIGN IN THIS SECTION AS THE FIRST DEFENSE ATTORNEY. DO NOT CHECK THE BOX FOR NON-ATTORNEY REPRESENTATIVE. ALL OTHER FIELDS IN THIS SECTION ARE LEFT BLANK.

JUNE
First Name

JONES
Last Name

98574
Firm Number

PUT UAN OF LAW FIRM IF DEFENSE IS REPRESENTED.

RESPONSIBLE ATTORNEY SAN LEANDRO
Law Firm Name

ENTER THE ADDRESS THAT IS IN THE UAN DATABASE.

498100 SOUTH ONE ST
Address/PO Box (Please leave blank spaces between numbers, names or words)

SAN LEANDRO — City
CA — State
98569 — Zip Code

Dated 10/31/2008
MM/DD/YYYY

DEFENSE ATTORNEY SIGNS FORM.

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

Example

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

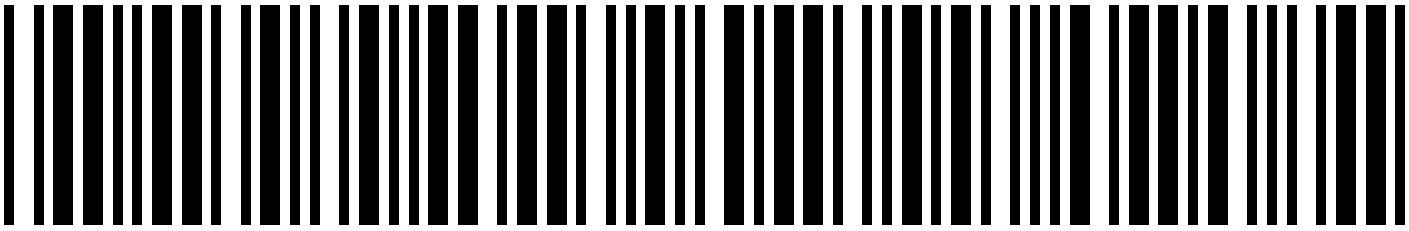
Defense Attorney Signature

Interpreter Licence Number:

Interpreter Name

Interpreter License Number

DOCUMENT SEPARATOR SHEET



Product Delivery Unit: ADJ

Document Type: MEDICAL DOCS

Document Title: QME REPORTS

ENTER DATE OF DOCUMENT FOLLOWING DOCUMENT SEPARATOR SHEET

Document Date: 02/29//2008
MM/DD/YYYY

Author: DR JANE BONECUTTER

Office Use Only

Received Date
MM/DD/YYYY

[redacted]

[redacted]
Qualified Medical Evaluator
Diplomat, American Board of Physical Medicine & Rehabilitation
Diplomat, American Board of Electrodiagnostic Medicine (EMG)

[redacted] Evaluation

Patient	[redacted]
Evaluation Date	March 14, 2008
Date of Injury	March 19, 2005
Claim Number	[redacted]
WCAB Number	
Employer	

Interval History

Oral thrush

Oral thrush is still treated with Diflucan prescribed by [redacted]

Urticaria

Itching ostensibly due to Norco has resolved

Right upper extremity

Pain persists in the region of the right lateral epicondyle and extensor digitorum communis and radial tunnel

Left lower extremity

Pain has not changed and is provoked with prolonged standing.

Examination

Sitting

Sitting was again characterized by weight bearing on the right side and avoiding weight bearing on the left.

[redacted]

[redacted]

[redacted]

[redacted]
March 14, 2008
[redacted]
Page 2

Mouth

Tongue showed less fungal whiteness but a thrush-like appearance remained.

Elbow

Tenderness remained in the right epicondylar region.

