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Electrodiagnostic Medicine

April 18, 2023

Name: Bhargav Shah
Date: April 18, 2023
Referring Physician: Frank Guellich, M.D.

ELECTROMYOGRAM (Upper Extremities)

An electromyogram was performed of both upper extremities and cervical paraspinous muscles. The muscles tested included the deltoid, biceps, triceps, pronator teres, first dorsal interosseous, opponens pollicis, and the cervical paraspinous muscles from C3 to T1 bilaterally.

In all muscles tested, there was electrical silence at rest, and the motor unit pattern was of normal number, amplitude and duration.

COMMENTS:

There is no EMG evidence of lower motor neuron or muscle disease in the areas tested.

IMPRESSION:

Normal EMG of both upper extremities and cervical paraspinous muscles.

ELECTROMYOGRAM (Lower Extremities)

An electromyogram was performed of both lower extremities and lumbar paraspinous muscles. The muscles tested included the quadriceps femoris, tibialis anterior, extensor hallucis longus, extensor digitorum brevis, gastrocsoleus, first dorsal interosseous and the lumbar paraspinous muscles from L2 to S1.

In all muscles tested, there was electrical silence at rest, and the motor unit pattern was of normal number, amplitude and duration.

COMMENTS:

There is no EMG evidence of lower motor neuron or muscle disease in the areas tested.

IMPRESSION:

Normal EMG of both lower extremities and lumbar paraspinous muscles.

NERVE CONDUCTION STUDY (Upper Extremities)

Bilateral Ulnar Nerves:

	RIGHT	LEFT	NORMAL
Proximal motor latency above the elbow is:	7.0 msec	7.5 msec	
With an amplitude of:	10 millivolts	10 millivolts	
Proximl motor latency below the elbow is:	6.0 msec	6.5 msec	
With an amplitude of:	10 millivolts	10 millivolts	
Distal motor latency of the wrist is:	2.0 msec	2.5 msec	< 4.0 msec
With an amplitude of:	10 millivolts	10 millivolts	> 6 millivolts
The distance above elbow to wrist is:	31 cm	31 cm	
Motor nerve conduction velocity above elbow to wrist is:	62 M/sec	62 M/sec	> 51 M/sec
Distance below elbow to wrist is:	25 cm	25 cm	
Motor nerve conduction velocity below elbow to wrist is:	63 M/sec	63 M/sec	> 51 M/sec
Sensory latency at the wrist is:	2.9 msec	3.0 msec	< 3.5 msec
With an amplitude of:	40 microvolts	40 microvolts	> 20 microvolts

Sensory latency at mid-palm is (orthodromic):	0.9 msec	1.0 msec	< 2.3 msec
With an amplitude of:	40 microvolts	40 microvolts	> 20 mcv

COMMENTS:

Nerve conduction study of both ulnar nerves reveals no delay in motor and sensory conduction. Also, motor nerve conduction velocity is within normal limits.

IMPRESSION:

Normal nerve conduction studies, motor and sensory, both ulnar nerves, above elbow to wrist and below elbow to wrist (no evidence of tardy ulnar palsy).

NERVE CONDUCTION STUDY

Bilateral Median Nerves:

	RIGHT	LEFT	NORMAL
Proximal motor latency above elbow to wrist:	7.2 msec	7.6 msec	
With an amplitude of:	10 millivolts	10 millivolts	
Distal motor latency at the wrist:	3.2 msec	3.6 msec	< 4.6 msec
With an amplitude of:	8 millivolts	8 millivolts	> 4 millivolts
The difference is:	4.0 msec	4.0 msec	
Distance from proximal to distal site of stimulation:	25 cm	25 cm	
Motor nerve conduction velocity:	63 M/sec	63 M/sec	> 48 M/sec
Sensory latency at the wrist:	2.8 msec	2.9 msec	< 3.8 msec
With an amplitude of:	40 microvolts	40 microvolts	>20 microvolts

Sensory latency at mid-palm is (orthodromic):	0.8 msec	0.9 msec	< 2.3 msec
With an amplitude of:	40 microvolts	40 microvolts	> 20 mcv

COMMENTS:

Nerve conduction study of both median nerves revealed no delay in motor or sensory conduction across the wrist. Also, motor nerve conduction velocity was well within normal limits.

