Nelhs Betancourt, M.D.

Internal Medicine - Occupational Medicine - Occupational Toxicology
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April 23, 2021

Zurich North America
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Attention: Eva Reale, Claims Evaluator

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Attention: Amanda A. Manukian, Esquire

Workers Defenders Law Group
8018 Santa Ana Canyon Rd., Suite 100.215
Anaheim, CA 92808
Attention: Natalia Foley, Esquire

Claimant Name	:	Anisa Chaney
Social Security No.	:	XXXX-XX-6450
Date of Birth	:	09/06/1973
Date of Panel QME:		April 22, 2021
Panel Number	:	7382307
WCAB Number	:	ADJ13521045
Date of Injury	:	CT 01/06/2020 - 06/30/2020
Claim Number	:	2080381794
Employer	:	Bold Quail Holdings, LLC

COMPREHENSIVE PANEL QUALIFIED MEDICAL EVALUATION

State of California Workers' Compensation Program

Dear Concerned Parties:

The Claimant was evaluated on the date shown above, in my office as shown in the Disclaimer section. I personally performed this evaluation based upon specific request from the parties.

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I was asked to physically examine and evaluate the Claimant, and to prepare a report to answer specific medical legal issues as stated in the cover letter. Please find a copy of the letter requesting this medical legal report attached to this report.

The primary focus of this evaluation is Toxicology: ___Yes _X_No

Face-to-face was 1 hour and 45 minutes.

Pursuant to Labor Code Sections 4620, 4621 and 4622, the evaluation and report of the Examinee is based on the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition. The medical-legal billing codes used are effective 04/01/2021. Please find attached to this report a copy of the Official Medical Legal Billing Codes.

Based on 8 California Code of Regulations Sections 9793, 9794, and 9795, this report is billed under ML 201:

-95 Evaluation performed by a panel selected Qualified Medical Evaluator

HISTORY AS RELATED BY THE CLAIMANT:

Ms. Chaney is a 47-year-old African-American female Examinee originally hired as a Nurse Consultant/RN Supervisor around April 2010. The examinee denied a history of hypertension, diabetes, asthma, epilepsy or any other chronic medical conditions. Until recently she was taking Ativan (last time 1 month ago) and lansoprazole (discontinued, no longer needed). Her last day at work took place on July 6, 2020.

The examinee is complaining of difficulty breathing, which appears to be situational. She denied a history of coronary artery disease, cardiopulmonary conditions or any other underlying respiratory medical problem. She is also complaining of occasional headaches, but noted that this has resolved, and is normal now. At some point, she was diagnosed with irritable bowel syndrome, but has no symptomatology as of this writing.

The examinee related that around April 2010, which is the date of hire, she became a night shift RN supervisor at a skilled nursing home servicing 99 beds. The job required taking care of patient calls, infection control, regular nursing activities and a significant amount of paperwork.
Although she was assigned 8 hour shifts, the examinee noted that she usually worked between 10 and 12 hours a shift. Initially she worked 4 nights a week, but as she continued to work, she was assigned an extra night due to "staffing issues".

The examinee is left handed dominant. As she performed her duties, she started to have left upper extremity, left cervical and jaw pain. This took place around the latter part of 2018. The symptoms

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were intermittent initially, but as they got more persistent, the examinee visited her primary care physician and was referred for an MRI of the brain. She was concerned because her mother had died at the age of 42 years old from an aneurysm in the brain. Her brain MRI turned out to be normal. Her physician then prescribed pain medications, but the examinee declined.

The examinee continued to perform her usual and customary duties, but started to feel her left upper extremity was weaker. She was also having trouble sleeping on her left side because of left shoulder pain. She was taking care of the pain by taking nonsteroidal anti-inflammatory agents intermittently. She was not referred out for an orthopedic evaluation and was not offered surgery.

The examinee went on to perform her usual and customary job activities, and she seemed to be stable until early 2019 when the company changed hands. In the interim, the examinee had been complaining about supervision issues. She had difficulty with certain work activities like transferring patients and pushing a heavy cart because these activities would exacerbate her left shoulder pain. She had requested assistance, but her employer had not provided any and she had to "cover the floor" during her entire shift. As a supervisor, she was expected to "take everybody else's' slack", and that complicated her required work activity, as she had no assistance from the CNA's under supervision because "everyone was overworked"; "they would not help".

The new holding company met with her. She explained her difficulties to her new supervisor, and was assured that the company would make changes to make it better, even offering a, hourly pay raise (which according to the Examinee never happened). Before this meeting, she was getting ready to leave her employment. The Examinee thinks that she was promised the changes because the facility had to complete a State Survey, and her supervisor begged her to stay until the survey was completed. The company had had a history of issues with state requirement fulfillment, especially those requirements that addressed patient care. When her supervisor promised her changes would be coming and a pay raise was in the horizon, she decided to stay and keep going with the survey.

However, as time went on, and changes did not happen, the examinee became disappointed and started to plan her resignation towards the end of 2019. Her plans became derailed when Covid hit. She had originally been complaining of feeling over stressed, overworked and having difficulty dealing with chronic shoulder pain. However, things became more taxing when Covid hit and a number of patients under her supervision died suddenly. She became quite concerned about infectious control and went to her supervisor with suggestions to implement to protect the residents from contagion. Her supervisor was not pleased.

She was advised that they were not isolating or testing patients for Covid. The staff where not required to quarantine if exposed or require her to be compliant with personal distancing. The Examinee expressed her frustration and her supervisor became angry. She was isolated.

One day a patient "disappeared"; the examinee could not locate where he was. She became concerned that he had left the facility unsupervised and called the police. However, her supervisor instructed her to cancel the call, adding "your shift is over". The examinee was upset, and she went to her primary care physician. Her PMD prescribed Ativan and placed her off work for 1 week. When she return to work, she was fired.

The examinee developed oppressive chest pain during the latter part of 2019. The pain was present usually as she was getting ready to go to work, and she believes it was secondary to anxiety. She also had intermittent diarrhea and frequent stomach cramps. Again, these happened primarily just before she was scheduled to start her shift, but not consistently every time. She had these symptoms 2 or 3 times a week. Usually the diarrhea was present 30 minutes before starting to work, and she had 1 or 2 episodes of liquid consistency associated to bloating and cramping. Her weight, which is stable around 136 pounds dropped to 125 or 123 pounds. She was consuming her usual diet, and was not trying to lose weight. After she started working, her diarrhea lessened and she started to feel better.

She denied a history of heartburn, chronic nausea or vomiting, vomiting of blood, black, tarry stools, rectal bleeding, hemorrhoids, jaundice, gastritis or history of hepatitis. She used Pepto-Bismol and Maalox/Mylanta to treat her diarrhea, noting that she frequently experiences epigastric burning pain. She did not have an upper GI series or an upper endoscopy, and the gastrointestinal symptoms resolved spontaneously. She started to improve around December 2020.

The examinee is working for a school, starting the day after this evaluation. She saw a physician and was prescribed omeprazole.

Her last episode of chest pain took place around September 2020. It presented with shortness of breath and cold diaphoresis, and the examinee complained of palpitations only associated with anxiety. There was a negative history of congenital heart disease, valvulopathy, mitral valve prolapse, rheumatic heart disease, peripheral edema, congestive heart failure or arrhythmias. There is no history of lipid disorders and she denied having had an acute myocardial infarction in the past. She usually does not suffer from shortness of breath on exertion, however, she did have mild shortness of breath while using an N95 mask.

She was required to wear an N95 mask and a face shield (in addition to the usual gloves). She was never fitted for the N95 mask, and all of the masks available were a small size. She has trouble wearing it and it was not comfortable. The mask caused her to have shortness of breath, and at one time "I thought I had Covid". She went to the urgent care to be tested, and the results were negative. She received a Z-Pak.

The company did not enforce the quarantine requirements and offer no testing for Covid. The company also made her utilize her vacation days until her Covid negative results came back, which took 1 week. The examinee noted that some of her coworkers got infected with Covid, and because

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they could not afford to be off work without pay, some of them continued to work even with symptoms. The examinee recalls several night nurses (Arlo Davis, April Jefferson) who were infected. She was working with all of them. She is afraid that some of the patients were also infected with Covid.

The examinee denied a history of shortness of breath (except as noted above), and has no history of chronic cough either dry or productive. She does have a history of snoring, which started recently and is not associated to choking or waking up with a dry mouth. She denied a history of wheezing, hemoptysis, sinusitis, bronchitis, pneumonia, tuberculosis, bronchial asthma, emphysema, Valley Fever, Obstructive Sleep Apnea, COPD, cancer, GERD, deep venous thrombosis, bouts of pulmonary embolism or symptoms consistent with a connective tissue disorder. The examinee does have a history of environmental allergies for which she has used Claritin or Benadryl sporadically. Her symptoms are primarily seasonal and rarely any required medication. They consist of rhinorrhea, sneezing, watery, itchy eyes or nasal congestion.

She is a former smoker, having started to smoke at the age of 20 or 21 years old. On average, she consumed half a pack of cigarettes a day and quit approximately 5 years ago.

The examinee had a couple of incidents in which her blood pressure was elevated during acute anxiety attacks. The blood pressure was 150/90; her blood pressure is usually normal. She does not have a history of hypertension.

Activities of Daily Living Survey, AMA Guides, 5th Edition.

The Claimant denied any problems with self-care, communicating, sensory functions, traveling, or with sexual function.

The Claimant referred the following problems: physical activities (due to discomfort and pain), hand activities (grasping-left hand, numbness of fingers), sleeping (problem sleeping due to discomfort in back, neck, shoulders).

When asked: "What part or parts of your job could you perform now?" the Claimant responded: "All except lifting excessively, excessive bending."

CURRENT COMPLAINTS:

Constant bilateral shoulder and neck pain. Rated 5-7/10. It is made worse when sleeping and with activity. It is improved by warmth and creams.

Intermittent lower back pain. Rated 5-7/10. Made worse depending on position and when lifting. Improved by stretching, warmth, and creams.

Constant left arm and hand pain. Rated 4-6/10. Made worse with activity and position, and made better by stretching and creams.

Constant bilateral knee pain. Rated 4-6/10. Made worse when walking, running, bending, standing. Improved by creams, wearing a brace, warmth.

PAST HISTORY; PERTINENT FINDINGS:

The claimant has never used recreational drugs. She drinks alcoholic drinks, having started at age 21, but only rarely. She used to smoke, but has since quit. She started smoking approximately in 1999, and smoked for five years. She smoked less than one half a pack of cigarettes a week.

The claimant did not list any type of exercise or if she pursues any particular diet. She drinks one cup of either caffeinated or decaffeinated coffee a day, and consumes tea and sodas, but frequency was not shown.

Family history is pertinent for a father who died at age 59 of unknown causes. He had suffered from alcoholism. Her mother died at age 41 of an aneurysm, and had also suffered from high blood pressure and suffered a stroke. She listed one brother age 49 and one sister, age 33, all in apparent good health. The only thing known about her grandparent is that they all died, her maternal grandmother age 89, her maternal grandfather in his 70s, her paternal grandmother at age 89, and her paternal grandfather in his 70s. The claimant did not list her marital status, but listed one son age 15 and one daughter age 28, both in apparent good health.

The claimant listed no current hobbies. She has another part time or full-time job as a drug consultant/home health. She does housework, and yard work.

Allergies: Seasonal. Present with sneezing, swollen eyes.

Surgeries: none.

REVIEW OF AVAILABLE MEDICAL RECORDS:

"A physician may not bill for review of documents that are not provided with this accompanying required declaration from the document provider. Any documents or records that are sent to the physician without the required declaration and attestation shall not be considered available to the physician or received by the physician for purposes of any regulatory or statutory duty of the physician regarding records and report writing."

Attestation has been received and is acknowledged herein __X_Yes ___No (419 pp)

Undated Consent to Treatment. Examinee consented for treatment, release of information, assignment of insurance benefits, financial agreements and certification.

01/27/12 Consent Form for HIV Blood Test. Examinee consented for HIV blood test to be done by Dr. Valentin Hernandez.

01/27/12 Quest Diagnostics. Laboratory Report. Total Cholesterol: 115. Basic Metabolic Panel. Glucose: 104.

Hepatic Function Panel. Globulin: 2.0. Albumin/Globulin Ratio: 2.4.

Complete Urinalysis. Squamous Epithelial Cells: 6-10. Comments: Moderate mucous threads.

Cytology Report. Pap Test. Source: Cervix. Result: Negative for intraepithelial lesion or malignancy.

Thyroid Panel, Complete Blood Count (includes Differential/Platelet) was performed and their values were found to be within normal range.