Lumbar Sacral Region

Abnormal finding or pain that are absent are designated as 0, that are mild are designated 1, that are moderate are designated 2, that are severe are designated 3

Tenderness	Left	Right	Normal
Thoraco-lumbar junction	0	0	0
Lumbar sacral junction	1	1	0

Pelvis

Abnormal finding or pain that are absent are designated as 0, that are mild are designated 1, that are moderate are designated 2, that are severe are designated 3

Tenderness	Left	Right	Normal
Sacroiliac joint	1	1	0
Sacroiliac joint compression	1	1	0
Piriformis muscle	1	1	0
Posterior iliac crest	0	0	0
Sciatic notch	2	2	0
Anterior psoas tendon insertion	2	0	0

Straight Leg Raising

Straight leg raising aggravated pain. Pressure on the left posterior hamstrings above the knee and along the sciatica nerve aggravated significant pain. The same pain complaints were provoked with pressure on the buttocks and on the sciatic notch and even on the anterior pelvis in the region of the iliacus

Diagnostic Test

Magnetic resonance imaging of lumbar sacral spine on March 4, 2008 revealed L2-L3. L3-L4 2 to 3 millimeter far left lateral sub ligamentous protrusion with mild proximal left neural foraminal stenosis at both levels and 1 to 2 millimeter antero listhesis of L3 with respect to L4. At L4-L5 a 1-2 millimeter intervertebral disc bulge was noted. At L5-S1, a less than 2 millimeter intervertebral disc bulge was noted Left renal cyst was also found

[redacted] reported that on March 6, 2005 magnetic resonance imaging of the lumbar sacral spine revealed degenerative disc disease from L2 through S1, small posterolateral annular tears at L3-L4, L4-L5 and L5-S1, and facet arthropathy with mild neural foraminal stenosis at the left L5-S1 area with the left L5 nerve root displaced against the body of L5

In the cervical region the magnetic resonance imaging from March 4, 2008 showed a C3-C4, 1-2 millimeter left lateral intervertebral disc bud and osteophyte with mod left neural foraminal stenosis, a C5-C6 1-2 millimeter bugle and osteophytic ridge with moderate right mild left neural foraminal stenosis and borderline spinal canal narrowing, and C6-C7 1-2 millimeter lateral intervertebral disc bulge.

Diagnosis

L3, L4, L5, degenerative changes with annular degenerative changes primarily on the left side with left-sided sciatica with significant left-sided neural foraminal stenosis at the left L4 region, as noted on her most recent magnetic resonance imaging with significant sciatica noted on examination

Cervical degenerative disc disease with radiating pain to the proximal upper extremities

Left hemi hypalgesia, etiology unclear

Sleep disorder, aggravated by chronic pain

Depression and anxiety, aggravated by chronic pain

History of bladder incontinence, etiology unclear

History of adverse reactions to Baclofen, Cyclobenzaprine and Soma or Carisoprodol with the development of oral thrush

History of adverse reaction to Lyrica causing difficulty breathing

History of adverse reaction to Neurontin or Cymbalta, actual agent not clear, causing significantly increased pain in limbs and joints

History of adverse reaction to Norco or hydrocodone causing urticaria

History of adverse response to Sulfa causing difficulty breathing

Future Medical Treatment

Avoid

Baclofen, Flexeril and Soma as they aggravated thrush.

Lyrica due to adverse effects on her ability to breathe.

Neurontin as it provoked limb and abdominal pain.

Norco as it provoke urticaria.

Increase

Ultram to 300 milligrams ER in an attempt to reduce pain without increasing the amount of controlled substances

Restart

Cymbalta 20 milligrams once again to assess its efficacy on [redacted] sciatica versus adverse effects.

Start

TENS to reduce pain and muscle spasm and sciatica.

[redacted]

March 14. 2008

[redacted]

Continue

Percocet 5/325 to reduce sciatica even though it causes mild cognitive problems. This is preferable to other medications that have caused more adverse reactions

Consider

Other medication in an attempt to find one that does not cause adverse conditions but reduces sciatic pain. I will consider Mexilitine in subsequent evaluations to reduce nerve pain

Re-evaluate

In two weeks

Prolonged Evaluation

Added time was spent in educating [redacted] According to _Title 8 California Code of Regulations Sections 9792.20 - 9792.23, the Department of Industrial Relations has published a Medical Treatment Utilization Schedule to replace Chapter 6, Pain, Suffering, and the Restoration of Function of Occupational Medicine Practice Guidelines, Second Edition, of the American College of Occupational and Environmental Medicine (ACOEM Practice Guidelines) education is recommended The State of California Medical Treatment Utilization Schedule advises practitioners to develop and implement an effective strategy with skills to educate patients and recommends an education-based paradigm to start with inexpensive communication providing reassuring information to the patient The Schedule also recommends more in-depth education to exist within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. It advises that no treatment plan is complete without addressing issues of patient education as a means of facilitating self-management of symptoms and prevention