IMPRESSION:

Normal nerve conduction studies, motor and sensory, both median nerves (no evidence of carpal tunnel syndrome).

NERVE CONDUCTION STUDY

Bilateral Superficial Radial Nerves:

	RIGHT	LEFT	NORMAL
Sensory latency at wrist	2.3 msec	2.3 msec	< 3.0 msec
With an amplitude of:	10.0 mcv	10.0 mcv	> 7 mcv

COMMENTS:

Nerve conduction study of the bilateral superficial radial nerves reveals no delay in sensory conduction across the wrists.

IMPRESSION:

Normal nerve conduction study, bilateral superficial radial nerves.

NERVE CONDUCTION STUDY (Lower Extremities)
BILATERAL PERONEAL NERVES

	Right	Left	Normal
Proximal motor latency above the knee is:	13.5 msec	13.5 msec	
With an amplitude of:	8 millivolts	8 millivolts	

Proximal motor latency below the knee is:	12.5 msec	12.5 msec	
With an amplitude of:	8 millivolts	8 millivolts	
Distal motor latency at the ankle is:	4.5 msec	4.5 msec	< 6.0 msec
With an amplitude of:	8 millivolts	8 millivolts	
Distance above knee to ankle:	48 cm	48 cm	
Motor nerve conduction velocity above knee to ankle is:	53 M/sec	53 M/sec	50 +/- 6 M/sec
Distance below knee to ankle:	42 cm	42 cm	
Motor nerve conduction velocity below knee to ankle is:	53 M/sec	53 M/sec	50 +/- 6 M/sec

COMMENTS:

Nerve conduction study of the peroneal nerves reveals no delay in motor conduction across the knee. Also, motor conduction velocity is well within normal limits.

BILATERAL POSTERIOR TIBIAL NERVES

Lateral Plantar Branch	**Right**	**Left**	**Normal**
Proximal latency above the knee is:	13.5 msec	13.5 msec	
With an amplitude of:	8 millivolts	8 millivolts	
Distal motor latency at the ankle is:	5.5 msec	5.5 msec	5.9+/-0.8 msec
With an amplitude of:	8 millivolt	8 millivolts	
The difference is:	8.0 msec	8.0 msec	
The distance from the proximal to distal sites of stimulation is:	42 cm	42 cm	

Motor nerve conduction velocity is:	53 M/sec	53 M/sec	51 +/- 6 M/sec
Medial Plantar Branch			
Proximal latency above the knee is:	13.0 msec	13.5 msec	
With an amplitude of:	8 millivolts	8 millivolts	
Distal motor latency at the ankle is:	5.0 msec	5.5 msec	5.3 +/- 0.8 msec
With an amplitude of:	8 millivolts	8 millivolts	
The difference is:	8.0 msec	8.0 msec	
The distance from the proximal to distal sites of stimulation is:	42 cm	42 cm	
Motor nerve conduction velocity is:	53 M/sec	53 M/sec	51 +/- 6 M/sec

COMMENTS:

Nerve conduction studies of the posterior tibial nerves, including medial and lateral plantar branches reveals no slowing conduction across the ankles. Also, nerve conduction velocity was well within normal limits.

IMPRESSION:

Normal nerve conduction studies, both posterior tibial nerves, medial and lateral plantar branches (no evidence of tarsal tunnel syndrome).

BILATERAL SURAL NERVES

	Right	**Left**	**Normal**
Sensory latencies at ankles	3.29 msec 40 microvolts	3.1 msec 40 microvolts	<4.5 msec

COMMENTS:

Nerve conduction study of the sural nerves reveals no delay in sensory conduction across the ankles.

