Lawrence M. Richman, M.D.

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March 25, 2021

DEPARTMENT OF INDUSTRIAL RELATIONS
Subsequent Injury Benefit Trust Fund
1750 Howe Avenue, Suite 370
Sacramento, California 95825-3367

WORKERS DEFENDERS LAW GROUP
8018 East Santa Ana Canyon, Suite 100-215
Anaheim Hills, California 92808
Attention: Natalia Foley, Esquire

EMPLOYEE	**BENETIA YOUNG**
EMPLOYER	Star View Adolescent Center
D/INJURY	CT January 22, 2018 – March 9, 2018; April 18, 2019
SIBTF NO.	Pending
WCAB NO.	ADJ12213522; ADJ12620825
DATE OF BIRTH	January 8, 1965
EXAM DATE	March 25, 2021

COMPREHENSIVE INDEPENDENT MEDICAL NEUROLOGIC SIBTF EVALUATION REPORT

Gentlepersons:

Per your request I performed an Independent Medical-Legal Evaluation of the above-noted applicant to determine eligibility for the Subsequent Injury Benefits Trust Fund pursuant to Labor Code 4751. This evaluation is not for the applicant's current function and is not related to their above-noted industrial injury. This evaluation is being performed to address the applicant's pre-existing disability to differing body parts, other than the industrial injury. I have been authorized to evaluate the industrial injury and any pre-existing problems. I have also been advised to order further evaluations if needed from other specialists.

The Applicant was informed that a doctor-patient relationship was not established today and that a copy of my medical-legal report would be sent to the requesting parties. This history and physical is not intended to be construed as a general or complete medical evaluation; it is intended solely for medical-legal purposes and focuses on those issues in question by the parties. By performing this medical-legal examination, no treatment relationship is established or implied.

This examination was performed in the county of Los Angeles at 2760 East Florence Avenue, Huntington Park, California 90255 on March 25, 2021.

ML104-95

Causation is addressed per written request
Apportionment is addressed between 2 ore more injuries/causes to 2 or more body systems

Face-to-face time	2 hours
Review of medical records (500 pages)	4 hours and 45 minutes
Review of deposition dated 10/09/19 (58 pages)	1 hour
Report preparation and review	4 hours and 30 minutes
Report editing	1 hour and 30 minutes

THE TIME REQUIRED FOR THIS PHYSICIAN TO ISSUE THE REPORT: 13 hours and 45 minutes.

This report is billed as a ML104 with Regulation 9795.

Thank you for asking me to perform an Independent Medical Evaluation in neurology in order to determine a disability for the Subsequent Injury Benefits Trust Fund, pursuant to Labor Code 4751. I have personally evaluated this patient and prepared this report.

INTRODUCTION

Per Labor Code 4751: If an employee, who is permanently and partially disabled receives a subsequent compensable injury resulting in additional permanent / partial disability, so that the degree of disability caused by the combination of both disabilities is greater than that which would have resulted from the subsequent injury alone, on the combined effect of the last injury on the previous disability or impairment, is a permanent disability equal to 70% or more of the total, he/she shall be paid in addition to the compensation due under the code for the permanent disability caused by the last injury, compensation of the remainder of the combined permanent disability existing up to the last injury, as provided in this article: provided, that either (a) the previous disability or impairment affected a hand, an arm, a foot, a leg or an eye, on the permanent disability resulting from the subsequent injury affects the opposite and corresponding member, and such allowed permanent disability, when considered alone and without regard to, or adjustment for, the occupation or age of the employee, is equal to 5% or more of the total, or (b) the permanent disability resulting from the subsequent injury, when considered alone and without regard to or adjustment for the occupation or the age of the employee, is equal to 35% or more of the total.

The Subsequent Injury Benefits Trust Fund (SIBTF) liability deals with pre-existing impairment and/or pre-existing disability. In other words, disability which was present prior to the industrial injury noted above. In essence, we are looking into the past to determine to what extent the injured worker was disabled, at some time prior to the settled industrial injury noted above.

A contemporaneous and retrospective review of the medical history and medical records is performed to determine if it is medically probable that there was labor disabling impairment, which pre-existed the date of the last injury in question and whether or not the sum of the combined industrial and nonindustrial impairment rates to 70% disability or more. Prior impairment ratings for industrial injuries are reviewed for accuracy and if necessary, re-rated.