01/27/12 Dr. Valentin Hernandez, Internal Medicine. WorkflowOne. History and Physical. Examinee had been having a sore throat with cough and phlegm and green mucous with fevers which were not getting better even though she was drinking a lot of fluids. Examinee had noted a fungus over the extremities as well as the groin, which was quite pruritic and feels like it was on fire. Examinee complained of cough, phlegm, sore throat and hoarseness getting worse and worsening fungus with redness of the skin and desquamation. Review of systems was significant for persistent cough with expectoration and sore throat. Examinee had a spreading and worsening fungus on the skin. There were no hematomas or nodules or abrasions. Vitals: BP: 112/64. Height: 62". Weight: 140 lbs. Temperature: 97.6. PR: 64. RR: 20. General examination revealed Examinee appeared in pain. Examination of the skin revealed the skin was slightly red but without excoriations. HEENT Examination revealed the tympanic membrane was neither red nor retracted. The nose was tender with purulent mucous. Examination of the neck revealed supple with palpable nodes. Impression: Pharyngitis. Tinea corporis. Plan: Ordered complete blood count, SMA-7, cholesterol, LFT's (liver function tests), thyroid, urinalysis, and papanicolaou smear.

02/02/12 Dr. Valentin Hernandez. Valentin Hernandez, MD, Inc. History and Physical. Examinee felt weak and tired and felt no matter how much sleep still tired progressively getting worse over the past few weeks to the point now that barely able to do most of the work such that even one block of exercise was enough to

make Examinee tired. Examinee has not had any rest over the past two weeks as the cough had been getting worse and was associated with phlegm and feeling warm and sore throat and pleuritic chest pains associated with dyspnea. Examinee was having worsening and pruritic burning pain all over the toes and feet as well as the groin, which was quite red. Examinee complained of being exhausted with even the most elementary work and tired and a persistent cough not getting better in spite of medications and keeping the Examinee was awake and redness and thickness of the skin with pruritus. Review of systems was significant for feeling quite tired and was not eating well. Vitals: BP: 118/64. Height: 62". Weight: 134 lbs. Temperature: 97.8. PR: 62. RR: 14. General examination revealed Examinee looked nervous. Examination of the skin revealed there was an erythematous and papular rash. HEENT examination revealed nose and turbinates were red and purulent. Pharynx had hemorrhages with purulent mucous. Examination of the neck revealed the neck was supple and the anterior nodes were tender. Examination of the chest revealed diffuse rhonchi bilaterally without percussion dullness. Impression: Anemia, iron deficiency. Bronchitis. Tinea corporis. Rx: FeSO4 325 mg po once a day # 30, Lamisil 250 mg po once a day # 30 and B complex 1 tab po once a day #30. Plan: Prescribed Tinactin cream twice a day x 10 day #30 gm. Work Status: Examinee was unable to go to work from 02/02/12 to 02/05/12 due to treat for flu symptoms. Examinee was able to return to work on 02/06/12.

12/18/12 Dr. Valentin Hernandez. WorkflowOne. History and Physical. Examinee had noted pain in most of the large joints especially over the knees and sore throat with phlegm and cough with a thick phlegm and redness and thickness of the skin with pruritus. The joint pains were getting worse even with the medicines especially in the mornings even though Examinee had tried applying warm packs and towels to the joints. Examinee had been having a purulent cough over the past few days not getting any better and had noted difficulties with hoarseness even though she had been doing gargling. Review of systems was significant for diffuse joint pains. Persistent cough with expectoration and sore throat. Vitals: BP: 103/59. Height: 62". Weight: 143 lbs. Temperature: 97.3. PR: 66. RR: 19. General examination revealed looked younger than the Examinee said but was worried. Examination of the skin revealed the skin was red and desquamative. HEENT examination revealed the throat had white exudate with injection. Examination of the neck revealed supple with tender anterior nodes. Had decreased range of motion and was tender bilaterally from C1-C7. Examination of the back revealed limited motion of the lower back with tenderness over the lumbar spine. Extremity examination revealed swelling and tenderness over the knees and ankles with decreased range of motion. Impression: Osteoarthritis. Pharyngitis. Tinea corporis. Rx: Tylenol #3 1 tab po four times a day prn #30. Plan: Continue FeSO4 325 mg, B complex and Tinactin cream 30 g. Rest of the treatment plan remains

the same as previous visit. Additional Comments: Ordered aspartate aminotransferase test. Dermatology for lesion on left shoulder.

12/21/12 Dr. Valentin Hernandez. History and Physical. Examinee had noticed hot and pruritic redness and a worsening rash over the feet and groin which was not responding to the over the counter creams. Examinee had noted an increase in the cough, phlegm, sore throat and headaches over the past week even though the Examinee had been taking some over the counter medications. Complained of redness and thickness of the skin with pruritus and sore throat with phlegm and cough with a thick phlegm. Vitals: BP: 104/62. Height: 62". Weight: 143 lbs. Temperature: 97.2. PR: 82. RR: 18. General examination revealed dyspneic and exhausted. Examination of the skin revealed there was an erythematous and papular rash. HEENT examination revealed the nasal mucosa was injected and watery. Pharynx had hemorrhages with purulent mucous. Rest of the exam remains the same as previous visit. Impression: Tinea corporis. Pharyngitis. Rx: Nizoral 200 mg po once a day #30.

05/24/13 Dr. Valentin Hernandez. History and Physical. Examinee had redness over the skin and warmth which had not responded to the antibiotics Examinee was on at that time and was coming in for change of medication. Examinee had developed a white vaginal discharge over the past week which was getting worse on taking the medications the Examinee had difficulties because of the intense pruritus. Examinee complained of infection and redness of the skin which was getting worse and a vaginal discharge with white-yellow consistency and chest pains and shortness of breath with a persistent cough of thick and difficult to expectorate phlegm and fevers. Review of systems was significant for although the Examinee had an infection of the skin which was getting worse. Examinee had developed a vaginal discharge and infection but there was no exposure to anyone with the same and was not immunocompromised or appeared to be exposed to antibiotics. Vitals: BP: 110/68. Height: 62". Weight: 132 lbs. Temperature: 97.8. PR: 76. RR: 18. Examination of the abdomen revealed tenderness over the bladder with normal bowel sounds. On exam, there was a vaginal exudates, but no masses. Impression: Cellulitis. Vaginitis. Bronchitis. Rx: Tylenol #3 1 tab po four times a day prn #30. Plan: Ordered serum pregnancy test. Rest of the treatment plan remains the same as previous visit. Additional Comments: Ultrasound of the right pelvis for pains for 2 weeks.

05/24/13 Quest Diagnostics. Laboratory Report. Total Cholesterol: 105. Basic Metabolic Panel. Urea Nitrogen (BUN): 6.

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Complete Urinalysis. Appearance: Hazy. Leukocyte Esterase: 2+. WBC: 10-20. Squamous Epithelial Cells: 6-10. Bacteria: Moderate. Comments: Few mucous threads.
Pap Test. Result: Negative for intraepithelial lesion or malignancy. Shift in vaginal flora suggestive of bacterial vaginosis.

Chlamydia Trachomatis DNA, SDA, Pap Vial: Not detected. Neisseria Gonorrhoeae DNA, SDA, Pap Vial: Not detected.

Hepatic Function Panel, and Complete Blood Count (includes Differential/Platelet) was performed and their values were found to be within normal range.

05/25/13 Dr. Alan Todd Turner, Diagnostic Radiology. United Medical Imaging of Inglewood. Pelvic ultrasound revealed the first endometrium measures 1.2 cm in thickness. The second endometrium measures 1 cm in thickness. Multiple images over the adnexa reveal the right ovary to measure 4.0 x 2.0 x 2.6 cm. The left ovary measures 4.1 x 2.4 x 2.9 cm. Cyst in the right ovary measures 2.2 x 1.4 x 1.7 cm. Multiple follicular cysts are seen in both ovaries. Impression: Uterus didelphys. Right ovarian cyst.

05/29/13 Dr. Valentin Hernandez. History and Physical. Examinee had been having dysuria and burning on urination for the past week associated with fevers and not getting better with fluids and medications the Examinee had and now flank pains. Examinee complained of fevers, dysuria, and pains in the flanks going down into the groin and a purulent greenish cough, with sore throat and headaches. Review of systems was significant for dysuria, burning and fevers. Vitals: BP: 110/60. Height: 62". Weight: 132 lbs. Temperature: 97.9. PR: 66. RR: 18. HEENT examination revealed the pharynx was red with pus. Rest of the exam remains the same as previous visit. Impression: Urinary tract infection. Pharyngitis. Rx: Doxycycline 100 mg po twice a day #20, Diflucan 150 mg po once a day #2, Nizoral 200 mg po once a day # 30, FeSO4 325 mg po once a day # 30 and B complex 1 tab po once a day # 30.

06/14/13 Dr. Valentin Hernandez. History and Physical. Examinee had noted pain in the flank with heat over the bladder on urinating and chills and fevers over the past four days which was getting worse even on fluids although Examinee does not relate any previous infections of this type. Examinee felt weak and tired and felt no matter how much sleep still tired progressively getting worse over the past few weeks to the point now that barely able to do most of the work such that even one block of exercise was enough to make Examinee tired. Examinee complained of

flank pains with fevers and dysuria and being exhausted with even the most elementary work and tired. Vitals: BP: 110/60. Height: 62". Weight: 134 lbs. Temperature: 98.1. PR: 72. RR: 16. Exam remains the same as previous visit. Impression: Urinary tract infection. Anemia, iron deficiency.

12/29/13 WorkflowOne. Medical Questionnaire and Physical Form. Examinee wears glasses occasionally. Examinee's last physical examination was in 12/2012.

12/30/13 Dr. Valentin Hernandez. History and Physical. Examinee's complaints remain the same as previous visit. Vitals: BP: 110/60. Height: 62". Weight: 135 lbs. Temperature: 97.6. PR: 876. RR: 14. Exam remains the same as previous visit. Impression: Tinea corporis. Pharyngitis. Rx: Tylenol #3 1 tab po four times a day prn # 30. Plan: Prescribed Lamisil cream twice a day x 10 days # 30 g. Additional Comments: Ob/Gyn for mass of right perineum.

10/02/15 Dr. Valentin Hernandez. History and Physical. Examinee complained of greenish mucous from a very productive cough which was not altered by cough medicines and cough, phlegm, sore throat and hoarseness getting worse and a vaginal discharge with white-yellow consistency and had been having pains over the joints and some of them have become swollen. The cough had been keeping the Examinee from getting any sleep and every time the Examinee coughs the chest hurts and felt like a burning inside in spite of trying lozenges and over the counter cough medicines. Examinee had difficulties moving the wrists, closing the hands, and walking because of pains of the ankles and knees and hips hurting at different times but getting worse over the past two weeks. Vitals: BP: 118/60. Height: 62". Weight: 122 lbs. Temperature: 98.1. PR: 74. RR: 16. General examination revealed Examinee looked under stress and tired. Examination of the back revealed there was no kyphosis, scoliosis, or tenderness but there was decreased range of motion. Extremity examination revealed swelling and tenderness over the knees and ankles with decreased range of motion. Impression: Bronchitis. Pharyngitis. Vaginitis. Osteoarthritis. Rx: Doxycycline 100 mg po twice a day #20 and Diflucan 150 mg po once a day # 2. Plan: Prescribed Clotrimazole cream twice a day x 10 day # 30 g. Ordered HIV and mammogram screen. Rest of the treatment plan remains the same as previous visit. Additional Comments: Examinee was under a lot of stress at home and at work. Examinee was also having neck pains. Ordered Lipids/RPR/urine for chlamydia/GC and ultrasound of the pelvis-questionable mass.

10/02/15 Valentin Hernandez, MD, Inc. Consent Form for HIV Blood Test. Examinee consented for HIV blood test to be done by Dr. Valentin Hernandez.

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10/02/15 Quest Diagnostics. Laboratory Report. Lipid Panel with Reflex To Direct LDL. Total Cholesterol: 115.

Hepatic Function Panel. Total Bilirubin: 1.6. Direct Bilirubin: 0.4.

Complete Urinalysis. Leukocyte Esterase: Trace.

Chlamydia Trachomatis RNA, TMA: Not detected. Neisseria Gonorrhoeae RNA, TMA: Not detected. RPR (Monitor) W/REFL Titer: Not-reactive.

HIV 1/2 Antigen/Antibody, Fourth Generation W/RFL: HIV Antigen/Antibody, 4th Generation: Non-reactive.

Basic Metabolic Panel, Thyroid Panel, Complete Blood Count (includes Differential/Platelet) was performed and their values were found to be within normal range.

10/12/15 Dr. Arash Tehranzadeh, Diagnostic Radiology. ICM Medical. Pelvic transvaginal ultrasound revealed the uterus measures 7.5 cm in length x 3.9 cm AP x 5.7 cm transverse. The uterus is retroverted. There is presence of an anterior myometrial uterine body fibroid measuring 1.1 x 0.9 x 1.6 cm in size. Small free fluid is present in the cul-de-sac. The endometrial stripe measures 5 mm in size. The right ovary measures 2.6 x 1.9 x 2.6 cm. The left ovary measures 3.1 x 2.1 x 2.7 cm. Impression: Anterior myometrial uterine body fibroid measuring 1.1 x 0.9 x 1.6 cm.