IMPRESSION:

Nerve conduction studies of both sural nerves were normal.

Sincerely,

Ronald D. Levin, M.D.
Diplomate, American Board of
Electrodiagnostic Medicine

RDL:csc/0418shah

** INBOUND NOTIFICATION : FAX RECEIVED SUCCESSFULLY **

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May 17, 2023 at 5:03:30 PM EDT	Fax	67	2	Received

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SHAH, BHARGAV
MRN: 30999415
DOB: 05-01-1956 Sex: M
Phone:(714) 322-2674

Date of Service: 05-17-2023

EXAM: CT RIGHT SHOULDER ARTHROGRAPHY INJECTION

HISTORY: Pain. Prior surgery: No.

DOSE INFORMATION: The total DLP was 188 mGy-cm and the CTDI was 11.36 mGy. Low dose protocols were performed.

One or more of the following dose reduction techniques were used: automated exposure control, adjustment of the mA and/or kV according to patient size, use of iterative reconstruction technique. A total of 0 CT (Computed Tomography) examinations and 0 myocardial perfusion studies have been performed on this patient over the past 12 months. Counts as indicated include examinations performed within our network.

(Note: The above reported CTDIvol and DLP values are CT scanner radiation output related dose indices, and, as such, they do NOT represent actual patient dose estimates. A medical physicist should be consulted for specific questions regarding the radiation dose for this exam).

PROCEDURE: The patient was first informed of the nature of the procedure, alternatives, and risks. Questions were answered and informed consent was obtained. Timeout was performed.

The patient was placed on the CT table in the supine position. The right shoulder joint was prepped and draped in sterile fashion. The skin and subcutaneous tissues were anesthetized with 1% lidocaine. Using CT guidance, a 22 G needle was advanced into the joint. Approximately 11 mL mixture of Optiray 240, 0.1 mL Clariscan and saline was administered. The needle was removed.

The patient tolerated the procedure well and there were no immediate complications.

FINDINGS:

There is contrast material within the right shoulder joint.

IMPRESSION:

Successful CT guided arthrogram for MRI arthrogram. Please refer to MRI report.

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In compliance with recent Worker's Compensation legislation (Labor Code Section 4628 (j) and 5703 (a) and Insurance Code Section 556): I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and 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 described the information provided to me and, except as noted herein, that I believe it to be true. Furthermore, this evaluation is in compliance with the guidelines established by the Industrial Medical Council or Administrative Director pursuant to paragraph (5) of subdivision (j) of Labor Code Section 139.2 or 5307.6.

Signed by me in the County of Orange, this 17 day of 5 2023.

End of diagnostic report for accession: 37973701
Dictated: 05-17-2023 10:51:41 AM
Electronically Signed By: Nourisamie, Kourosh, MD 05-17-2023 10:51:41 AM

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SHAH, BHARGAV
MRN: 30999415
DOB: 05-01-1956 Sex: U
Phone:(714) 322-2674

Date of Service: 04-18-2023

EXAM: MRI LEFT KNEE WITHOUT CONTRAST

HISTORY: Lateral knee pain. Assess for lateral meniscus tear.

TECHNIQUE: MRI was performed on the GE Signa HD 1.5 Tesla magnet.

Axial FSE T2, coronal T1, coronal proton density with fat saturation, sagittal proton density with fat saturation, sagittal proton density weighted images were performed.

COMPARISON: No previous relevant examinations available for comparison.

FINDINGS:

The patella is not malpositioned. There is preserved cartilage associated with the central patellar apex and lateral patellar facet. However, there is grade 2+ chondral thinning of the medial patellar facet. This is best seen on image 14 of series 102. Findings confirmed on sagittal images 10 through 12 of series 106.

The extensor mechanism is intact. There is a small enthesophyte at the insertion of the quadriceps.

There is a joint effusion without a popliteal cyst.