INITIAL SIBTF SUMMARY:

1. **Did the worker have an industrial injury?**
   Answer – Yes on 4-18-2019. The applicant reports being subjected to repetitive trauma / continuous trauma involving the spine and shoulders, as well as working in a hostile work environment causing her emotional stress, anxiety and depression. She also notes being assaulted several times by clients in the facility where she worked. On one occasion sustained blunt head trauma and was dazed, but did not lose consciousness. She experiences difficulty with memory that has persisted to the present. She also reports having experienced headaches that have persisted to the present. Other complaints reported by the patient due to continuous trauma include pain in the shoulders and lower limbs.

2. **Did the industrial injury rate to a 35% disability without modification for age and occupation?**
   Answer – Not known. Please defer to a specialist in orthopedics to readdress the musculoskeletal injuries.

3. **Did the worker have a pre-existing labor-disabling permanent disability?**
   Answer – Yes. Prior to the patient's industrial injury, she reported a history of hypertension. She reported a history of a brain tumor diagnosed at the age of 28 for which she was treated at Kaiser Permanente. She is unaware of any visual or memory complaints related to the brain tumor. There has been no history of seizures from the brain tumor. The extent and impact of the patient's brain tumor is not known without the patient undergoing further assessment and evaluation, including neuropsychology testing and brain imaging. The hypertensive condition should be assessed by a board certified internal medical specialist.

4. **Did the pre-existing disability affect an upper or lower extremity or eye?**
   Answer – Please defer to a specialist in orthopedics to readdress the musculoskeletal injuries.

Did the industrial permanent disability affect the opposite or corresponding body part?
Answer – Yes. The medical records indicate that the patient had symptomatology of the bilateral shoulders, more so on the left. Please defer to a specialist in orthopedics to readdress the musculoskeletal injuries.

5. **Is the total disability equal to or greater than 70% after modification?**
Answer – Unknown.

6. **Is the employee 100% disabled or unemployable from other pre-existing disability and work duties together?**
Answer – Unknown.

7. **Is the employee 100% disabled from the industrial injury?**
Answer – No.

8. **Additional records reviewed?**
Answer – Yes. See record summary below.

9. **Are evaluations or diagnostics needed?**
Answer – Yes. The patient requires an internal medical evaluation for hypertension and other internal medical conditions, a repeat brain scan / MRI scan, a psychiatric consultation and neuropsychological consult and testing. I recommend a specialist in orthopedics readdress the musculoskeletal injuries and an audiologist for hearing loss complaints.

SUMMARY OF SURGICAL AND MEDICAL PROBLEMS:

The patient is a 56-year-old right-hand female, who was subjected to repetitive trauma during the course of her employment. She has pain in the spine, shoulders and radicular symptoms from continuous trauma. She was also assaulted during the course of her employment, as well as subjected to harassment at work.

In an Application For Adjudication Of Claim dated May 21, 2019 refers to an injury date of April 18, 2019 when she was attacked by a client and drug by the client injuring her neck, shoulders, scapula and back. There was also a continuous trauma claim filed for January 23, 2018 through March 9, 2018 for stress and strain from repetitive motion, an injury to both shoulders, lower back, lower limbs, stress, depression and anxiety due to a hostile work environment.

There is a Compromise & Release for the continuous trauma claim of January 23, 2018 through March 9, 2018 for the entire neck, entire back, both shoulders, both lower limbs, stress, anxiety and depression.

There is a Compromise & Release for an injury on April 18, 2019 to the neck, head, spine, headaches, shoulders, face, ears and psyche.

The medical records refer to the patient having anxiety, problems with sleep, dizziness, headaches, muscle pain, difficulty with concentration and reference to post-concussive symptoms.

PRE-EXISTING MEDICAL OR SURGICAL PROBLEMS:

Based on the history provided by the patient, there is a pre-existing history of hypertension which beyond my area of expertise and should be addressed by a board certified internal medical specialist.

There is a prior history of a brain tumor that caused an impairment at the age of 28. The patient is not aware of any visual or memory complaints. This does not necessarily mean that there may not be an underlying neuropsychologic impairment.

The medical records reviewed did not refer to any other significant or labor-disabling underlying pre-existing nonindustrial neurological disorders.