10/15/15 Dr. Valentin Hernandez. History and Physical. Examinee had been having progressively and worsening weakness over the past month and runs out of breath with almost any work not being able to complete most things able to be done in the past. Examinee complained of being weak and tired and having difficulties doing normal work and cough, phlegm, sore throat and hoarseness getting worse. Vitals: BP: 120/70. Height: 62". Weight: 124 lbs. Temperature: 97.2. PR: 82. RR: 14. Exam remains the same as previous visit. Impression: Anemia, iron deficiency. Pharyngitis. Rx: FeSO4 325 mg po once a day # 30, Lamisil 250 mg po once a day # 30 and B Complex 1 tab po once a day #30. Treatment plan remains the same as previous visit.

10/15/15 Quest Diagnostics. Cytology Report. Pap Test. Source: Cervix. Results: Negative for intraepithelial lesion or malignancy. HPV mRNA E6/E7: Not detected. Chlamydia Trachomatis RNA, TMA: Not detected. Neisseria Gonorrhoeae RNA, TMA: Not detected.

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04/13/16 Dr. Valentin Hernandez. History and Physical. Examinee complained of being exhausted with even the most elementary work and tired and sore throat with phlegm and cough with a thick phlegm. Vitals: BP: 120/70. Height: 62". Weight: 129 lbs. Temperature: 97.8. PR: 72. RR: 16. Exam remains the same as previous visit. Impression: Anemia, iron deficiency. Pharyngitis. Treatment plan remains the same as previous visit. Work Status: Examinee was able to return to work without any limitations on 04/21/16. Examinee was unable to go to work on 04/13/16 to 04/20/16.

04/13/16 Quest Diagnostics. Laboratory Report. Total Cholesterol: 106.

CBC (Includes Differential/Platelet): Hemoglobin: 12.4. Hematocrit: 37.2.

Complete Urinalysis. HCG, Total, QL: Positive.

Basic Metabolic Panel, Hepatic Function Panel, and Thyroid Panel was performed and their values were found to be within normal range.

04/20/16 Dr. Valentin Hernandez. History and Physical. Examinee had missed the period and was worried of the consequences since it was scheduled to occur two weeks ago and had noticed some cramps and tenderness. Examinee being weak and tired and having difficulties doing normal work. Review of systems was significant for noticed the period was gone. Vitals: BP: 120/60. Height: 62". Weight: 130 lbs. Temperature: 98.1. PR: 74. RR: 16. Exam remains the same as previous visit. Impression: Amenorrhea. Anemia, iron deficiency. Additional Comments: Pregnancy-needs abortion imp 02/29/16.

05/27/16 Dr. Valentin Hernandez. Request for Medical Information. Examinee presented medical problem from 04/13/16 to 04/20/16 at intervals of weekly. Examinee was pregnant and was considering abortion. Examinee complained of tremulous/difficulties concentrating. Positive pregnancy test. Pregnancy terminated of future EDC 12/05/16. Disability commenced on 04/13/16. Diagnosis: Anxiety. Plan: Advised rest. Referred to psychiatry for evaluation and treatment. Estimated regular duty on 04/20/16. Non-industrial accident.

05/15/18 Dr. Peter Sungpop Chong, Internal Medicine. Kaiser Permanente. Office Visit. Examinee comes for checkup. Doing ok. Would like to have pap smear. Also like to have lab works including STDs. Social History: Current every day smoker. Special occasion's alcohol consumption. Vitals: BP: 109/44. Height: 5'2". Weight: 127 lbs. Temperature: 98.7. Pulse: 74. RR: 18. BMI: 23.35 kg/m2. Genitourinary examination revealed Examinee had marble size cyst on right low

vagina entrance. Pap smear obtained. Assessment: Smoking cessation counseling. Screening for cervical cancer. Screening for HPV. Vaccination for diphtheria, tetanus and acellular pertussis. Screening for STD. Screening. Tobacco smoker. Treatment: Tdap given. Plan: Ordered screening lab works, Vacc Tdap, HPV Cotest screening, age 30-65, high risk types, amplified probe glucose, fasting lipid panel hemoglobin A1c, screening or prediabetic monitoring HIV screen (HIV AG, HIV 1, 2 AB), qualitative syphilis antibody screen, immunoassay chlamydia/GC, urine amplified probe technique, complete blood count no differential, TSH and gyn cytology. Recommended stop smoking.

05/15/18 Kaiser Permanente. Gyn Cytology Report. Pap Smear. Source: Cervix, Liquid Based Pap Test. Result: Negative for intraepithelial lesion or malignancy (normal pap result).

HPV 16+18+31+33+35+39+45+51+52+56+58+59+68 DNA, Cervix, Probe. Source: Cervix. Result: Negative.

06/05/18 Kaiser Permanente. Laboratory Report. Fasting Glucose: 69.

Syphilis Antibody Screen, Immunoassay. Treponema Pallidum Antibody, EIA: Non-reactive.

Chlamydia + GC, Urine, Amplified Probe. Chlamydia Trachomatis RNA, Urine, Amplified Probe, Qual: Negative. Neisseria Gonorrhoeae RNA, Urine, Amplified Probe, Qual: Negative.

Complete Blood Count No Differential. HGB: 11.6. HCT, Auto: 34.6. MCV: 80.5.

Lipid Panel, Hemoglobin A1C%, TSH was performed and their values were found to be within normal range.

06/13/18 Zoila Argentina Paz, N.P. Kaiser Permanente. Progress Notes. Examinee complained of vaginal lump to right side of vaginal near opening for years. Noted no pain or change to lump since she initially felt lump. Vitals: BP: 94/44. Height: 5'2". Temperature: 98.2. Pulse: 63. RR: 20. BMI: 23.35 kg/m2. Last menstrual period on 05/27/18. Genitourinary examination revealed Vulvar cyst at 7 o'clock measuring 1-1.5 cm. Round and freely moveable. Impression: Smoking cessation counseling. Vulvar cyst. Plan: Provided Examinee with assurance. Advised to return to care for WWE to reassess vulvar cyst annually or when she notes change in size of cyst.

Date of Exam: April 22, 2021

04/13/20 Dr. Valentin Hernandez. History and Physical. Examinee had been having fevers associated with cough and phlegm and sore throat and headaches which were not getting better even though the Examinee had attempted to fight it. Examinee complained of persistent cough not getting better in spite of medications and keeping Examinee awake and cough, phlegm, sore throat and hoarseness getting worse and had been having pains over the joints and some of them have become swollen. Impression: Bronchitis. Pharyngitis. Osteoarthritis. Additional Comments: Go to the urgent care clinic.

06/08/20 Dr. Valentin Hernandez. History and Physical/Telehealth Visit. Examinee had noted pleuritic chest pains associated with a persistent cough which seems to be getting worse over the past few days and making it difficult to do any type of work. Examinee had noticed the period was due a week ago and had not come and possibly due to new onset irregularity or even pregnancy would have missed it and was now concerned. Examinee complained of an increase in cough, phlegm, fevers, sore throat, headaches, and shortness of breath and sore throat with phlegm and cough with a thick phlegm and had been having pains over the joints and some of them have become swollen and had not had their usual period and was concerned. Impression: Bronchitis. Pharyngitis. Osteoarthritis. Amenorrhea. Plan: Return to clinic as needed.

06/23/20 Dr. Valentin Hernandez. History and Physical. Examinee had been quite worried about the future and whether they would be able to control and or manage the future problems that would be coming. Examinee had noted pain in most of the large joints especially over the knees and a purulent greenish cough, with sore throat and headaches and upset over the way life was taking a turn and was quite nervous. Review of systems was significant for quite nervous and depressed over the events in their life. Vitals: BP: 98/60. Height: 62". Weight: 125 lbs. Temperature: 96.6. PR: 78. RR: 16. BMI: 22.9 kg/m2. General examination revealed nervous and the stated age. Rest of the exam remains the same as previous visit. Impression: Osteoarthritis. Pharyngitis. Anxiety. Rx: Buspar 10 mg po every bed time #30. Treatment plan remains the same as previous visit. Work Status: Examinee was able to return to work on 06/30/20. Examinee was unable to go to work on 06/23/20 to 06/29/20.Additional Comments: Psych for anxiety. Ordered labs.

07/06/20 LabCorp. Laboratory Report. Comprehensive Metabolic Panel. Glucose: 47.

Routine Urinalysis. Appearance: Cloudy. WBC Esterase: Trace. Protein: Trace. WBC: 6-10. Mucus Threads: Present. Bacteria: Few.

Complete Blood Count with Differential/Platelet, Hepatic Function Panel, Total Cholesterol, Triglycerides, Thyroxine (T4) and T3 Uptake were performed and their values were found to be within normal range.

07/20/20 Dr. Valentin Hernandez. History and Physical/Telehealth Visit. Examinee complained of dysuria getting worse with burning and a red-tinge and flank pains and worsening fungus with redness of the skin and desquamation. Review of systems was significant for dysuria, burning, fevers but no history of sexual contact with someone with the same, or renal-cortical damage, or injuries to the kidneys or operations. Impression: Urinary tract infection. Tinea corporis. Rx: Bactrim DS 1 tab po twice a day x 10 days #20 and Lamisil 250 mg po once a day #30. Additional Comments: Labs-COVID 19 antibody.

07/31/20 LabCorp. Laboratory Report. SARS-CoV-2 Antibody, IgG. DiaSorin SARS-C0V-2 Ab, IgG A: Negative.

08/20/20 Worker's Compensation Claim Form (DWC 1). Date of Injury: CT 01/06/20-06/30/20. History of Injury: Examinee developed stress due to hostile work environment. Difficulties to breath, chest pain, irritable bowel syndrome, headache and high blood pressure.

08/23/20 Worker's Compensation Appeals Board. Application for Adjudication of Claim. Examinee sustained cumulative injury from 01/06/20 to 06/30/20 that caused injuries to nervous system – stress, head not specified, and chest including ribs, digestive system stomach, and body system not specific. Examinee had stress and strain due to hostile work environment. Examinee was forced to wear mask N95 that caused her difficulties of breathing, chest pain, irritable bowel syndrome, headache, high blood pressure.

09/09/20 Dr. Valentin Hernandez. History and Physical/Telehealth Visit/Real Time Synchronous Audio and Video Visit. Examinee had an unrelenting cough of green and yellow phlegm which was associated with a painful sore throat and hoarseness over the past week. Examinee had been having an increase in the joint pains and it was more difficult to move in the morning than in the afternoons although the medications have not been helping to any significant degree. There was an effusion of the knee with tenderness and warmth. Examinee complained of a purulent greenish cough, with sore throat and headaches and had noted pains and difficulties moving the joints as they were quite stiff. Impression: Pharyngitis. Osteoarthritis. Additional Comments: Labs were negative.

10/05/20 Dr. Eric E. Gofnung, Chiropractic Medicine/Dr. Mayya Kravchenko, Chiropractic Medicine. Eric E. Gofnung Chiropractic Corporation. Primary

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Treating Physician's Initial Evaluation Report and Request for Authorization. Date of Injury: CT 07/06/19 to 07/05/20. History of Injury and Treatment: Examinee was asymptomatic and without any disability or impairment prior to the continuous trauma injury from 07/05/19 to 07/05/20 as related to the neck, bilateral shoulder, greater in the left shoulder, left arm, wrist/hand and finger, low back, left hip, bilateral knees, ankles and bilateral feet. Cumulative Trauma: Examinee stated that while working at her usual and customary occupation as a registered nurse for Sunbridge Hallmark Health Sew. DBA; Playa Del Rey Cir, she sustained a work-related injury to her neck, bilateral shoulder, greater in the left shoulder, left arm, wrist/hand and fingers, low back, left hip, bilateral knees, ankles and bilateral feet, which she developed in the course of her employment due to continuous trauma dated from 07/06/19 to 07/05/20. Examinee attributed the injuries due to the repetitive movements while pushing the medi-cart and assisting Examinee with lifting or mobility and transfers. Explained that she began having symptoms in her neck and bilateral shoulders, greater in the left in 2019. Examinee had difficulty performing her work duties; the pain was causing interruption of sleep. Examinee self-treated her symptom with massages and over-the-counter medications. Examinee reported the injuries to her supervisor and did advise her that the physical therapy was available, and they offered to reduce her work duties, but it never happened. Examinee continued working with pain and discomfort. Stated progressively with the same workload, she began experiencing pain in her left arm, wrist/hand and finger, low back, left side hip, bilateral bees and bilateral feet. Reported these injuries, to her supervisor and all they would say they were working on it, and she never received medical attention. Examinee continued to self-treat. Around 2019, Examinee visited her primary care physician, Dr. Hernandez about some discomfort in her neck and back, she was given medication. Examinee was advised to try and reduce her work load. Examinee occasionally had follow-up visits and was complaining of anxiety, stress and depression, due to her work environment. Examinee was prescribed pain medication, anti-inflammatory, and anti-depressants. She was referred to a psychiatrist. 05/20, Examinee was seen by a psychiatrist, he prescribed medication for anxiety and depression, she continues under his treatment every month, one on one basis. He would implement a psychologist and group therapy, which was pending. Initially reported injury to the employer on 2019. After reporting the injury to the employer, Examinee was not provided with an Employee Workers' Compensation Claim Form. Examinee was not provided with medical attention by the employer. Information regarding Medical Provider Networks and their rights if they were injured was not posted in their place of work on the walls in a common area. Upon being hired, they were not provided information relating to Medical Provider Networks and their rights if injured at work. Upon reporting their injury, they were not provided information pertaining to Medical Provider Networks and their rights if injured at work. Current