The cruciate and collateral ligaments are intact. In the lateral compartment there is minimal cartilage thinning. There is no lateral meniscus tear. The popliteus tendon is normal.

In the medial compartment coronal image 10 of series 104 and axial image 20 of series 102 which shows a root avulsion tear of the posterior horn of the medial meniscus. The adjacent and partially extruded meniscal body shows some degree of enlargement due to mucoid changes which are internal.

In addition, there is chondromalacia of the femoral condyle and tibial plateau which is quite modest although there is a suggestion of very early osteoarthrosis.

IMPRESSION:

1. Chondromalacia patella, especially medial patellar facet. (See above)

2. Joint effusion.

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3. Chondromalacia medial tibiofemoral compartment.

4. Root avulsion tear of the medial meniscus. (See above).

In compliance with recent Worker's Compensation legislation (Labor Code Section 4628 (j) and 5703 (a) and Insurance Code Section 556): I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and 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 described the information provided to me and, except as noted herein, that I believe it to be true. Furthermore, this evaluation is in compliance with the guidelines established by the Industrial Medical Council or Administrative Director pursuant to paragraph (5) of subdivision (j) of Labor Code Section 139.2 or 5307.6.

Signed by me in the County of Orange, this 20 day of 4 2023.

End of diagnostic report for accession: 37979447
Dictated: 04-20-2023 2:21:47 PM
Electronically Signed By: Burnett, Keith, MD 04-20-2023 2:21:47 PM

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Date of Service: 04-18-2023

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EXAM: MRI RIGHT KNEE WITHOUT CONTRAST

HISTORY: Right knee pain.

TECHNIQUE: Imaging of the right knee was performed on a 1.5 Tesla MRI scanner with the following sequences obtained: Coronal T1 and PD FS, sagittal PD and PD FS, and axial T2.

COMPARISON: None available.

FINDING

The ACL and PCL are normal. The lateral meniscus is normal. The medial meniscus is normal. The medial and lateral collateral ligaments and the extensor mechanism appears normal. Small suprapatellar effusion without fracture. Mild patellofemoral narrowing is seen. Grade 3 medial patellar facet cartilage loss noted with grade 2 femoral trochlear cartilage loss. Mild medial and lateral femoral tibial joint space narrowing is seen, grade 2/3 lateral and grade 3 medial joint line cartilage loss noted. 5 mm posterior joint body seen. The posterior neural vascular structures are normal. The popliteus muscle and tendon appears normal.

IMPRESSION:

1. ACL, PCL, menisci, collateral ligaments and extensor mechanism are intact.
2. Tricompartmental degenerative changes as described, small joint effusion, no acute fracture seen.
3. There is a 5 mm joint body seen within the posterior joint space.

In compliance with recent Worker's Compensation legislation (Labor Code Section 4628 (j) and 5703 (a) and Insurance Code Section 556): I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and 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 described the information provided to me and, except as noted herein, that I believe it to be true. Furthermore, this evaluation is in compliance with the guidelines established by the Industrial Medical Council or Administrative Director pursuant to paragraph (5) of subdivision (j) of Labor Code Section 139.2 or 5307.6.

Signed by me in the County of Orange, this 23 day of 4 2023.

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SHAH, BHARGAV
MRN: 30999415
DOB: 05-01-1956 Sex: M
Phone:(714) 322-2674

Date of Service: 05-19-2023

EXAM: CT LEFT SHOULDER ARTHROGRAPHY INJECTION

HISTORY: Pain. Prior surgery: No.

DOSE INFORMATION: The total DLP was 174 mGy-cm and the CTDI was 10.8 mGy. Low dose protocols were performed.

One or more of the following dose reduction techniques were used: automated exposure control, adjustment of the mA and/or kV according to patient size, use of iterative reconstruction technique. A total of 1 CT (Computed Tomography) examinations and 0 myocardial perfusion studies have been performed on this patient over the past 12 months. Counts as indicated include examinations performed within our network.

