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December 6, 2019

Athens Administrators
P.O. Box 696
Concord, CA 94522

Re:	Benetia Young
WCAB #:	ADJ12620825
Claim #:	19006760
Employer:	Star View Adolescent Center
SSN:	547-08-0936
DOB:	1/8/1965
DOI:	CT: 04/18/2019-10/10/2019

THREE-DAY LETTER

To Whom It May Concern:

Please be advised that the aforementioned person has been provided with psychological consultation, evaluation, treatment and management services for a claimed industrial injury. Attached is the Doctor's First Report of Occupational Injury or Illness.

There will be an initial comprehensive psychological evaluation report to follow in a few days with an attachment of a formal request for authorization for treatment at that time. In the interim, please feel free to telephone my office to discuss this case with my staff or with me personally. There will be more detailed reports to follow.

Yours truly,

Gayle Windman, Ph.D.

cc: Natalia Foley, Esq.

STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the self-insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of this report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

	PLEASE DO NOT USE THIS COLUMN
1. INSURER NAME AND ADDRESS Athens Administrators P.O. Box 696 Concord CA 94522	
2. EMPLOYER NAME Star View Adolescent Center	Case No.
3. Address No. and Street City Zip 4025 W 26th Street Torrance, CA 90505	Industry
4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes)	County
5. PATIENT NAME (first name, middle initial last name) Benetia Young — 6. Sex ☐ Male ☒ Female — 7. Date of Birth Mo Day Yr 1/8/1965	Age
8. Address: No. and Street City Zip 20322 S Amantha Ave., Carson, CA 90746 — 9. Telephone number [1] 310-415-1029	Hazard
10. Occupation (Specific job title) Shift Lead — 11. Social Security No. 547-08-0936	Disease
12 Injured at No. and Street City County Star View Adolescent Center 4025 W 26th Street, Torrance, CA 90505	Hospitalization
13. Date and hour of injury or onset of illness Mo. Day Yr. CT: 04/18/2019-10/10/2019 Hour ______ a.m. ______ p.m. — 14. Date last worked Mo. Day Yr. 10/25/2019	Occupation
15. Date and hour of first Examination or treatment Mo. Day Yr. 11/18/2019 Hour ______ a.m. ______ p.m. — 16. Have you (or your office) previously treated patient ☐ Yes ☑ No	Return Date/Code

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. **DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED** (Give specific object, machinery or chemical. Use reverse side if more space is required.)
Due to attack by a patient at the workplace.

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use reverse side if more space is required)
Stress, anxiety, flashbacks, headache, sleep loss, neck/shoulder/low back tension/pain, TMJ/dental reaction, nausea, chest pain, shortness of breath and high blood pressure.

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required)
A. Physical Examination N/A B. X-ray and laboratory results (State if none or pending.) N/A

20. **DIAGNOSIS** (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? ☐ Yes ☐ No
F32.9 Major Depressive Disorder, Single Episode F41.1 Generalized Anxiety Disorder F54 Psychological Factors Affecting Other Medical Conditions

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? ☑ Yes ☐ No If "no", please explain.

22. Is there any other current condition that will impede or delay patient's recovery? ☐ Yes ☑ No If "yes", please explain.

23. **TREATMENT RENDERED** (Use reverse side if more space is required.) Evaluation/Psychotherapy and prescriptions through the medical staff at this office

24. If further treatment required, specify treatment plan / estimated duration. Six (6) cognitive behavior psychotherapy (CBT) sessions over the next two months. Because of the severity and urgency of the need for treatment, there will be the immediate provision of prescriptions as needed in addition to weekly psychotherapy to be initiated as soon as possible.

25. If hospitalized as inpatient, give hospital name and location N/A Date Mo. Day Yr. Estimated Stay

26. **WORK STATUS**- Is patient able to perform usual work? ☐ Yes ☑ No Patient is TTD
If "no", date when patient can return to: Regular work: ______________ Modified work: ______________
Specify restrictions: Would the employer please initiate a good faith interactive process with the employee relevant to the appropriate work conditions necessary to accommodate the medical condition

Doctor's Signature ______________________ CA License Number PSY 19944
Doctor Name and Degree (please type): **Dr. Gayle Windman, Ph.D.** IRS Number 95-4581634
Address: 14531 Hamlin Street, Van Nuys, CA 91411 Telephone (818) 780-4409

FORM 5021 (Rev. 4) 1992

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying Workers' Compensation benefits or payments is guilty of a felony.