Complaints: Examinee complained of moderate, frequently neck pain and limited range of motion or twisting and turning the head and neck. The pain was aggravated with flexing or extending the head and neck, turning her head from side to side, prolonged positioning of the head and neck, forward bending, pushing, pulling, lifting and carrying greater than 5-10 lbs., and working or reaching at or above shoulder level. There was radiating pain from the neck into his/her shoulders, and down the left arm to the finger tips. Examinee had been experiencing frequent headaches and numbness and tingling. Examinee had difficulty falling asleep and was often awakened during the night by the neck pain. There was stiffness and restricted range of motion in the head and neck. Her pain level varies throughout the day. Pain medication, analgesic balms, heating pads, give her temporary relief, she remains symptomatic. Examinee complained of moderate, frequently bilateral shoulders pain greater on the left and the pain radiated to her left elbow, arm and wrist/hand and fingers. Examinee had instability in the left shoulder and experiences weakness and a restricted range of motion for the shoulder as well as in the left side, there was numbness and tingling in the shoulder, arm, hand and fingers. The numbness and tingling in the hands and fingers awaken at night. Examinee complained of stiffness and experiences increased pain with repetitive motion of the arms/shoulders, the pain was aggravated with backward, lateral, and overhead reaching, pushing, pulling, lifting and carrying greater than 3-5 lbs., and repetitive use of the bilateral upper extremities. Examinee's pain level varies throughout the day, depending on activities. Examinee was would occasionally, however when lying her shoulder, they become numb. Examinee had difficulty falling asleep and awakens throughout the night due to the pain and discomfort. Examinee complained of moderate, frequently bilateral hands/wrist/fingers pain, greater in the left and the pain was aggravated with gripping, grasping, torqueing motions, flexion, and extension of the wrist/hand, pinching, fine finger manipulation, driving, repetitive use of the left upper extremity pushing, pulling and lifting and carrying greater than 2-3 lbs. Examinee had cramping, weakness, and loss of grip strength in hand and wrist and had dropped objects, as a result. There was tingling in the hands and fingers. Examinee had difficulty sleeping and awakens with numbness, tingling and pain, and discomfort. Examinee's pain level varies throughout the day, depending on activities. Examinee complained of moderate and frequent lower back pain which increased becoming aching cramping and depending how she move, becoming sharp and the pain radiates to her bilateral hip, greater in the left hip, down her left buttocks and back of her thighs. Examinee does have numbness and tingling in her left leg, to the foot. Examinee stated coughing and sneezing aggravate the back pain. The pain increases with activities of standing or walking as well as sitting over 15 minutes as well as activities of kneeling, stooping, squatting, forward bending, ascending and descending stairs, forceful pushing and pulling, lifting and carrying greater than 5-10 lbs., going from a seated position to

a standing position and twisting and turning at the torso. Examinee complained of muscle spasms, pain and difficulty with intimate relations/sexual activity due to increased pain to her lower back. Examinee does awaken from sleep as a result of the low back pain. Examinee self-restricts by limiting her activities. Examinee occasionally drags or leans her left side due to low back symptoms. Pain medication, analgesic balms, and had temporary relief, but she remains symptomatic. Examinee complained of moderate, frequently bilateral knees pain greater on the left side and the pain increased with flexing, extending, prolonged standing and walking, going up and downstairs, bending, stooping, squatting, and walking on uneven surfaces or slanted surfaces. There was popping and grinding in both knees and experiences buckling episodes. Examinee had lost balance as a result of the buckling. The knees were slightly swollen, and the pain radiates down to the calves. Examinee had episodes of swelling in the knees, and feels she had fluid. Examinee was unable to kneel and squat and had difficulty ascending and descending stairs, occasional limping. Examinee complained of moderate, frequently bilateral ankles/heels pain greater in the left and there was slight swelling and cracking of the ankles. Examinee complained of the instability of the ankles and cramping of the feet, worse on the left ankle. The pain was aggravated with standing and walking over 15 minutes, flexing, extending, squatting, stooping, and standing on the tiptoes. Examinee could not hop, jump, or run due to the pain. There was radiating pain from the ankles into the toes, numbness and tingling in her toes. Examinee occasionally limps while walking and ambulating. There was slight swelling and cracking of the ankles. Examinee complained of moderate, frequently feet pain, greater in the left foot, becoming sharp, and numbness. Examinee's pain travels up to her leg, and down to her toes. Examinee had cramping, swelling, numbness and tingling in bilateral feet, greater in the left foot. Ankle/foot had given out, causing her to lose her balance. Examinee had difficulty standing and walking for a prolonged period and her pain worsens when she flexes/extends or rotates his/her foot/ankle. Examinee's pain level varies throughout the day, depending on activities. Examinee had difficulty sleeping and awakens with pain and discomfort. Pain medication, heating pads, and ice packs provide temporary relief. Examinee had continuous episodes of anxiety, stress, and depression due to chronic pain and disability status. Examinee had difficulty sleeping, often obtaining a few hours of sleep at a time. Examinee felt fatigued throughout the day and finds herself lacking concentration and memory at times. Examinee worried over her medical condition and the future. Examinee's condition had worsened due to lack of medical treatment, and activities of daily living. Job Description: Examinee was employed by Sunbridge Hallmark Health Serv. DRA: Playa Del Rey Center as a registered nurse at the time of the injury. Examinee began working for this employer in April 2010. Examinee worked full time. Job activities included working with Examinee's, medication, pushed a very heavy medi-cart, supervising the floor for what

assistance the other employees required, computer work, carried out medication orders constantly, assisting Examinee with mobility including transfers. During the course of work, the Examinee was required to perform sifting, walking, standing, flexing, twisting, and side-bending and extending the neck, bending and twisting at the waist, squatting, and kneeling. Examinee's physical activities included using the bilateral upper extremities repetitively for simple grasping, power grasping, fine manipulation, keyboarding, writing, pushing and pulling, reaching at shoulder level, reaching above shoulder level, and reaching below shoulder level. Examinee was required to lift and carry objects while at work. Examinee was required to lift and carry objects weighing up to 50 pounds and carry these objects up to 40 feet. Examinee was not exposed to dust, fumes, vapors; she was required to wear scrubs, goggle and gloves. Examinee worked 8-12 hours per day and 5-6 days a week. Normal work hours were eight, lunch break was 30 minutes. Rest break was 10 minutes, which she rarely took due to her work schedule. The job involved working 100% indoors. The last day Examinee worked for Sunbridge Hallmark Health Serv. DBA: Playa Del Rey Ctr was 07/05/20, stopped working due to injuries and inability to continue performing job duties. There was concurrent employment at the time of the injury with My Life Foundation, she began working for them in January 2010, home health care, driving to Examinee's homes, she worked 15-20 hours a week. In April 2020, she was exposed to COVID-19 and had to stop working. Prior Work History: Regarding prior employment, the Examinee worked for IHSS, she worked off and on for 10 years, home health aide and was a cosmetologist working only part-time for 25 years. Past Medical History: 2003: Examinee was the driver, she sustained a whiplash type injury to her neck and back and received chiropractic treatment, her symptoms resolved. Social History: Socially alcohol consumption. Current Meds: Ativan 0.5 mg, Prozac 10 mg and Tylenol or Motrin. Review of systems was significant for trouble sleeping, muscle and joint pain, stiffness, anxiety, depressed mood, social withdrawal, emotional problems, and stress. Vitals: BP: 110/80. Height: 5'2". Weight: 130 lbs. Pulse: 75. Examination of the cervical spine revealed tenderness to palpation with muscle guarding of bilateral paracervical and left upper trapezius musculature. Tenderness and hypomobility were noted at C3 through C7 vertebral regions. Shoulder depression test was positive on the left. Decreased range of motion of cervical spine and painful. Examination of the shoulders and upper arms revealed antalgic position of the left shoulder. Tenderness to palpation with myospasm of left supraspinatus, infraspinatus, and periscapular musculature. Hawkins test was positive at the left shoulder. Range of motion was right normal and left decreased and painful. Examination of the elbows and forearms revealed tenderness to palpation at left elbow medial epicondyle and left forearm extensor muscle group. Valgus Stress Test was positive at the left elbow. Range of motion within normal limits with pain at the left elbow. Examination of the wrist and hands revealed tenderness to

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palpation at left carpals, distal ulna, distal radius, TFCC. Tenderness at left thenar region. Tinel's sign was positive at the left. Finkelstein's and Phalen's test were positive at the left. Range of motion within normal limits with pain at the left. Examination of the finger revealed digital painful ranges of motion of digits one and five on the left hand. Tenderness at the left thumb was noted during palpation. Ranges of motion for the fingers were within normal limits with pain at the left first and fifth digits. Examinee complained of increased pain at the left hand during the testing. Motor testing of cervical spine and upper extremities revealed Deltoid (C5), Biceps (C5), Triceps (C7), Wrist Extensor (C6), Wrist Flexor (C7), Finger Flexor (C8) and Finger Abduction (T1) motor testing was normal and 5/5 bilaterally with the exception of deltoid left 4/5; wrist extensor left 4/5; finger flexor, finger abduction and wrist flexor 4/5 on the left; triceps left 4/5. All other myotomes 5/5. Sensory testing revealed C5 (deltoid), C6 (lateral forearm, thumb & index finger), C7 (middle finger), C8 little finger & medial forearm) , and T1 (medial arm) dermatomes were intact bilaterally as tested with a Whartenberg's pinwheel with the exception of dysesthesia at left C6-C7 dermatomal levels, dysesthesia in left hand medial nerve distribution. Examination of the thoracic spine revealed tenderness to palpation with myospasm of left parathoracic and left trapezius musculature. Tenderness and hypomobility were noted at T1 through T8 vertebral regions. Kemp's test was positive on the left. Ranges of motion for thoracic spine were decreased and painful. Examination of the lumbosacral spine revealed tenderness to palpation with muscle guarding of bilateral paralumbar musculature. Tenderness at left sacroiliac joint. Tenderness and hypomobility at L3 through L5 vertebral regions. Milgram's test was positive. Sacroiliac joint compression test was positive on the left. Straight Leg Raising Test (supine) elicited increased low back pain with increased radiculopathy to left lower extremity: Right: 45 degrees. Left: 40 degrees. Ranges of motion for the lumbar spine were decreased and painful. Examination of the knees and lower legs revealed tenderness to palpation at left knee medial joint line and tenderness to palpation was noted at left lower leg musculature, including gastrocnemius and peroneal musculature. McMurray's test was positive at the left knee. Pain and weakness at the left knee during the squat. Range of motion for the knees decreased with pain on the left. Examination of the ankles and feet revealed tenderness to palpation at left talus, calcaneus, talonavicular joint, anterior talofibular ligament, Achilles tendon and tibialis posterior tendons. Anterior drawer test was positive on the left. Ranges of motion for the ankles, right normal and left decreased and painful. Motor, gait & coordination testing of the lumbar spine and lower extremities revealed ankle dorsiflexion (L4), great toe extension (L5,), ankle plantar flexion (L5/S1), knee extension (L3, L4), knee flexion, hip abductor and hip Adductor motor testing was normal and 5/5 with the exception of knee extension left 4/5, ankle dorsiflexion left 4/5. All other myotomes 5/5. Squatting was positive for back pain and left knee pain. Heel and toe walking was

positive for back pain and left knee and left ankle pain. Antalgic gait favoring left lower extremity. Examination of sensory testing revealed L3 (anterior thigh), L4 (medial leg, inner foot), L5 (lateral leg and midfoot) and S1 (posterior leg and outer foot) dermatomes were intact bilaterally upon testing with a pinwheel with the exception of dysesthesia at left L5 dermatomal level. Lower Extremity Measurements Circumferentially & Leg Length in Centimeters of thigh-10 cm, above patella with knee extended 55 in left and 55.5 in right. Calf-at the thickest point 35.5 in left and 36 in right. Leg length-anterior superior iliac spine to medial malleolus 97 in right and left. Diagnoses: Cervical spine myofasciitis. Cervical facet-induced versus discogenic pain. Cervical radiculitis left, rule out. Thoracic spine myofasciitis. Thoracic facet-induced versus discogenic pain. Lumbar spine myofasciitis. Left sacroiliac joint dysfunction, sprain/strain. Lumbar facet-induced versus discogenic pain. Lumbar radiculitis left, rule out. Left shoulder tenosynovitis/bursitis. Left shoulder impingement syndrome, rule out. Left elbow medial epicondylitis. Left brachioradialis tendinitis. Left wrist tenosynovitis. Left carpal tunnel syndrome, rule out. Triangular fibrocartilage complex tear, left, rule out. Knee internal derangement, left, rule out. Tenosynovitis of left lower leg. Tenosynovitis of left ankle and foot. Left Achilles tendinitis. Anxiety and depression, sleeping difficulty. Medical Causation Regarding AOE/COE: Dr. Gofnung opined, it was within a reasonable degree of medical probability that the causation of this Examinee's injuries, resultant conditions, as well as need for treatment with regards to cervical, thoracic and lumbar spine, left upper extremity and left lower extremity were industrially related and secondary to continuous trauma from 07/06/19 to 07/05/20 while working for Sunbridge Hallmark Health Serv. DBA: Playa Del Rey Ctr as a registered nurse. Dr. Gofnung opined based on this Examinee's job description, history of injury as reported, medical records (if any provided), as well as Examinee's complaints, physical examination findings and diagnostic impressions, and absent evidence to the contrary. Plan: Recommended comprehensive treatment course consisting of chiropractic manipulations and adjunctive multimodality physiotherapy 2 x/week for 4 weeks. Ordered x-ray of the cervical, thoracic and lumbar spine, left shoulder, left elbow, left wrist left knee and left ankle. Permanent and Stationary Status: Examinee's condition was not permanent and stationary. Work Status/Disability Status: No lifting in excess of 15 pounds. No repeated work with left arm above shoulder height. No repeated bending or twisting. No repeated or forceful grasping, torqueing, pulling, and pushing with left hands. No repeated squatting, kneeling, or climbing. If modified duty as indicated was not provided, then the Examinee was considered temporarily totally disabled until reevaluation in four weeks.