(Note: The above reported CTDIvol and DLP values are CT scanner radiation output related dose indices, and, as such, they do NOT represent actual patient dose estimates. A medical physicist should be consulted for specific questions regarding the radiation dose for this exam).

PROCEDURE: The patient was first informed of the nature of the procedure, alternatives, and risks. Questions were answered and informed consent was obtained. Timeout was performed.

The patient was placed on the CT table in the supine position. The left shoulder joint was prepped and draped in sterile fashion. The skin and subcutaneous tissues were anesthetized with 1% lidocaine. Using CT guidance, a 22 G needle was advanced into the joint. Approximately 11 mL mixture of Optiray 240, 0.1 mL Clariscan and saline was administered. The needle was removed.

The patient tolerated the procedure well and there were no immediate complications.

FINDINGS:

There is contrast material within the left shoulder joint.

IMPRESSION:

Successful CT guided arthrogram for MRI arthrogram. Please refer to MRI report.

RAF/HCC: No.

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In compliance with recent Worker's Compensation legislation (Labor Code Section 4628 (j) and 5703 (a) and Insurance Code Section 556): I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and 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 described the information provided to me and, except as noted herein, that I believe it to be true. Furthermore, this evaluation is in compliance with the guidelines established by the Industrial Medical Council or Administrative Director pursuant to paragraph (5) of subdivision (j) of Labor Code Section 139.2 or 5307.6.

Signed by me in the County of Orange, this 19 day of 5 2023.

End of diagnostic report for accession: 37973930
Dictated: 05-19-2023 10:56:48 AM
Electronically Signed By: Nourisamie, Kourosh, MD 05-19-2023 10:56:48 AM

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SHAH, BHARGAV
MRN: 30999415
DOB: 05-01-1956 Sex: M
Phone:(714) 322-2674

Date of Service: 04-19-2023

EXAM: MRI CERVICAL SPINE WITHOUT CONTRAST

HISTORY: Neck pain and arm pain

TECHNIQUE: Multisequence and multiplanar MRI of the cervical spine was performed on a 1.5 Tesla MRI scanner without contrast.

COMPARISON: None available.

FINDINGS:

The cervical spine is visualized from the craniocervical junction through inferior T2 level.

Postoperative changes of anterior cervical discectomy and fusion seen at C4-C5.

The vertebral body heights are preserved. Modic type II endplate changes are seen at C5-C6 and C6-C7. No suspicious osseous lesions. There is straightening of the cervical spine without discrete spondylolisthesis. There is mild levoconvex curvature centered at the cervicothoracic junction. Multilevel intervertebral disc height loss which is worst and moderate to severe at C6-C7.

C2-3: No disc bulge or protrusion. No spinal canal stenosis. No foraminal narrowing.

C3-4: Broad-based 1 to 2 mm disc protrusion indents the thecal sac. No spinal canal stenosis. Uncovertebral hypertrophy results in mild bilateral foraminal narrowing.

C4-5: Surgical level. Mild residual narrowing of the thecal sac. Uncovertebral hypertrophy and facet arthrosis results in mild right and moderate left foraminal narrowing.

C5-6: Broad-based 1 to 2 mm disc protrusion partially effaces the thecal sac. Mild spinal canal stenosis. Uncovertebral hypertrophy and facet arthrosis results in mild bilateral foraminal narrowing.

C6-7: Broad-based 1 to 2 mm disc protrusion partially effaces the thecal sac. No spinal canal stenosis. Uncovertebral hypertrophy and facet arthrosis results in moderate bilateral foraminal narrowing.

C7-T1: Broad-based 2 mm disc protrusion indents the thecal sac. No spinal canal stenosis. No foraminal narrowing.

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Normal cord signal.

The cervical soft tissues are unremarkable.