She did undergo a psychological evaluation with Dr. Windman, Ph.D. on December 9, 2019. The patient did report acidity of the stomach, abdominal cramping and stress related constipation and diarrhea, which appear to be a part of the patient's industrial claim / industrially related symptoms. She experienced insomnia.

Other complaints included blurred vision, loss of balance, sensitivity to noise and light, diminished libido and cognitive impairment, which may represent a longstanding disorder. She was diagnosed with major depressive disorder and psychologic factors affecting medical conditions.

She was evaluated by orthopedic Panel Qualified Medical Evaluator on January 10, 2020 and diagnosed with a sprain of the cervical spine and sprain of the lumbar spine.

In her deposition dated October 9, 2019, it is reported that the patient is overweight with her weight being 165 pounds. She discussed her prior and current claims. She described the incident which was described as being assaulted by her client and injured. She was taken off work for a few days. The client was arrested. She was able to return to work at full duty following the incident. She complained of headaches, pain in the spine, shoulders and emotional more than memory problems.

ACTIVITIES OF DAILY LIVING:

The patient reports problems with constipation and incontinence, possibly indicating the presence of Irritable Bowel Syndrome which should be addressed by an industrial neurologist. She has impaired sleep due to pain, averaging three to four hours of sleep per night. She scores 5 out of 24 on the Epworth Sleepiness Scale. She feels less alert the following day. She has gained 60 pounds.

She is not sexually active and has lost her desire.

She reports difficulty with hearing due to the specific injury at work from her head being struck.

REVIEW OF RECORDS

In compliance with Labor Codes 4062.3 (d), 4628 (a) (2), and Title 8 CCR 10606 and Title 8 CCR 41 (b)(2), attached at the end of this report is a listing and summary of the records that I received, reviewed, and relied upon in the preparation of this report.

NEUROLOGICAL EXAMINATION:

CRANIAL NERVE EXAMINATION:

Cranial nerves II-XII are serially tested and are within normal limits with the exception of diminished auditory acuity in the left ear to finger rub which should be addressed by a board certified otolaryngologist.

MOTOR EXAMINATION:

There is a normal motor examination. The patient showed full (5/5) motor force of the upper and lower limbs without evidence of wasting, weakness or fasciculations.

SENSORY EXAMINATION:

The patient has diminished sensation of the left hand.

DEEP TENDON REFLEXES:

All reflexes are 1+.

COORDINATION:

Finger-to-nose testing was normal.

PATHOLOGIC REFLEXES:

Babinskis are absent.

GAIT AND STATION:

The patient has a normal gait and normal tandem. Romberg tests are negative.

CLINICAL IMPRESSIONS:

1. A specific injury while employed by Star View Adolescent Center with the patient sustaining injuries to the head, neck, shoulders and back.
2. History of continuous trauma involving the spine, shoulders, lower limbs and headaches due to the patient's employment for Star View Adolescent Center, pre-existing to the subsequent injury.
3. History of hypertension, pre-existing.
4. Hearing loss in the left ear, pre-existing.
5. Brain tumor pre-existing.
6. Cognitive disturbance, possibly, in part industrial and in part pre-existing.

DISCUSSION:

Ms. Young is a supervisor and youth counselor who was previously employed by Star View Adolescent Center, who was subjected to continuous trauma during the course of her employment. She also worked in a hostile work environment and experienced emotional complaints, including depression.

She sustained an assault on May 21, 2019 with injuries to the head, neck, shoulders and back. It is unclear whether there was any significant head injury from this assault. The patient does report difficulty with memory, per the medical records. She does report difficulty with figuring out solutions for day-to-day problems, keeping track of time and time relationships from the Clinical Dementia Rating Scale from Table 13-5 which would support an impairment rating in Class I of Table 13-4.

The patient does have a pre-existing brain tumor which was treated at Kaiser Permanente. It is likely that this would be impacted due to the brain tumor and its treatment with respect to her cognitive complaints. It is unclear whether there was any significant injury to the head during the course of her employment. It is my best estimate that the patient qualifies for a 5% whole person impairment from Table 13-6, based on the limited information available to me at this time on a nonindustrial basis. The patient requires neuropsychological testing and an MRI scan of the brain.

Her hypertension should be addressed by a board certified internal medical specialist. The hearing loss in the left ear should be evaluated by an otolaryngologist.

In my opinion, at the present time, 100% apportionment of her cognitive complaints are due to the pre-existing brain tumor pending further review.