11/09/20 Dr. Marvin Pietruszka, Family Medicine/Dr. Koruon Daldalyan, Internal Medicine. Del Carmen Medical Center. Primary Treating Physician's Initial Evaluation Report. Date of Injury: CT 01/06/20 to 06/30/20; CT 07/06/19 to

07/05/20. History of Injury: Examinee filed two continuous trauma claims between the dates of 07/06/19 and 07/05/20 and between 01/06/20 and 06/30/20, for injuries that she sustained during the course of her employment. Examinee related that at the time of her injuries she was working for Sunbridge Hallmark Health Services at Playa del Rey Center, a skilled nursing facility. Examinee stated that the company had a license facilitating up to 99 patients. Examinee stated that she worked as the supervisor and would provide supervising duties for the entire staff including the CNA's, LVN's and other registered nurses. Examinee also performed administrative duties. Examinee stated that throughout the course of her work there was a very low amount of staff. Examinee stated that she began to notice that she was performing various job duties besides her administrative duties as the registered nurse supervisor. Examinee would perform duties for CNA's, LVN's and other RN's. Examinee stated that over time, she began to have increased stress levels. When she reported her stress to her supervisors, she was advised that additional personnel would be hired for assisting her. Stated that the company never hired additional personnel causing her stress levels to continue. Stated that she eventually presented to an urgent care center as she had the onset of a panic attack. Examinee was provided various medications and she was referred to a psychiatrist for which she continued in treatment with. Examinee stated that she was prescribed various medications including Prozac and Buspar. Examinee did have some relief with both of these medications. However, at this time, Examinee was on Tylenol and at times she takes Ativan. Examinee's significant stress continues at the workplace. Also had other symptoms including abdominal pain, nausea, vomiting, and diarrhea and weight loss, difficulty with concentration and sleep also headaches and dizziness. Examinee also complained of musculoskeletal pain that had progressed since leaving her workplace, pain in the cervical spine, left shoulder, left elbow and left hand also numbness of the left hand, as well as dropping items with the left hand and also bilateral knee, left ankle and left foot pain. Examinee had been in treatment with Dr. Hernandez prior to coming to this office. Prior to working as a registered nurse, Examinee worked in cosmetology. Examinee's musculoskeletal complaints involved cervical spine pain 8/10, lumbar spine pain 7/10, left shoulder pain 8/10, left elbow pain 7110, left wrist pain 7/10, bilateral hand pain 5/10, left hip pain 6-8/10, right knee pain 6/10, left knee pain 7/10, left ankle pain 6/10 and left foot pain 6/10. There was a complained of peripheral edema and swelling of the ankles. Examinee's psychosocial complaints include anxiety, depression, difficulty concentrating, difficulty sleeping, and difficulty making decisions. Examinee complained of diaphoresis, but denies a complaint of fever, chills or lymphadenopathy. Occupational Exposure: Examinee was exposed to chemicals, dust and vapors during the course of her work. Examinee was exposed to excessive noise during the course of her work. Examinee was exposed to excessive heat and cold. Current Meds: Tylenol 1,000 mg, Ativan 0.5 mg, Prozac

10 mg and Buspar 10 mg. Review of systems was significant for headaches, dizziness, lightheadedness, chest pain, palpitations, and shortness of breath, abdominal pain, nausea, vomiting, diarrhea, and weight loss. Vitals: BP: 109/53. Weight: 130 lbs. Temperature: 97.0. Pulse: 65. RR: 16. Examination of the head revealed left sided temporomandibular joint tenderness. EENT examination revealed hearing appears to be uninvolved. Musculoskeletal examination revealed Examinee was ambulatory. There was tenderness of the left side of the cervical spine and lumbar paraspinal musculature, left shoulder, left elbow, and left wrist, left hand and left knee. Tinel's was positive at the left wrist. Decreased range of motion of cervical spine, lumbosacral spine, shoulder, hips, forearm and wrist. Special Diagnostic Testing: A pulmonary function test was performed revealing an FVC of 2.74 L (104.1%), an FEV 1 of 2.22 L (90.0%), and an FEF of 2.43 Us (77.8%). A 12-lead electrocardiogram was performed revealing normal sinus rhythm and a heart rate of 71 per minute. A pulse oximetry test was performed today and was recorded at 99%. Laboratory Testing: A random blood sugar was performed today and was recorded at 67 mg/dL. The urinalysis performed by dipstick method was reported as 1+ protein. Diagnoses: Musculoskeletal injuries involving cervical spine, lumbar spine, left shoulder, left elbow, left wrist, bilateral hands, left hip, bilateral knees, left ankle and left foot. Cervical spine sprain/strain. Lumbar spine sprain/strain. Internal derangement, left shoulder. Epicondylitis left elbow. Carpal tunnel syndrome left wrist. Internal derangement left knee. Internal derangement bilateral ankles. Elevated blood pressure, rule out hypertension. Cephalalgia. Vertigo. Chest pain. Palpitations. Dyspnea. Gastritis secondary to NSAID medications. Nausea/vomiting. Irritable bowel syndrome manifested by diarrhea. Weight loss. Peripheral edema/swelling of ankles. Anxiety disorder. Depressive disorder. Sleep disorder. Diaphoresis. Causation: The various diagnoses listed appear to be consistent with the type of work that would typically cause such abnormalities. Dr. Pietruszka, therefore, believes that the diagnoses listed thus far were AOE/COE. Rx: Ativan 0.5 mg daily. Disability Status: Examinee was to continue on temporary and total disability for a period of one month. Subjective Complaints: Headaches. Dizziness. Lightheadedness. Chest pain. Palpitations. Shortness of breath. Abdominal pain. Nausea. Vomiting. Diarrhea. Weight loss. Cervical spine pain. Lumbar spine pain. Left shoulder pain. Left elbow pain. Left wrist pain. Bilateral hand pain. Left hip pain. Right knee pain. Left knee pain. Left ankle pain. Left foot pain. Peripheral edema and swelling of the ankles. Anxiety. Depression. Difficulty concentrating. Difficulty sleeping. Difficulty making decisions. Diaphoresis. Objective Findings: Left sided TMJ tenderness. Tenderness of the left side of the cervical spine. Tenderness of the lumbar paraspinal musculature, left shoulder, left elbow, left wrist, left hand and left knee. Tinel's was positive at the left wrist. Plan: Please be advised that the denial of the claim by the employer would affect ability to either confirm or reject any of the stated diagnoses, which would also affect ability

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to provide evidentiary support for Dr. Pietruszka opinions. Treatment authorization, if already approved, was appreciated. If treatment had not yet been approved, it was hereby requested. Examinee was to continue with her current medications. Prescribed Flurbiprofen topical cream to apply twice a day and Gabapentin topical cream to apply twice a day. Referred for an EMG nerve conduction study of the upper extremities. Follow up in 6 weeks.

11/13/20 Deposition of Examinee. This is a 119-page deposition.

Examinee resides at 13200 Doty Avenue, Apartment 101, Hawthorne, California 90250.

Page 9: Examinee's full name was Anisa Michelle Chaney. She was born on September 6, 1973. Her married last name was Stakely.

Pages 10-13: Examinee took OTC Tylenol in the 24 hours for pain and discomfort in neck and lower back. She took it almost 2-4 tablets every day for the past 7-8 months for neck and lower back pain. She had headache, left arm pain, left leg, knee, foot and hip pain. She took Ativan 0.5 mg for anxiety in the past seven days, prescribed by a doctor.

Pages 14-16: Examinee was prescribed Lorazepam 5 mg by a psychiatrist, Dr. Michael in Culver City. She was prescribed Ativan in May 2020 by Long Beach Urgent Care.

Page 17: Examinee started treating with Dr. Michael N in July 2020. She was unable to see the doctor as she lost insurance.

Pages 20-22: Examinee spent an hour with her attorney in preparation of deposition. She was born in California. She had been living at the current residence for about 3-1/2 years with children and her brother. She had two children, daughter Taylor aged 27 and son Anthony aged 14. She was paying a rent of $1685 per month. Her brother contributed a rent of about $500. She spent utility bills per month.

Pages 23, 24: Before current residence, Examinee lived in an apartment #3 in Gardena, California 90249 for about 1-1/2 years. Her husband, Tyrone Stakley was a youth counselor. Prior to that, she lived at 3311 West 139th Street, Apartment No. A, Hawthorne 90250 with her husband and children for 18 years. She did not live with her husband in current address because they were separated. She was presently married about 20 years.

Pages 25-27: Examinee currently did not have health insurance. She last had Aetna health insurance on July 31, 2020 through employer, Playa del Rey Center.

Pages 28-30: She separated from her husband due to irreconcilable differences. Her PCP was Dr. Valentine Hernandez at Hawthorne. She had been seeing Dr. Hernandez for 20 years. She had changed her insurance to Kaiser for a year in 2018.

Pages 31-33: Examinee was treated with pain medication for her work injuries. She also saw a psychiatrist at an urgent care for stress on Long Beach Boulevard in May 2020. She had seen Dr. Gofnung in Los Angeles and also saw Dr. Daldalyan. She first saw Dr. Gofnung in late September 2020. She went to Dusk to Dawn in June 2020 with complaints of chest pain, shortness of breath, headaches. She saw Dr. Daldalyan with stomach pain, headaches, anxiety, and bowel problem.

Page 35: Examinee received unemployment benefit through EDD of about 3000 a month since terminated on July 6, 2020.

Pages 36, 37: Examinee was hired at Playa in April 2010 as an RN supervisor. She worked in every area. On the last day, she was paid $39 an hour. Her supervisor was May Young. Her job duties were to supervise the staff, the LVNs, the CNAs, maintain the building integrity. During her shift, she was the night shift supervisor, did patient care, med pass, housekeeping. Her physical requirements were lifting, pushing a med cart, assisting patients with mobility, with transfers. Her shift was primarily from 11:00 pm to 7:00 am. At the time of termination, she was working on full duty.

Pages 38-40: While working for Playa, she concurrently worked at My Life Foundation for 10+ years as a nurse consultant. Job duties were to assess and consult with the staff and the clients with the foundation in their homes, in-home care visits. She stopped working there because she was exposed to COVID at Playa del Rey. She could not work anywhere after leaving there. When she went to a house for assignment to regularly monitor it, she was paid per diem for My Life Foundation assignments. Last year, her employer was Genesis HealthCare and New Gen.

Pages 42, 43: Examinee last worked at My Life Foundation on April 1, 2020. She was previously self-employed as a cosmetologist. She was still an active member of the Board of Cosmetology and worked for IHSS. She last did cosmetology in 2019 during spare time.

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Pages 44-46: Examinee was doing makeup, was dealing with two clients in a week. She started in Los Angeles location and ended up in Hawthorne office. In the last 5 years, she was seeing two patients. Her duties varied. She did grocery shopping, light housekeeping, laundry, assist their personal care, drove them to doctor's appointments, and other appointments. She last took care of the patient, Billy Fletcher. She was taking care of Billy for about more than 2 years. He was limited, but partially independent.

Pages 48, 49: While doing makeup, Examinee practiced braiding and weaving. She used to carry a small bag that weighed 10-15 pounds. She was receiving unemployment every two weeks. She was applying jobs and seeking out less physical positions.

Pages 50, 51: Examinee received an RN license in 2009 and worked with My Life Foundation. She was taking Tylenol for her low back pain. She had headaches, pain in left arm, knees, ankles, feet and hip more on the left side.

Pages 52, 53: Examinee sometimes had pain that goes from her jaw down her neck, shoulder, arm down to her fingers. She described her neck pain as annoying, 4/10. She had whole left arm pain. She felt numbness and dropped things. She had tingling in her fingers. She felt aching during sleeping and trying to move. She felt her arm was heavy and numb. She rated left arm pain as 3-4/10.

Pages 54, 55: Examinee got tension headaches couple times a week. She felt left knee pain while she was a nurse. She felt left knee pain with little bit walking, bending. When she tried to get up, she felt pressure on her. She rated her knee pain as 6-7/10. She got pain in right knee with bending or excessive walking, driving. She rated it as 3-4/10.