IMPRESSION:

1. Mild narrowing of the thecal sac/spinal canal stenosis at C4-C5 and C5-C6.
2. Multilevel mild-to-moderate foraminal narrowing.
3. Normal cord signal.
4. Postoperative changes of ACDF at C4-C5.

In compliance with recent Worker's Compensation legislation (Labor Code Section 4628 (j) and 5703 (a) and Insurance Code Section 556): I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and 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 described the information provided to me and, except as noted herein, that I believe it to be true. Furthermore, this evaluation is in compliance with the guidelines established by the Industrial Medical Council or Administrative Director pursuant to paragraph (5) of subdivision (j) of Labor Code Section 139.2 or 5307.6.

Signed by me in the County of Orange, this 26 day of 4 2023.

End of diagnostic report for accession: 37973165
Dictated: 04-26-2023 8:33:06 AM
Electronically Signed By: Patel, Sagar, MD 04-26-2023 8:33:06 AM

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Exam requested by:FRANK GUELLICH MD

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SHAH, BHARGAV
MRN: 30999415
DOB: 05-01-1956 Sex: M
Phone:(714) 322-2674

Date of Service: 04-19-2023

EXAM: MRI LUMBAR SPINE WITHOUT CONTRAST

HISTORY: Back pain

TECHNIQUE: Multisequence and multiplanar imaging of the lumbar spine was performed on a 1.5 Tesla MRI without contrast.

COMPARISON: None available.

FINDINGS:

For the purposes of this examination the last fully formed intervertebral disc space is L5-S1.

The vertebral body heights are preserved. Degenerative Modic type II endplate changes are seen at L5-S1. Multilevel small benign hemangiomas are also seen. There is no significant spondylolisthesis or scoliosis. Severe disc height loss at L5-S1. Mild disc height loss at T12-L1 and L3-L4.

T12/L1: Diffuse disc bulge. No facet hypertrophy. Mild spinal canal stenosis. No left foraminal narrowing. Mild to moderate right foraminal narrowing.

L1/L2: Diffuse disc bulge with thickening of ligamentum flavum. No facet hypertrophy. No spinal canal stenosis. Mild bilateral foraminal narrowing.

L2/L3: Mild diffuse disc bulge with thickening of the ligamentum flavum and minimal facet arthrosis. No spinal canal stenosis. Mild bilateral foraminal narrowing.

L3/L4: Diffuse disc bulge with thickening of the ligament flavum and mild facet arthrosis. Slightly increased bilateral facet joint fluid seen. Mild spinal canal stenosis. Moderate bilateral foraminal narrowing with abutment and slight deformity of the exiting L3 nerve roots.

L4/L5: Diffuse disc bulge with thickening of the ligamentum flavum and moderate facet arthrosis. There are bilateral facet joint effusions. There is effacement of the right greater than left lateral recesses with possible impingement of the traversing L5 nerve roots. Moderate to severe spinal canal stenosis. Moderate to severe bilateral foraminal narrowing with abutment and slight deformity of the exiting L4 nerve roots.

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L5/S1: Diffuse disc bulge with mild to moderate facet arthrosis. No spinal canal stenosis. Moderate left and mild right foraminal narrowing. There is abutment of the exiting left L5 nerve root

The posterior paraspinal soft tissues appear unremarkable. 9 mm rounded T1 and T2 hypointensity in the right ilium is nonspecific.

There is crowding of the cauda equina at L4-L5. The remaining cauda equina nerve roots appear unremarkable without thickening or clumping. The conus terminates normally at L1.

IMPRESSION:

1. Moderate to severe spinal canal stenosis at L4-L5 with possible impingement of the traversing L5 nerve roots.
2. Mild spinal canal stenosis at T12-L1 and L3-L4.
3. Multilevel foraminal narrowing which is worst and moderate to severe at L4-L5. There is deformity of multiple exiting nerve roots as detailed above.
4. A focal 9 mm T1 hypointensity in the right iliac bone is nonspecific and favors a benign etiology such as a lipid poor hemangioma, although neoplasm is not excluded.