Declaration

I declare under penalty of perjury that I have not violated the provisions of California Labor Code 139 3 with regard to the evaluation of this patient or the preparation of this report

[redacted]

March 14. in the [redacted] California

DOCUMENT SEPARATOR SHEET

Product Delivery Unit: ADJ

Document Type: MEDICAL DOCS

Document Title: QME REPORTS

ENTER DATE OF DOCUMENT FOLLOWING DOCUMENT SEPARATOR SHEET

Document Date: 02/29//2008
MM/DD/YYYY

Author: JOHN PHYSICIAN MD

Office Use Only

Received Date: _____
MM/DD/YYYY

[redacted]

[redacted]
Qualified Medical Evaluator
Diplomat, American Board of Physical Medicine & Rehabilitation
Diplomat, American Board of Electrodiagnostic Medicine (EMG)

Neuro-Diagnostic Evaluation

Patient	[redacted]
Evaluation Date	February 29, 2008
Date of Injury	March 19, 2005
Claim Number	[redacted]

Clinical Information

Evaluate for cause of pain in either leg.

Findings

Sural sensory studies recorded at the lateral ankles exhibited mildly slowed conduction velocities. Both peroneal sensory latencies recorded at both anterior ankles revealed normal conduction velocities

Evoked tibial motor compound action potentials recorded from the abductor hallucis muscles both ankles were normal. The late tibial H reflexes recorded from the calf muscles revealed a significantly prolonged latency in the right medial gastrocnemius muscles muscle The late tibial F waves recorded from the abductor hallucis muscle in either foot were normal. the peroneal motor studies of the regions between the popliteal fossas and fibular heads and the regions between the fibular heads and the ankles recorded from the extensor digitorum brevis muscles in both feet were within normal limits. The late peroneal F waves recorded from the extensor digitorum brevis muscles revealed a prolonged latency on the left.

Needle electromyography studies revealed normal findings bilaterally without evidence of radiculopathy or axonal degeneration. The conduction velocity studies, however, show findings that are compatible with mild polyneuropathy with possible mild polyradiculopathy.

Impression

Mild polyneuropathy with possible mild polyradiculopathy. Clinical corroboration is warranted.

[redacted]

POB 488
[redacted]

[redacted]

[redacted]

Diplomates Electrodiagnostic Med

[redacted]

Neurodiagnostic EMG & NCS

Patient: [redacted]
Skin temp: 32° C

Physician [redacted]
Test Date: 02/29/08

Motor Nerve Study

Peroneal Nerve

Rec Site EDB	Lat (ms)		Dur (ms)		Amp (mV)		Area (mVms)		Dist (mm)		C V (m/s)	
STIM SITE	L	R	L	R	L	R	L	R	L	R	L	R
Ankle	6 3	5 1	4 3	5 9	1 8	2 5	4 7	6 3	70	70		
Fib Head	13 8	12 3	6 5	5 9	1 9	2 3	5 8	7 2	380	330	50 1	45 5
Pop Fos	15 2	14 1	6 3	5 5	1 8	2 4	6 0	6 7	60	80	45 0	45 7

Tibial Nerve

Rec Site AH	Lat (ms)		Dur (ms)		Amp (mV)		Area (mVms)		Dist (mm)	
STIM SITE	L	R	L	R	L	R	L	R	L	R
Ankle	6 8	5 3	2 8	3 6	4 3	6 9	7 6	12 2	80	80

Sensory Nerve Study

Peroneal Nerve

Rec Site dors ft	Lat (ms)		Pk Lat (ms)		Amp (uV)		Dist (mm)		C V (m/s)	
STIM SITE	L	R	L	R	L	R	L	R	L	R
Lower leg	3 0	2 1	3 5	3 0	10 0	11 0	120	120	40 2	57 1