Pages 56, 57: Examinee felt left hip pain with walking, changing position during sleeping. She had 7/10 left foot pain with excessive walking for more than 15 minutes.

Pages 59, 60: Examinee was driving, riding while working with My Life. She had low back pain of about 3-4/10, but it escalated to 8/10 where she almost wanted to cry. She also had pain in shoulders, arm, neck. Her left shoulder was agonizing. She felt that her pain started from neck and goes down to shoulder. She rated left shoulder pain as 7-8/10. She was little annoying about 3/10. She felt shoulder pain all the time. She also felt neck pain all the time, but not 7/10 all time. She had stiffness, rated as 3/10. When it started hurting, it would go up to 7-8/10.

Pages 61, 62: Examinee would fall asleep because she was tired. Her sleep was broken because she was waking up to discomfort. She had been able to lift heavy things. She was working every day at Playa, lifting things. She reported her neck pain to the director, Mae Young about a year ago who referred her to take Tylenol and rest.

Pages 66, 67: Examinee treated her neck pain with Dr. Hernandez at Kaiser about a year ago. She was off work for a few times.

Pages 68, 69: Examinee first started feeling left arm pain in 2019 because of the job at Playa. She reported it to Mae Young. She sought treatment with Dr. Hernandez.

Pages 70, 71: Examinee did not ask for medical treatment at the workplace, but she asked them to adjust her work assignment.

Pages 74, 75: Examinee started feeling tension headaches about a year ago. She reported it to Mae. She told Mae that the work was overwhelming, causing her physical distress. She was in pain and physical symptoms.

Pages 81-84: Examinee stated that her left knee pain started in June or July 2019. She reported to it to Mae and she asked for an additional staff to assist. She did not get treatment for left knee pain when she first reported and recently started getting treatment. She used knees braces, Tylenol, topical gel. She last received treatment for left knee in 2020.

Pages 86-88: She started treating left knee pain in 2020 with Dr. Gofnung. She reported her work-related back and leg pain to Mae who offered her Tylenol.

Pages 89, 90: Examinee stated that the self-medication would help her get through her shifts, but it did not go away completely. She would feel tired and sleep in pain. She reported pain to the doctor. She also complained her low back and leg pain to her personal doctor in 2019. She was told that she needed more appointments. She did not return back to Kaiser. She ended up at Aetna. She was having problem with her insurance.

Page 95: Examinee reported her work-related injuries to Mae at least twice a month over the last year.

Pages 97, 98: Examinee was offered pain medicine by Dr. Hernandez. The doctor offered Celebrex, anti-inflammatories, anxiety and depression meds. She picked up her prescription at CVS in Hawthorne, Rosecrans, and Prairie.

Pages 99, 100: Examinee had other complaints of stress, overwhelming, and anxiety. She also had complaints of chest, shortness of breath, headache and abdominal discomfort daily. She stated that her chest pain started around January. She started having increased anxiety, fast heart rate, palpitations, sweaty palms. She stated that due to pandemic, had to wear masks, felt suffocating, started having shortness of breath.

Page 102: Examinee stated that her high blood pressure started in January 2020.

11/16/20 Dr. Eric E. Gofnung/Dr. Mayya Kravchenko. Eric E. Gofnung Chiropractic Corp. Primary Treating Physician's Follow up Evaluation Report. Examinee felt some improvement with treatment she was undergoing while under our care. Examinee denies any new accidents or injuries; however, she remains symptomatic. Current Complaints: Examinee complained of neck pain best described as intermittent and slight to moderate, occasionally becoming moderate with prolonged posturing, bilateral shoulder pain, frequent and slight to moderate, worse on the left on the right occasional and slight, on the left frequent and moderate, bilateral wrist and hand pain, worse on the left and on the right intermittent and slight and on the left frequent and moderate, associated with numbness and tingling in both hands, lower back pain frequent and moderate, worse with prolonged weight bearing, forward bending, lifting, pushing or pulling, left knee pain, intermittent to frequent and moderate, associated with occasional swelling and giving way and bilateral ankle and foot pain, intermittent and slight to moderate. Examination of the lumbosacral spine revealed Straight Leg Raising Test (supine) elicited increased low back pain with increased radiculopathy to left lower extremity of right 50 degrees and left 40 degrees. Rest of the exam remains the same as previous visit. Diagnoses: Cervical spine myofasciitis. Cervical facet-induced versus discogenic pain. Cervical radiculitis left, rule out. Thoracic spine myofasciitis. Thoracic facet-induced versus discogenic pain. Lumbar spine myofasciitis. Left sacroiliac joint dysfunction, sprain/strain. Lumbar facet-induced versus discogenic pain. Lumbar radiculitis left, rule out. Left shoulder tenosynovitis/bursitis. Left shoulder impingement syndrome, rule out. Left elbow medial epicondylitis. Left brachioradialis tendinitis. Left wrist tenosynovitis. Left carpal tunnel syndrome, rule out. Triangular fibrocartilage complex tear, left, rule out. Knee internal derangement, left, rule out. Tenosynovitis of left lower leg. Tenosynovitis of left ankle and foot. Left Achilles tendinitis. Anxiety and depression, sleeping difficulty. Plan: Recommended to continue with comprehensive treatment course consisting of chiropractic manipulations and adjunctive multimodality physiotherapy 1 x/week for 4 weeks cervical, thoracic and lumbar spine, left shoulder, left elbows left wrist and hand, left knee, lower leg, left ankle and foot. Recommended to proceed with x-rays of cervical, thoracic

and lumbar spine, left shoulder, left elbow, left wrist, left knee and left ankle. Permanent and Stationary Status: Examinee's condition was not permanent and stationary. Work Status/Disability Status: No lifting in excess of 15 pounds. No repeated work with left arm above shoulder height. No repeated bending or twisting. No repeated or forceful grasping, torqueing, pulling, and pushing with left hands. No repeated squatting, kneeling, or climbing. If modified duty as indicated was not provided, then the Examinee was considered temporarily totally disabled until reevaluation in four weeks.

12/04/20 Deposition of Examinee. This is a 91-page deposition.

Pages 113, 114: Examinee testified that as a result of her employment, she injured her neck, left shoulder, left arm, back, left leg, and hip, leg down to left knee, foot, and ankle. She also felt discomfort in right hand fingers and foot.

Pages 115-117: Examinee stated that in 2017 while handling a patient, she injured her left arm and left shoulder. At times, she reported it to director of nursing, Rose Mansel. After that incident, she went to the Dr. Hernandez because she was having some constant pain in arm. She had x-ray and MRI of brain and Dr. Hernandez reviewed that and revealed it as normal.

Pages 118, 119: Examinee stated that around 2018, the issues as to the left arm and left shoulder from this 2017 incident disappeared. She last worked on July 6, 2020.

Pages 121-124: Examinee stated that her neck, left shoulder and left arm symptoms started in 2017 and her back symptoms started since fall of 2019. Her left leg, left hip, and left foot symptoms started in early 2019. She felt these due to handling of the residents, assisting the residents, and with mobility or positioning, lifting, and pulling. She testified that she also had stress from work. She also had intestinal discomfort and saw Dr. Daldalyan.

Pages 125-128: She was having headaches, chest pain and shortness of breath. Her blood pressure elevated, so had seen Dr. Allan at Dusk to Dawn urgent care. Her intestinal discomfort started about January of 2020 and had abdominal pain secondary to stress.

Pages 129-132: Her headaches started in January 2019. She admitted that overworked and overwhelmed with work caused her stress in early January 2019. Initially she spoke to Rose regarding stress. She felt that headaches are better now. Her chest pain and shortness of breath started in February 2020. She felt N95 mask was hindering her breathing. She had heart palpitations and anxiety.

Pages 133-136: She started wearing the N95 mask since late January 2020. She filed a claim for injuries starting January 6, 2020 until June 30, 2020 and alleged stress and strain due to hostile work environment. During that time it was hostile because Examinee's boss was not happy with her constant complaining regarding her pain, anxiety, and fear of situations, and she got backlash from that. Also felt hostile because of the staff not cooperating, not following the precautions with the virus, putting them in dangerous situations. Examinee felt that wearing of N95 causing difficulties of breathing, chest pain, irritable bowel syndrome, headache and high blood pressure as well as felt uncomfortable and suffocating. She had many issues with staff and their performance.

Pages 137-142: Examinee testified that kind of things such as lack of staff, being manipulated to work overtime, and not being able to go home on time, and have two days, a day and a half there caused stress. She stated that she had counseling due to a family situation about 2014 or 2015 pertaining to her daughter. Her daughter was having a mental health crisis and some psychotic episodes. They said she was bipolar schizophrenic, but her daughter currently was doing well. She had a son at 14 and he's a high school freshman. Her son is in good health. She stated that he was getting Bs and Cs.

Pages 144-148: She stated that her daughter was doing okay and she watched her get better. She stated that her daughter was at 28. She had a domestic violence issue once upon a time with estranged husband and had a physical altercation. After this incident, they went for counseling with their church.

Pages 149-151: Examinee did have a relationship with him and stated that he was her husband and the father of her son. She testified that her husband was arrested only during that domestic violence. She stated that she was looking for work every day. She was working on my bachelor's degree on psychology, pre-counseling. She had discrimination at work. As an RN, she was forced to do duties that the other RNs in her position of other races did not have to do and these activities made her work environment as hostile.

Pages 151-155: She complained of pain and was addressing certain issues, and then got terminated after ten years. She also received threats and harassment from staff. When Rose was the director she had some issues. She had written up few times for some reason and had a dispute with the corporate. She had to do all this excessive work.

Pages 156-158: She had problems with people whom she had to supervise and they were complaining about her standards. She was the supervisor at night and

stated that LVNs or CNAs were complaining of her attitude towards them a lot. She had meetings with corporate about these complaints.

Pages 159-163: In the past 30 days, she had seen Dr. Daldalyan and Gofnung. She was getting therapy sessions from Dr. Gofnung and also was getting some kind of electrical stimulation and some massage, and different exercises. She stated that Dr. Daldalyan gave her some creams for neck, shoulders and back. She had taken a Tylenol for headache. She stated that sometimes she would take Pepto-Bismol or Maalox for GI issues. She was having a prescription for Ativan. She and her husband had marriage counseling at Central Baptist Church in Inglewood. She stated that her husband lives with his brother.

Pages 164-166: She wasn't married previously, but her daughter had another father, a different father and she stated that they were friends. Her daughter good relationship with her father. While working with Genesis, she concurrently worked at My Life Foundation. She was exposed to COVID in April 2020. She stopped working for My Life Foundation in April 2020 due to COVID.

Pages 167-171: Examinee started wearing N95 masks in January of 2020 at Genesis. She started feeling shortness of breath because of wearing the masks and that caused stress on her. She was having anxiety a long time at that job excessive work. She had been to counseling with Dr. Ronald Milestone at Gilbart & Associates.

Pages 174-177: Examinee stated that she still was working with COVID patients every day because they were out on the floor and stated N95 masks became mandated by the State and also with the face shield. She had to wear the whole PPE. She admitted that they used a different N95 and caused suffocation.

Pages 178-180: Examinee requested Mae, Renemar and Kyle Colt for a comfortable mask. She performed different from supervising position and duties as direct patient care, med pass, and housekeeping. Examinee had specific training regarding staff injuries.

Pages 184-188: She filed for bankruptcy about two years ago. In 2018, she lost part of income because she and her husband were separated, but they were still married in the state of California. Her husband would do things between him and her son. She and her husband had a joint responsibility. Her uncle died of cancer in December of 2019 and also cousin died at age of 48 in the end of 2019. She was close to her uncle ad cousin. Her mother passed away in 1992, and her dad passed away in 1996.

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Pages 190-194: She stated that she was pregnant with her daughter at the time her mom died. She raised her children, little sister and helped her brother. She testified that she took care of both of her grandparents after her parents passed away for many years. Then she went to nursing school, became an RN, married and raised her children. She stated that stress and anxiety made her dysfunctional. She still was having stress and anxiety but felt a lot better now. She felt that now she is functional. She stated that she was a student of psychology.

REVIEW OF SYSTEMS:

General	Positive for anxiety and depression. The Claimant denies having recently had fever, chronic fatigue, unexplained weight changes, psychiatric problems.
Head and Neck	Positive for headaches and neck pain. There is no history of dizziness, hearing difficulties, rhinitis, ear infections, difficulty or pain in swallowing, excessive thirst, dental problems, loss of vision, double or blurred vision, or throat infections.
Lungs	Positive for shortness of breath and respiratory infections. The Claimant denied having chronic coughing, sputum production, hemoptysis.
Cardiovascular	Positive for chest pain. There is no history of heart murmurs, arrhythmias, pedal edema, or recent Myocardial Infarction.
Gastrointestinal	Positive for diarrhea, abdominal pain. The Claimant denied having had dark or tarry stools, hematemesis, jaundice, constipation, heartburn, or chronic vomiting.
Urinary	The Claimant denied frequent urinary infections, blood in the urine, difficulty or pain while urinating.
Neurological	The Claimant denied seizures, loss of consciousness, difficulty walking, or head injuries.
Muscles and Joints	Positive for joint pain. The Claimant denied having had joint swelling, recent bone fractures, or effusion.