Her current headache complaints, in my opinion, are modest and qualify for a 1% whole person impairment with 100% apportionment of permanent disability due to industrial factors. This has already been incorporated into her prior settlement / assignment for Workers' Compensation claim, as noted in the Compromise & Release of February 15, 2020, which includes headaches. Neither of the Compromises & Releases refers to a cognitive impairment, but rather anxiety and depression.

Neurologic Subjective Factors of Disability

- Difficulty with memory.
- Difficulty with figuring out solutions for day-to-day problems.
- Difficulty with keeping track of time and time relationships.
- Headache complaints.
- Diminished auditory acuity in the left ear.

Please defer to the other recommended specialists for other Subjective Factors of Disability.

Objective Factors and Findings

- The patient has diminished sensation of the left hand.

Please defer to the other recommended specialists for other Objective Factors and Findings.

AMA IMPAIRMENT RATING, 5TH ED.

IMPAIRMENT ARRISING OUT OF THE SUBSEQUENT INJURY

She does report difficulty with difficulty figuring out solutions for day-to-day problems, keeping track of time and time relationships from the Clinical Dementia Rating Scale from Table 13-5 which would support an impairment rating in Class I of Table 13-4.

Her current headache complaints, in my opinion, are modest and qualify for a 1% whole person impairment.

PRE-EXISTING IMPAIRMENTS

It is my best estimate that the patient qualifies for a 5% whole person impairment from Table 13-6, based on the limited information available to me at this time on a pre-existing basis due to the

brain tumor. Should neuropsychological testing and an MRI scan of the brain be performed, I would be glad to review that information and provide a supplemental report.

APPORTIONMENT

In my opinion, at the present time, 100% apportionment of her cognitive complaints are due to the pre-existing brain tumor pending further review and 0% to the subsequent industrial injury.

Her current headache complaints, in my opinion, are modest and qualify for a 1% whole person impairment with 100% apportionment of permanent disability due to industrial factors and 0% to prior injuries or underlying condition.

There are likely many other per-existing impairments which should be evaluated by the appropriate specialists listed below.

SPECIALTY REFERRAL

It is my medical opinion that the claimant needs the following specialist evaluations to more specifically address possible impairment and disabilities which are outside my scope of expertise:

1. **Mental Health Specialist**: For the multitude psychiatric concerns.

2. **Neuropsychologist:** For the brain injuries, cognitive concerns, and brain tumor impact. A brain MRI may be helpful.

3. **Musculoskeletal Specialist (Ortho, Chiro or PM&R):** For the spine and other musculoskeletal concerns and to verify the impairments within the C&R.

4. **Internal Medicine:** For all internal medical and hypertensive issues.

5. **Audiologist:** For the hearing loss complaints

REASONS FOR OPINION

1. History as related by the patient.
2. Findings on examination.
3. Review of the medical file.
4. Consistency of the objective findings with subjective complaints.
5. Genuineness of the patient.

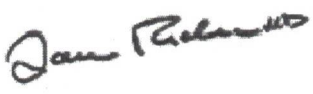
If I can be of further assistance regarding this case, please do not hesitate to contact this office.

SOURCE OF ALL FACTS AND DISCLOSURE:

The source of all facts was the history given by the examinee and review of the previous examiner's medical reports. I personally interviewed the examinee, performed the physical examination, reviewed the history with the examinee, reviewed the medical records provided, dictated this report and it reflects my professional observations, conclusions and recommendations. Face-to-face time conformed with DWC Guidelines. I declare under penalty of perjury that the information contained in this report and its attachments, if any, are true and correct to the best of my knowledge and belief, except as to the information that I have indicated and received from others. As to this information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true. Labor Code 139.3 was not violated. Assistance with preparation of this report was provided by Rena Martinez, Assistant and Rapid Care, Record Summarizer, each of whom were trained by Arrowhead Evaluation Services, Incorporated. Please note that all times listed reflect physician time spent and not staff time.

Date of Report: March 25, 2021. Signed this 07th day of May, 2021 at San Bernardino County, California.