In compliance with recent Worker's Compensation legislation (Labor Code Section 4628 (j) and 5703 (a) and Insurance Code Section 556): I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and 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 described the information provided to me and, except as noted herein, that I believe it to be true. Furthermore, this evaluation is in compliance with the guidelines established by the Industrial Medical Council or Administrative Director pursuant to paragraph (5) of subdivision (j) of Labor Code Section 139.2 or 5307.6.

Signed by me in the County of Orange, this 26 day of 4 2023.

End of diagnostic report for accession: 37973164
Dictated: 04-26-2023 8:42:42 AM
Electronically Signed By: Patel, Sagar, MD 04-26-2023 8:42:42 AM

Copy to:ONE CALL CARE DIAGNOSTICS BROKER
Exam requested by:FRANK GUELLICH MD

Declaration Pursuant to Cal. Code Regs., Title 8, § 9793(n)

Injured Worker:	**BHARGAV K. SHAH**
Claims Administrator:	**Disney Anaheim**
Claim #:	**DLRW2018083560**
DOI:	**7/3/2018**
WCAB:	**ADJ15867699**

I, DANIEL MONROY, declare:

I am a **SR. CLAIMS EXAMINER** for Disney Anaheim, the claims administrator for the employer, Disneyland Resort, PSI, a party to this action and the provider of documents herein. Pursuant to Cal. Code Regs., Title 8, § 9793(n), I declare as the provider of the documents that we have complied with the provision of Labor Code § 4062.3 before providing the documents to the physician.

I declare that **the total additional page count of the documents provided to Dr. Guelich/QME is** 21 (which includes this declaration).

I declare under penalty of perjury under the law of the State of California that the foregoing statements are true and correct.

Executed on 6/20/2023 , at ANAHEIM, California.

Daniel Monroy

DANIEL MONROY
SR. CLAIM EXAMINER
DISNEY ANAHEIM/DISNEYLAND RESORT

6/20/2023
DATE

Dr. GUELICH: LEASE REVIEW THE MRI REPORT AND THE CT REPORTS THAT YOUR EQUESTED IN YOUR REPORT DATED 4/10/23. PLEASE SEND US YOUR SUPPLMENTAL REPORT ONCE YOU REVIEW THE DOCUMENTS.

THANK YOU.

Re: Bhargav K. Shah
File: DLRW2018083560
DOI: 7/3/2018
ADJ15867699

PROOF OF SERVICE

1013a (3) CCP Revised 5/1/88

STATE OF CALIFORNIA, COUNTY OF ORANGE

I am employed in the county aforesaid, I am over the age of 18 and not a party to the within action; my business address is:

Walt Disney Parks & Resorts US, Inc.
Workers' Compensation Department
P.O. Box 3909
Anaheim, CA 92803

On **6/20/2023**, I served the foregoing document described as:

FILING AND SERVING ADDITIONAL MEDS TO QME

- **DECLARATION FORM**
- **COPIES OF ADDITIONAL MEDICALS ATTACHED**

On **the parties listed below** in this action by placing a true copy thereof enclosed in sealed envelopes addressed as follows:

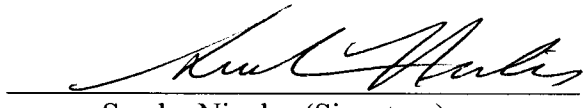
Dr. Guelich/QME
Examworks
15350 Sherman Way, Site 240
Van Nuys, CA 91406

Workers Defenders Law
751 S. Weir Canyon Road, suite 157-455
Anaheim, CA 92808

I, **Sandra Nicolas**, am "readily familiar" with the Company's practice of collection and processing correspondence for mailing. Under the practice it would be deposited with U.S. Postal Service on that same day with postage thereon fully prepaid at Anaheim, California in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing in affidavit.

Executed on **6/20/2023** at Anaheim, California.

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



Sandra Nicolas (Signature)