PHYSICAL EXAMINATION:

The Claimant was examined on the Date of Evaluation shown on the first page of this report.

Vital Signs:

Weight, pounds	Height	BP, mm Hg	HR bpm	RR/min	Temp., °F
138	62 inches	116/62	67	12	97.2

Claimant is left handed. Body Mass Index is 25.2. The examinee is wearing a double cloth mask covering her nose and the inferior half of her face.

General: The Claimant was found to be alert to time, person and place. The Claimant did not appear to be in acute distress, was fully cooperative and appeared to be at ease.

Head & Neck:

Head: Examination of the head failed to show any evidence of recent acute trauma, bleeding, abrasions or lacerations.

Eyes: The conjunctivae were found to be within normal limits, with no evidence of jaundice, redness, trauma or infection. The pupils reacted equally to light and accommodation (PERLA). Extraocular muscle movements were found to be normal.

Ears: The external ear canal and outer ear structures were examined for signs of recent trauma, blood in the external/internal ear canal. No evidence of such was found. There was no evidence of infection. Hearing was found to be grossly normal.

Nose: Wearing facial covering.

Mouth: the oral mucosa was found to be well hydrated and without any signs of lesions or redness. Examination of the throat showed no signs of infection.

Neck: The neck was found to be supple. Palpation showed no evidence of masses or lymphadenopathy. The thyroid gland was found to be of normal size and consistency. It was found to be non-tender to palpation.

Lungs: Visual examination of the chest showed symmetric expansion of both lung fields. Auscultatory findings were within normal limits showing the lungs to be clear. Percussion of the chest failed to show evidence of fluid accumulation in the chest.

Cardiovascular: Palpation of the precordial area showed the point of maximum impulse to be located within normal limits. Auscultation of the cardiac sounds showed normal heart sounds, without evidence of clicks, gallops, or murmurs. No jugular venous distention was noted.

The peripheral pulses were present and of normal intensity in the upper and lower extremities.

Abdomen: The abdomen was found to be soft and depressible. Peristaltic sounds were of normal intensity and rhythm. The liver span was found to be within normal limits by percussion of the abdomen at the mid-clavicular line. Auscultation failed to show any evidence of bruits in the mid-abdominal area.

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Extremities: Examination of the extremities was negative for edema distally.

Neurological: Examination of the cranial nerves was unremarkable; however, it was limited by the fact that the examinee was wearing facial covering.

Motor function: The Claimant was observed while walking from and about the examiner's room. The gait was found to be normal with balance maintained throughout.

Sensation: Sensation was found to be adequate.

Reflexes: Deep tendon reflexes were found to be of normal intensity and symmetrical bilaterally.

Coordination: Claimant was found to have adequate coordination.

Skin: The skin was found to be warm and without any prominent skin lesions.

Genitalia/Rectal: Deferred.

In order for this Evaluator to render final and substantial compensability opinions as a QME, the necessary information on the issues that need to be addressed must be made available. The information required is necessary for diagnostic, compensability determinations or rating purposes.

THE FOLLOWING UP TO DATE TESTS/RESULTS/MEDICAL RECORDS ARE REQUESTED:

CBC WITH DIFFERENTIAL
METABOLIC 20
COLLAGEN PROFILE
HBA1C
TSH, T3, T4
URINALYSIS
PFT/DLCO
EKG
TREADMILL
ECHO
CXR PA/LAT
H. PYLORI BREATH

Epworth Sleepiness Score: 8/24

Date of Exam: April 22, 2021

DIAGNOSTIC IMPRESSION:

1. Shortness of breath, probably secondary to anxiety.
2. probable Obstructive Sleep Apnea
3. GERD by history
4. Recurrent, intermittent bronchitis, pre-existing.
5. Rule out a rheumatological condition
6. No evidence of hypertension.

SUMMARY and DISCUSSION:

Pertinent findings from the medical records:

I have received 419 pages of medical records for my review, based on the attestation page.

The chronology of the medical records dates back to January 2012. The examinee was hired around April 2010. She saw Dr. Hernandez, an internist for sore throat and cough on 01/27/12. At the time her weight was 140 pounds and blood pressure was 112/64. The following month the examinee went back to see Dr. Hernandez complaining of fatigue. Blood pressure was 118/64 with a weight of 134 pounds. His physical examination, Dr. Hernandez notes the examinee looked "nervous". She was diagnosed with iron deficiency anemia and bronchitis. She was treated with supplemental iron and was placed off work for 3 days.

In December 2012 the examinee went back to see Dr. Hernandez complaining of joint pains and productive coughing. She was diagnosed with osteoarthritis and pharyngitis.

Laboratories were completed on 5/24/13. BUN was 6, creatinine was 0.85 with normal electrolytes and normal liver function. Urinalysis was negative for ketones, occult blood, protein, nitrates but positive for leukocyte esterase and white blood cells. A CBC and differential was unremarkable.

The examinee complained of joint pain and fatigue on and off. In October 2015 she saw Dr. Hernandez complaining off persistent productive cough, hoarseness and joint pain with some swelling. She complained of difficulty moving her wrists, closing her hands and walking because of ongoing pain affecting the hips, ankles and knees; the symptoms had worsened during the prior 2 weeks. Her weight had dropped to 122 pounds with a blood pressure of 118/60. Dr. Hernandez diagnosed Herbert bronchitis, pharyngitis, vaginitis and osteoarthritis. She was treated with doxycycline. Dr. Hernandez added that the examinee was under a lot of stress at home and at work.

The examinee continued to complain of tiredness, sore throat, productive cough; in April 2016 her blood pressure was 120/70 with a weight of 129 pounds. She was diagnosed with iron deficiency anemia. Laboratories showed normal BUN and creatinine as well as normal electrolytes. Thyroid

function was unremarkable. Liver enzymes, total protein and bilirubin was unremarkable. The CBC & differential showed a hematocrit of 37.2%, which is below normal. WBCs were 8600 with normal differential and MCV and MCH were normal as well. Platelets were 170,000. Human chorionic gonadotropin was positive.

There is a gap in the medical records spanning May 2016 through May 2018.

The examinee saw Dr. Chong, a Kaiser Permanente internist on 05/15/18. Her history was significant for the fact that she was a current, daily smoker. Blood pressure was 109/24 with a weight of 127 pounds. BMI was 23.4. Laboratories performed showed a normal hemoglobin A1c (5.2%).

There is a gap in the medical records spanning from June 2019 through April 2020.

The examinee saw Dr. Hernandez in April 2020. She was complaining of persistent productive cough, sore throat and headaches. She had also experienced joint pain and swelling. She was diagnosed with bronchitis, pharyngitis and osteoarthritis.

In June 2020 the examinee went back to see Dr. Hernandez complaining of pleuritic chest pain associated with a persistent cough which appeared to be getting worse. During her next visit, the examinee expressed that she was worried about her future and whether she would be able to control/manage future problems that could be coming. She was still having joint pain (niece) and a productive cough with green sputum. Blood pressure was 98/60 with a weight of 125 pounds and a BMI of 22.9. Her physical examination note states that she looked nervous. She was prescribed BuSpar 10 mg at bedtime and referred to mental health professional. She was placed off work from June 23 through June 29, 2020. Laboratories performed the following month (July 2020) showed a glucose of 47 with normal CBC, lipid profile, thyroid profile and hepatic function.

There are two Workers' Compensation Claims dated 8/20/20 and 8/23/20. These address community of trauma type injury claims due to a hostile work environment, specifically affecting her breathing, chest pain, irritable bowel syndrome, headache and high blood pressure. The second 1 addressed similar body parts, adding the digestive system- the issue with the second one was the requirement to wear an N95 mask.

On September 9, 2020 the examinee went back to see Dr. Hernandez complaining off and unrelenting, productive cough associated to a sore throat and hoarseness. She also complained of joint pain which was worse in the morning. Medications had not been helping. Physical exam was not done, as this was a telehealth visit, but there was an effusion associated with tenderness and warmth of the knee (laterality unspecified).

In October 2020 the examinee went to see a chiropractor, Dr. Gofnung, for her occupational claim. She complained of pain in the left shoulder, left arm, wrist and fingers, low back, left hip, both

knees, ankles and feet. She had treated herself with massage and over-the-counter medication. Examinee had apparently been seen by us of interest, who prescribed medication for anxiety and depression. She was having difficulty sleeping due to the presence of pain. She had joint stiffness and restricted range of motion of the head and neck. She had trouble kneeling and squatting as well as going down stairs. The examinee was diagnosed with multiple musculoskeletal conditions. All the conditions were occupationally related, and therefore compensable.

On November 9, 2020 the examinee was evaluated by Dr. Marvin Pietruszka. Dr. Pietruszka states that the examinee started working for the above captioned employer on April 1, 2020-however that is not correct, based on the examinee's history. The examinee complained that she was assuming other roles at work, in addition to her nursing and administrative duties. She had experienced panic attacks and had been referred to a psychiatrist. She has been on Prozac and BuSpar, and was now using Ativan and Tylenol. Her work-related stressors continued. Examinee complained of abdominal pain, nausea, vomiting, diarrhea, and weight loss. She had difficulty with sleep and complained of headaches and dizziness. She also complained of musculoskeletal pain. Dr. Pietruszka states that "the patient was exposed to chemicals, dust and vapors during the course of her work. The patient was exposed to excessive noise during the course of her work. She was exposed to excessive heat and cold." Family history was significant for a brain aneurysm, hypertension and depression. Her father died of liver disease due to alcoholism. Blood pressure was 109/53 with a pulse of 65 and a weight of 130 pounds. An EKG was normal. Laboratories were unremarkable. Random blood sugar was 67 mg/DL. A urinalysis showed a 1+ protein. She had numerous subjective complaints. The examinee was diagnosed with a long list of musculoskeletal diagnoses, as well as gastritis (NSAIDs), irritable bowel syndrome ("manifested by diarrhea"), peripheral edema/swelling of the ankles, anxiety/depressive disorder, sleep disorder, diaphoresis, headache, vertigo, chest pain, palpitations and dyspnea. Dr. Pietruszka attributes all of her symptoms to the "level of stress that was placed upon her at the workplace". The diagnoses were "industrial in origin and are either initiated or aggravated by the patient's employment". The examinee started treating with Dr. Pietruszka. He prescribed Ativan, flurbiprofen topical cream and gabapentin topical cream. She was referred for electrodiagnostic studies of the upper extremities.

The Examinee was deposed on November 13, 2020. The examinee had been separated from her husband for about 2 years. The examinee stated she had been terminated on July 6, 2020. She last worked for My Life Foundation on April 1, 2020. The examinee had diffuse joint pain, with moderate knee pain and hip pain aggravated by walking. She was also complaining off shortness of breath and chest pain. She had increased anxiety, FRS heart rate, palpitations and sweaty palms. Varying masks made her shortness of breath worse. She complained of high blood pressure.

The deposition was continued on December 4, 2020. The examinee stated that in 2017, while handling a patient, she had injured her left arm and left shoulder. Her back symptoms started during the fall of 2019; the left leg and knee pain started in 2019. She did not know when the right shoulder started to bother her. She complained of stress and then mentioned she had seen a doctor,

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Dr. Daldalyan for gastrointestinal discomfort. Her headaches were "a lot better". She experienced shortness of breath and chest pain in association with phase covering requirements. The intestinal discomfort started around January 2020; she did not know exactly what triggered it and stated "maybe stress". It had improved since, and was only present occasionally. She was not taking any medications for the intestinal problem. She had diarrhea with her intestinal discomfort. She described her stressors as feeling "overworked". She complained that she was required to wear an N 95 mask and that hindered her breathing (she was not sure, but thought that the mask had played a part). She had developed heart palpitations and anxiety. She no longer had shortness of breath or chest pain.

The examinee continued to treat with Dr. Gofnung, a chiropractor. As of November 2020, the examinee was not at MMI. She was returned to work with restrictions.

COMMENTS:

High blood pressure, chest pain, shortness of breath:

The examinee does not fulfill the diagnostic criteria for hypertension. She has had blood pressure measurements well within the normal range throughout the last 9 years. The examinee is not obese, diabetic and does not have a metabolic syndrome. Although she may have stress complaints, her blood pressure is normal. There is no injury to the cardiovascular system.

In regards to her chest pain and shortness of breath, I doubt very much the examinee has any underlying cardiopulmonary conditions, and given her history and the information provided by the medical records I have reviewed, the chest pain and shortness of breath may be primarily associated to emotional upheaval associated to stress.

There may also be a component of gastrointestinal reflux in association with some of the medications that she was using or just an underlying mild GERD condition.

Gastrointestinal:

The examinee was arbitrarily diagnosed with Irritable Bowel Syndrome (IBS) just because she had a history of recent onset diarrhea. The diagnostic criteria for this condition requires exclusion of underlying organic disease, which clearly Dr. Pietruszka did not undertake. Other than that, the typical clinical presentation of IBS requires the presence of recurrent abdominal pain, which is typically cramping in nature and associated to defecation, on average at least one day per week for the previous 3 months. Abdominal pain is relieved by defecation, and the symptoms may be associated to abdominal distention, a sensation of incomplete evacuation and passage of mucus with stool (Manning Criteria). The abdominal pain is usually associated with a change in stool frequency and stool form/appearance (Rome IV criteria for IBS). Furthermore, to correct her eyes

Supp types of IBS, the Bristol Stool Form Scale (BSFS) should be used to record stool consistency. In her case, the usual expected stool form scale number would be 6-7.