Yours truly,



Lawrence M. Richman, M.D., Diplomate (Neurology),
American Board of Psychiatry and Neurology,
Diplomate, American Board of Electrodiagnostic Medicine,
Fellow, American Association of Neuromuscular and Electrodiagnostic Medicine,
NIH Fellowship, Neurovestibular Disorders and Neuro-Ophthalmology
LMR/kdp

REVIEW OF MEDICAL RECORDS:

Job Description: Employed at Star View as a Youth Counselor IV. Duties and Responsibilities: Child Care Duties: Supervise, protect and care for children individually and in groups at all times. Promotes and assists adolescents with self-help skills in the areas of eating, hygiene and grooming and other activities. Assist children in working in groups and in handling individual problems. Provide day-to-day supervision and care of children, including assistance with activities of daily living, personal care, planned activities, and school. Models and supports positive youth development and positive behavioral self-management through praise, attention, and use of behavioral incentive system. Attend and participate in morning rounds, change of shift meetings, and treatment team meetings as scheduled on the assignment sheet. Conducts or assists

both large and small activity groups. Encourages adolescent's interaction and socialization with other peers, providing feedback to adolescents on appropriate behavior while acting as a role model. L Participate in ProAct Team assignments and activities. Note children's progress in daily progress notes. Make sure children get up each morning; attend to their brushing, toileting, etc. personal hygiene (bathing, tooth. Assist and direct children with making beds, clean their rooms, dressing appropriately and getting ready for school or activities. Get clients to their meals and monitor their eating behavior and dietary intake. Make sure clients get to school each morning, to Day Treatment Groups, and provide supervision while they are in school and groups. Assist clients in making sure they wash their clothes. Assist clients with getting ready for bedtime. Assist with client point cards. Able to participate in agency's efforts to improve quality. Inventory new client's belongings and add and subtract as changes occur. Participates in in-service education as required by State and facility regulations. Transports adolescents or conducts facility business in facility vehicles as directed. This list of duties is illustrative of duties and not a complete list of all duties and assignments that may be required of the Youth Counselor. Physical Requirements: Ability to physically perform containment, escort, and restraint procedures with assaultive adolescents. Ability to physically assist in lifting and carrying assaultive adolescents weighing up to 200 lbs. Ability to visually and audibly assess adolescent's behavior and needs. Ability to walk, run and play active games with the adolescents.

Application for Adjudication dated 05/31/18, w/DOI: CT 01/22/18-03/09/18. Stress and strain due to repetitive movement, uncomfortable chair, inappropriate lighting and injured shoulders, neck, lower back and LE; stress/depression/anxiety due to hostile work environment and discrimination based on sex orientation. Nervous system. Employed by Kedren Community Los Angeles Youth Network as a Case Manager.

Application for Adjudication dated 05/21/19, w/DOI: 04/18/19. Pt was attacked by the patient in the facility, was dragged by her hair. Injured neck, shoulders-scapula and back. Employed at Star View Adolescent Ctr as a Shift Lead.

Application for Adjudication dated 10/10/19, w/DOI: CT 04/18/19-10/10/19. Stress, anxiety, flashbacks, HA, sleep loss due to attack by a patient at the work place on 04/18/19. Employed at Star View Adolescent Ctr as a Shift Lead.

WC Claim Form dated 05/15/18, w/DOI: CT 01/22/18 - 03/09/18. Stress and strain due to repetitive movement, uncomfortable chair, inappropriate lighting, injured shoulders, neck, lower back and LE; stress/depression/anxiety due to hostile work environment.

WC Claim Form dated 03/14/19, w/DOI: 03/13/19. R thumb. Employed at Star View Adolescent Ctr.

Employer's Rpt of Occupational Injury or Illness dated 03/14/19, w/DOI: 03/13/19. At employer's premises, employee was on the PHF dorm, and was restraining a client, when the client pulled employees thumb back. Employee sustained a sprain of R thumb. UE and thumb.

Strain. Returned to work on 03/13/19. Employed at Star Behavioral Health Grp as a Youth Counselor.

WC Claim Form dated 04/18/19, w/DOI: 04/18/19. Right side of body sore; neck, shoulder and back. Employed by SVAC.

Employer's Rpt of Occupational Injury or Illness dated 04/22/19, w/DOI: 04/18/19. Employee was doing her normal 15 min rounds and as she walks passes the client; she was assaulted by a resident/ client, in hallway of the PHF drome. Employee sustained a cervical strain in her neck area. Injured at employer's premises. Returned to work on 04/20/19. Employed at Star Behavioral Health Grp as a Youth Counselor.

WC Claim Form dated 05/16/19, w/DOI: 04/18/19. Stress and strain due to repetitive movement over period of time. Neck, shoulder and back, accident on 04/18/19.