Sural Nerve

Rec Site Ankle	Lat (ms)		Pk Lat (ms)		Amp (uV)		Dist (mm)		C V (m/s)	
STIM SITE	L	R	L	R	L	R	L	R	L	R
mid calf	3 3	3 8	3 9	4 7	3 6	7 0	120	120	36 9	31 4

F-Wave Study

Peroneal Nerve
Rec Site EDB
Stim Site Ankle

	Latency ms	
	L	R
M wave	5 83	5 50
F wave	55 67	50 50
F-M	50 83	45 00

Tibial Nerve
Rec Site AH
Stim Site Ankle

	Latency ms	
	L	R
M wave	5 83	4 83
F wave	55 17	50 67
F-M	49 33	45 83

[redacted]

H Reflex Study

Tibial Nerve
Rec Site Soleus
Stim Site Pop Fos

	Latency ms L	R
M wave	6 67	6 00
H wave	34 50	38 33

Right Tibial Nerve
Rec Site Soleus
Stim Site Pop Fos

	Latency ms
M wave	6 50
H wave	40 50

EMG Study

Name	Ins Act	Fibs	PSW	Fascics	Polyph	MU Amp	MU Dur	Config	Pattern	Recruit
L Gastroc Med	norm	none	none	none	none	norm	norm	norm	norm	norm
L Gastroc Ln	norm	none	none	none	none	norm	norm	norm	norm	norm
L Peroneus Ln	norm	none	none	none	none	norm	norm	norm	norm	norm
L Tibialis An	norm	none	none	none	none	norm	norm	norm	norm	norm
L Ext Hal Ln	norm	none	none	none	none	norm	norm	norm	norm	norm
L Ext Dig Br	norm	none	none	none	none	norm	norm	norm	norm	norm
R Gastroc Med	norm	none	none	none	none	norm	norm	norm	norm	norm
R Gastroc Ln	norm	none	none	none	none	norm	norm	norm	norm	norm
R Peroneus Ln	norm	none	none	none	none	norm	norm	norm	norm	norm
R Tibialis An	norm	none	none	none	none	norm	norm	norm	norm	norm
R Ext Hal Ln	norm	none	none	none	none	norm	norm	norm	norm	norm
R Ext Dig Br	norm	none	none	none	none	norm	norm	norm	norm	norm

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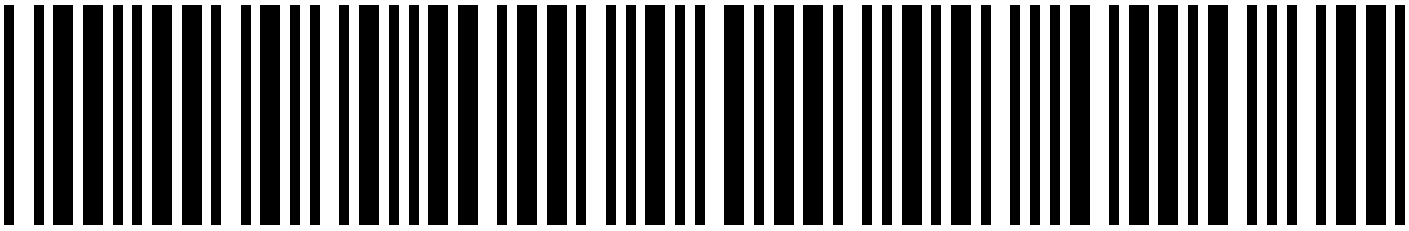

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I am at least 18 years of age, not a party to this action, and I am a resident of or employed in the county where the mailing took place.

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On 10/31/2008 served a true copy of the following documents, along with supporting documents, described as: Stipulations with request for award and qualified medical evaluation reports by enclosing them in a sealed envelope addressed to each of the parties named and at the addresses set forth in the Party List, and placing each envelope for collection and mailing at the business address herein following our ordinary business practices, with postage fully prepaid, or by other previously agreed-upon method of electronic service.

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

Dated: 04/16/2008

Declarant Signature [redacted]

Party List

[redacted]