Based on these diagnostic criteria requirements, Dr. Pietruszka's history is sorely lacking the necessary detail to warrant such a diagnostic impression. His entire gastrointestinal history states "the patient also has other symptoms including abdominal pain, nausea, vomiting, and diarrhea and weight loss." There is no explanation of when these symptoms started, their severity, if there are any triggers or patterns to their onset and/or resolution, what makes the symptoms better and what makes them worse; there is no explanation of what he means by "abdominal pain". Is it a dull, deep ache, is it stabbing in quality, is it intermittent, associated to food, cramping or bloating?

Therefore, in my professional opinion, Dr. Pietruszka's diagnosis is inappropriate and not compliant with current diagnostic criteria or guidelines.

Normal people may have loose stools when they are acutely stressed. The gastrointestinal system is densely innervated by a grid of nerve terminals and flooded by a variety of hormones capable of causing more or less intestinal motility that can result in bouts of diarrhea. The bouts are usually self-contained, not associated to dehydration or gastrointestinal bleeding. This situation usually resolves on its own and does not require prescription medications or formal medical treatment. I believe this is probably what happened to this Examinee.

The same rationale applies to Dr. Pietruszka's diagnosis of gastritis, which is unwarranted because there is no objective evidence this examinee is suffering from this condition. History has a very poor correlation to actual objective findings under visual review (upper endoscopy) and/or biopsy assessment. Just based on history, a medical diagnosis may be treated empirically, but such a hearsay diagnosis is inadequate, and probably speculative in a medical legal case. The AMA guides fifth edition require objective evidence of anatomical derangement in order for an upper gastrointestinal condition to be ratable.

The examinee related that during the latter part of 2019, she developed bouts of abdominal pain and brief bouts of diarrhea which were more prominent just before leaving home to go to work. She was using over-the-counter measures such as Mylanta, Maalox and Pepto-Bismol. In addition to the diarrhea, she felt a burning epigastric pain. By January 2020, she was better, and the bouts were less frequent. By the time of this evaluation, in April 2021, the examinee has no gastrointestinal symptomatology and has discontinued all of the medications, over-the-counter and prescribed, that she had been previously using. Her weight is back to her usual normal, which is around 130-138 pounds.

I have requested a Helicobacter pylori screening test. Pending its results, I have not found any evidence of gastrointestinal injury or residuals warranting a rating. My assessment is that the examinee was having gastrointestinal upset secondary to her stressors, and now that the stressors have been relieved, or gastrointestinal upset is resolved.

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Joint pain, swelling, warmth:

The review of records presents a pattern of recurrent, symmetric joint pain with swelling, effusion, and warmth in big, weightbearing joints but not sparing the distal upper extremities. She has had pain in her hands, wrists and upper extremities as well. She has also experienced recurrent upper and lower respiratory symptoms, at times associated to hoarseness, shortness of breath and productive cough. Physical examination performed by Dr. Hernandez has shown diffuse rhonchi in both lung fields.

I find it amazing that nobody has considered the possibility this examinee may have a rheumatological disorder. She has a history of early morning stiffness, joint swelling, warmth and pain which has remained unexplained by her private medical provider and probably over diagnosed by the occupational providers. Aside from the left shoulder pain, which can very well result from the stress of transferring a patient, the rest of her complaints have very poor correlation to any occupationally related exposure. The examinee does not have a history of having fallen, trauma to the joints, and granted-she may have a physical job-however, this type of physical activity does not cause her symptom conundrum. After having carefully reviewed her depositions, and carefully reviewed Dr. Hernandez' notes, the possibility of rheumatoid arthritis, mixed connective disease and even a mild case of lupus needs to be entertained.

I would also entertain including Polymyalgia Rheumatica (PMR), however, this condition is relatively uncommon in African-American patients. However, the possibility is alluring, because some of these patients have headaches triggered by subclinical arterial inflammation of the temporal arteries without evidence of Giant Cell Arteritis. Another interesting feature is that imaging findings frequently show bilateral subdeltoid/subacromial bursitis (bilateral involvement of the shoulders) with similar findings in the hips. If found, this supports a diagnosis of PMR.

At times, PET studies are necessary to demonstrate increased uptake of markers at the great trochanters and subdeltoid/subacromial areas. Distal symptoms are usually mild, however, still common in the wrist and metacarpophalangeal joints, occasionally also involving the knees. Morning stiffness or stiffness resulting from inactivity is very common, to the point that if it's absent, it usually excludes a diagnosis of PMR.

In addition to the above, these patients, in general, experience fatigue, depression, anorexia and weight loss. Clinically, the erythrocyte sedimentation rate and CRP are elevated. A normocytic anemia (present in this examinee) may be present. Anti-cyclic citrullinated peptide antibodies (CCP) are usually negative. Joint imaging is sometimes indicated and necessary to formulate/demonstrate a diagnosis. PET (positron emission tomography) may be necessary to rule out Giant Cell Arteritis in patients with headaches. If any of these findings are confirmed, a trial of low dose glucocorticosteroids would be indicated if no evidence of Giant Cell Arteritis was

found. In the event that the PET demonstrates increased vascularity in the temporal arteries, a trial of high dose glucocorticosteroids would be indicated.

I have requested a connective tissue disorder screening battery, and until that is completed, a rheumatologic condition would be at the top of my list to explain this examinee's diffuse joint pain.

N95 mask and shortness of breath:

When N95 are required in a work setting, they must be properly fitted and worn. N95 masks may come in different sizes, and they have to be properly fitted to assure a maximal seal along the borders. Under the requirements of the Occupational Safety and Health Administration (OSHA) Respiratory Protection, staff required to wear respiratory protection is also required to undergo training (29 CFR 1910.134). OSHA also requires an initial respirator fit test to identify the right model, style and size respirator for each worker.

The examinee apparently was instructed to wear the N95 mask without the appropriate fitting or training. As she described it to me, my impression was that the mask was too small for her to wear comfortably. When smaller masks are used in individuals that would otherwise fit in a larger respirator, the mask sits closer and tighter to the face leading to a claustrophobic sensation and shortness of breath in some individuals. It is important to note that although health care professionals in general, including nursing personnel, do wear surgical masks on a regular basis, an N95 mask is a different respirator. A NIOSH certified N95 mask filters 95% of particulate matter. Surgical masks are not as efficient as N95 masks primarily because of their loose seal to the face. There are no particular OSHA requirements for a surgical mask, whereas there are very specific requirements for workers who must wear an N95 respirator.

Finally, under other circumstances, absent Covid-19 issues, I would have ordered spirometry testing to make sure we are not dealing with an underlying respiratory condition yet undiagnosed.

CAUSATION & other compensability issues:

In regards to causation, I am waiting for the results of the tests requested above to make firm on my conclusions and render a causation opinion. So far my preliminary impressions are that the conditions she has been complaining of temporary, and subject to the compensability of her stress claim. I do not anticipate apportionment would be an issue.

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This report is submitted in compliance with Labor Code Section 139.2 (j) (I) and Rule 38(a), which requires this Evaluator to submit a report within 30 days of the examination date. Extensive testing has been requested to prove or disprove this applicant's Workers' Compensation claim; the results

are not available for inclusion with this report, but I will be glad to prepare a supplemental report if the parties so desire as soon as the results are available for my review. ***If a supplemental report with the final causation and rating is desired, I would appreciate the parties sending me a formal written request.*** I will provide definitive opinions regarding causation and other compensability issues at that time.

Providing piecemeal information on complex cases is just highly inefficient and exponentially bogs down my QME schedule for production of supplemental reports by increasing the amount of reports that must be produced to close a case. As a QME, I have no control over these repeated requests, nor the approval of the requested workup or availability of the necessary medical records.

Therefore, I respectfully request that the parties assist in securing the necessary information as enumerated above and abstain from requesting any additional reports until ALL the information requested above is available for my review.

If the information is not available to the parties for legal or administrative reasons, that fact must be made clear to this Evaluator so I can proceed to estimate causation and impairment with the caveat that my professional opinion may be speculative, AND may be changed at a future date if new information becomes available, but it is the best that can be provided within reasonable medical probability with the information at hand.

I thank you for referring this Claimant to my practice. Please feel free to call if you have any questions regarding this report.

DISCLAIMER

Declaration Pursuant Title 8, CCR § 10606

The undersigned certifies that, where applicable, this report was prepared in compliance with Section 10606 "Physician's Reports as Evidence"

Disclosure of Information Pursuant to Section 4628 [(a), (b), (c), (j)]

Claimant:	Anisa Chaney
Exam Date:	April 22, 2021
Location of the Examination:	**OccMed, Inc. – Gardena** 1141 W. Redondo Beach Blvd., Suite 202 Gardena, CA 90247 (909) 335-2323
Examining Physician:	**Nelhs Betancourt, MD, MPH, DABT, CHCQM, CIME**
Specialties:	**Internal Medicine/Occupational Medicine** **Occupational Toxicology**

Date of Exam: April 22, 2021

Qualifications:

Diplomate, American Board of Internal Medicine, Certificate No: 121664
Qualified Medical Evaluator Certificate Number: 915187
American Board of Independent Medical Examiners, re-certified 2020
Diplomate, American Board of Toxicology, 2012, 2017
Medical College of Wisconsin, MPH Degree, 1998
Master's Degree in Public Health - Occupational Medicine
Board Certified Health Care Quality Management
Physician Advisor, Workers' Compensation
Medical Director, Occupational and Environmental Health Program, OccMed, Inc.
Occupational Medicine Consultant

If this report shows a Review of Records, the preliminary medical records review was conducted by a professional record transcribing unit. The resulting document was then reviewed by this Evaluator using the original records for reference, corrected, and supplemented as necessary. The transcription of this report was done by this evaluator using voice recognition software. The subscriber performed the final dictation, and a professional proofreader corrected the report for grammatical and typographical errors as well as for internal inconsistencies.

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, except as noted herein, that I believe to be true. Signed, dated below.

Pursuant to Section 5703

I declare under penalty of perjury that there has been no violation of Labor Code Section 139.3, in that I have not offered, delivered, received or accepted any rebate, refunds, 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. The contents of the report and bill are true and correct to the best of my knowledge.

Limited scope of this evaluation

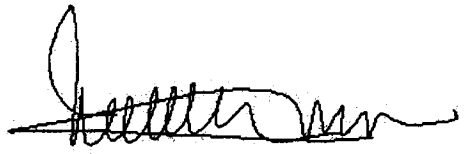
The scope of this report and any treatment offered, implemented or proposed by the health care provider signing below is specifically directed to address the issue(s) presented solely by the occupational injury, and not intended to address non-occupational medical conditions not related to the current injury. Therefore, the examination included herein is not to be construed as a complete medical exam for general health surveillance purposes.

Date of Exam: April 22, 2021

Pursuant to Labor Code Sec. 3208.3 (h)

If applicable under the circumstances set forth in this report, I defer to the Trier of Fact to determine if this is a Good Faith Personnel Action.

Signed this 19th day of May, 2021 at City of Corona, Riverside County, California.



Nelhs Betancourt, MD, MPH, DABT, CHCQM, CIME
BC Internal Medicine
BC Independent Medical Examiner
BC Health Care Quality Management
BC Occupational Toxicology
Occupational Medicine
Physician Advisor, Workers' Compensation

State of California
DIVISION OF WORKERS' COMPENSATION – MEDICAL UNIT

AME or QME Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))

Case Name: **Anisa Chaney** *(employee name)* v **Bold Quail Holdings, LLC** *(claims administrator name, or if none employer)*

Claim No.: **2080381794**

EAMS or WCAB Case No. *(if any)*: **ADJ13521045**

I, **SIMON THOMPSON** *(Print Name)*, declare:

1. I am over the age of 18 and not a party to this action.
2. My business address is: **1680 PLUM LANE, REDLANDS CA 92374**
3. On the date shown below, I served the attached original, or a true and correct copy of the original, comprehensive medical-legal report on each person or firm named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

A	depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.
B	placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.
C	placing the sealed envelope for collection and overnight delivery at an office [redacted] delivery carrier.
D	placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*
E	personally delivering the sealed envelope to the person or firm named below at the address shown below.

Means of service: *(For each addressee, enter A – E as appropriate)*	Date Served:	Addressee and Address Shown on Envelope:
A	05/20/21	Law Offices of Floyd, Skeren, Manukian & Langevin, LLP 215 N. Marengo Ave., Suite 201 Pasadena, CA 91101
A	05/20/21	Workers Defenders Law Group 8018 Santa Ana Canyon Rd., Suite 100.215 Anaheim, CA 92808
A	05/20/21	**Zurich- sent electronically**
A	05/20/21	

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date: 05/20/21

Simon Thompson
(signature of declarant)

SIMON THOMPSON
(print name)

QME Form 122
Rev. February 2009