WC Claim Form dated 10/10/19, w/DOI: CT 04/18/19-10/10/19. Stress, anxiety, flashbacks and sleep loss due to attack by a pt at the work place.

Compromise and Release dated 05/16/19, w/DOI: CT 01/22/18 – 03/09/18. Entire neck, entire back, B/L shoulders, BLE, stress, anxiety and depression. Employed by Los Angeles Youth Network as a Case Manager. Settlement amount: $5,000.00.

Joint Compromise and Release dated 02/15/20, w/DOI: 04/18/19. Neck, spine, head, HA, shoulders, face, ears and psyche. DOI: CT 04/18/19-10/10/19. Psyche, sleep, head, HA and nervous system. Employed by Stars Behavioral Health Grp as a Youth Counselor. Settlement amount: $25,000.00.

07/10/18 - PTP's Basic Medical Legal Rpt by Harold Iseke, DC. DOI: CT 01/22/18 – 03/09/18. DOE: 06/14/18. Pt while employed with Los Angeles Youth Network - Kedren Community as a Case Management for a period of two months. Started to experience pain in neck, lower back with radiating pain to BLE, shoulders, which she attributed to constant sitting and walking. Also developed symptoms of stress, depression and anxiety due to discrimination, overloaded with work and criticized. Reported these symptoms to her employer but no recommendations were given. She managed pain with OTC medication and resting. Continued working with persistent symptoms. Did not see any doctors. On 03/09/18, pt's employment was terminated. Since continued off work and treating on her own at home. C/o frequent, moderate, achy and throbbing C/S, L/S and T/S pain. C/o frequent, achy HAs in the occipital region. Loss of sleep due to pain. Due to prolonged pain and feeling like her condition will never improve, is experiencing anxiety, stress and depression. Current Meds: Taking Advil PRN and Melatonin. PSH: 24 years ago had a C-section and made a full recovery. Reports difficulty with ADLs. Epworth sleepiness scale yielded total score of 9. Pain Questionnaire: Pain score now, at its worst, on average, and frequency of pain score is 9. Pain aggravated by activity scored 8. Activity Limitation: Pain score of 9 is yielded in the following activities: Lifting 10 lbs, interfere with ability to sit for 1/

hr, participate in social activities, travel 1 hour by car, general daily activities, limit activities to prevent pain from getting worse, relationships with family/partner/significant others, ability to do jobs around home, ability to shower or bathe without help, ability to write or type, ability to dress herself, ability to engage in sexual activity, ability to concentrate. Pain score of 8 is yielded in the following activities: Ability to walk 1 block and stand for ½ hr. Pain score of 10 is yielded to get enough sleep. Mood: Overall mood – 7. Over past week, how anxious or worried, how irritable have been due to pain – 8. Over past week, how depressed have you been due to pain- 7. In general, how anxious/worried about performing activities because they might make your pain/symptoms worse - 9. ROS: Has headaches with slight dizziness. PE: Cervical compression and Soto Hall tests are positive. T/S and L/S: Kemp's positive. Dermatomes, myotomes and DTRs within normal limits. Dx: 1) HA. 2) Cervical s/s. 3) Cervicalgia. 4) Thoracic s/s. 5) T/S pain. 6) Lumbar s/s. 7) Lumbago. 8) Anxiety. 9) Loss of sleep. 10) Depression. 11) Acute stress reaction. 12) Myositis. 13) Chronic pain due to trauma. 14) Myalgia. Plan: Requested acupuncture therapy and Psych consult. Causation: Work-related accident on 01/22/18-03/09/18 during the course of her employment with Los Angeles Youth Network. Work Restriction: Pt is not working.

11/12/18 - Medical Examiner Recommendations by Marc Arnush, MD/Occupational Medicine at U.S. HealthWorks. Pt is medically acceptable for the position as a Youth Counselor at Star View Adolescent Ctr based on the PE conducted and Physical Agility Testing.

11/12/18 - TB Screening Questionnaire and Consent Form at U.S. HealthWorks.

11/13/18 - Physical Abilities Testing at U.S. HealthWorks. Grip and static strength testing was performed. Result: Normal.

03/14/19 - Injury Investigation Rpt. DOI: 03/13/19. While in a restraint inside timeout room on PHF with CX staff, R thumb was pulled back by CX causing injury. R thumb pain. Pt did not leave work.

03/14/19 – Work Status Rpt by James Black, PA-at Concentra. DOI: 03/13/19. Dx: Sprain of R thumb. Plan: Requested PT. Modified duty with pt may work their entire shift. May push/pull up to 10 lbs occasionally. May grip/squeeze/pinch with RUE occasionally. Wear splint/brace on RUE constantly. Must wear splint on R hand. Caution, cannot defend herself.

03/21/19 – Work Status Rpt by Louis Batch, MD/Preventive Medicine. Dx remains unchanged. Modified duty with pt may work entire shift. May lift up to 20 lbs frequently. Wear splint/brace on RUE constantly.

03/21/19 - Progress Note by Kenneth Kamfat Chu, MD/Internal Medicine at Kaiser. Pt c/o possible shingles onset 2 days. Vitals: BP 127/78. Wt 180 lbs.

03/28/19 – Work Status Rpt by Lesette Witherspoon, PA-C. Dx remains unchanged. Modified duty with pt may work entire shift. May lift up to 20 lbs frequently. Wear splint/brace on RUE constantly.

03/28/19 – Work Status Rpt by Louis Batch, MD. Dx remains unchanged. Modified duty with pt may work entire shift. May lift/push/pull up to 10 lbs frequently. Wear splint/brace on RUE constantly.

04/18/19 - Progress Note by Steve Stanford, MD at Concentra. DOI: 04/18/19. Pt works at facility with unruly teenagers (some of which are a danger to themselves and others). A 3 hrs prior a detained female teenager attacked her by pulling and dragging her by the hair, which resulted in a cervical muscle strain. Pt c/o mild intermittent B/L upper back pain at 3/10 along with back stiffness. ROS: HA, but no dizziness and no memory loss. Vitals: BP 157/113. Wt 180 lbs. PE: Normal muscle strength and tone. Dx: Cervical strain. Rx: Ibuprofen 200 mg. Plan: Requested PT for C/S and back. Modified duty with pt may work their entire shift. May lift/push/pull up to 15 lbs constantly.

04/19/19 – Dr's 1st Rpt by Steve Stanford, MD. DOI: 04/18/19. Pt c/o head, neck and L shoulder injury, 10/10. Dx: Cervical strain. Modified duty with may lift/push/pull up to 15 lbs constantly. (Partial document.)

06/03/19 - Telephone Encounter by Kenneth Kamfat Chu, MD. Ordered Atenolol 50 mg 30 pills.

08/12/19 - Progress Note by Kenneth Kamfat Chu, MD. Pt presents for PE with a HA. Has been diagnosed with HTN, on Atenolol outside KP 1 year. ROS: Positive for HAs (tightness in back of neck, admit to stress). Negative for dizziness. Vitals: BP 129/89. Wt 200 lbs. Dx: 1) HTN. 2) Insomnia. 3) Tension HA. 4) Overweight. Rx: Trazodone 50 mg, Amlodipine 2.5 mg and Ibuprofen 600 mg. Plan: Pt wants to change Atenolol. Ordered lab studies.

08/12/19 – Laboratory Rpt at Kaiser. Result: Hemoglobin A1C (H) 5.9. Lipid Panel: Cholesterol (H) 262, LDL calculated (H) 194, cholesterol/high density lipoprotein (H) 5.7.
Complete blood count with no diff, creatinine, Glucose, TSH is within normal limits.

08/13/19 – Message by Kenneth Kamfat Chu, MD. Pt's cholesterol very high, also pre diabetes.

09/17/19 - Telephone Encounter by Kenneth Kamfat Chu, MD. Abnormal mammogram result.

10/29/19 - Progress Note by Katherine Gloria Ross, OD at Kaiser. Pt presents for an eye exam. BP reading: 08/12/19 – 129/89. 03/21/19 – 127/78.

10/30/19 - PTP's Initial Eval by Eric E. Gofnung, DC / Mayya Kravchenko, DC at Eric E. Gofnung Chiropractic Corp. DOI: 04/18/19. While working her usual duties as a Shift Lead for Star View Adolescent Center, pt sustained a work-related injury to her neck, head, L shoulder

and back. She was doing her 15-minute rounds. While walking down a hallway, she was attacked by a client from behind. Client pulled her hair and dragged her 15 ft through a carpeted corridor and struck her with a closed fist on her head, face and body. A co-worker and a client were wrestled to pull the assailant off. Pt was helped to her feet and assisted in walking to the outside yard. Once she was out, pt fainted for several min. When she regained consciousness she experienced numbness and soreness throughout her head, neck, back and L shoulder. The house manager, Michael Trailer, assisted her and recommended medical care. Pt reported to an industrial clinic. Prescribed meds. Off for one day and Ms. Kelly administrator reminded pt what she signed up for and asked when she would return to work. Returned to work and moved to another unit as a floater. Continued working with pain. Returned to industrial clinic and completed three sessions of PT. Last seen around May 2019. Placed on light duty. In July of 2019, presented to PCP, Dr. Chu. Prescribed pain and sleep medication. Pt sought medical care on her own with a masseuse for her neck, R shoulder and back. Attended massage therapy once per week for several weeks. Last time she received massage therapy was in late September of 2019. Currently manages her pain by exercises in water. C/o moderate neck pain and symptoms occur frequently. There is soreness in her neck. There is radiating pain from neck into her shoulder blades, face and head. She has been experiencing frequent HAs. Experiencing N/T or burning sensations on left side of her face and neck. Has difficulty falling asleep and is often awakened during night by neck pain. There is stiffness and restricted ROM in head and neck. Pain level varies throughout the day. Moderate L shoulder pain and symptoms occur frequently. Pain radiates to her arm. Experiences weakness, as well as N/T in shoulder and arm. C/o stiffness and experiences increased pain with repetitive motion of the arm/shoulder. Pain level varies throughout the day depending on activities. Not able to sleep on L shoulder. Moderate T/S pain and the symptoms occur frequently in upper and mid-back. Radiates into her shoulder blades and upper back. C/o tightness in mid back area. There is N/T and muscle spasm. Moderate to severe LBP and symptoms occur frequently in the lower back, which increases becoming sharp and stabbing. Radiates down L buttocks. Has N/T in her back. C/o muscle spasms. Awakens from sleep due to LBP. Self-restricts by limiting his activities. Walks with a limp due to her low back symptoms. Has nausea, difficulty concentrating, dizziness, HAs, numbness of L side on her face. Psyche: Has episodes of anxiety, stress, and depression due to chronic pain and disability status. Pt's condition has worsened due to continued work, lack of medical treatment and ADLs. Current Meds: Amlodipine 2.5 mg, Trazodone and Ibuprofen 500 mg. ROS: Remarkable for trouble sleeping, muscle or joint pain, stiffness, anxiety, depressed mood, and stress. BP: 145/70, Wt: 165 lbs. PE: Tenderness at left occipital region. C/S: Shoulder depression test was positive on L. Hawkins test was positive at L shoulder. Grip Strength Testing: C/o increased pain at L arm/shoulder during the testing. With the exception of L deltoid 4/5, L wrist extensor 4/5, L wrist flexor 4/5, all other myotomes 5/5. DTRs normal and 2/2 B/L. Sensory Testing: Normal with the exception of dysesthesia at L C6-C7 dermatomal levels. L/S: Milgram's test was positive. SLR (supine) elicited increased LBP with radiculopathy to LLE. Right at 50 degrees, left at 40 degrees. Squatting is positive for back pain. Heel and toe walking difficulty and positive for back pain. DTRs are normal at 2/2 at L/S. Sensory testing; all dermatomes are intact bilaterally upon testing with a pinwheel. Dx: 1) Cephalgia, closed head trauma, tinnitus L, TBI, rule out. 2) C/S s/s, cervical facet-induced versus discogenic pain, cervical radiculitis L. 3) L/S

s/s lumbar face induced versus discogenic pain, radiculitis left. 4) L shoulder s/s. 5) L rotator cuff tear, rule out. 6) L shoulder tenosynovitis and bursitis. 7) Insomnia, anxiety and depression. Plan: Requested chiro therapy for C/S and L/S and L shoulder. Also requested x-rays of L shoulder, MRI of C/S and L/S and L shoulder. Ordered EMG/NCV of UE. Recommended psychiatric consult with Dr. Musher, Neurology consult. Modified duty with no repeated flexing, extending, or rotating of neck. No repeated work with L arm above shoulder height. No lifting in excess of 15 lbs. No repeated bending or stooping. TTD if no modified duty available.

11/18/19 - Dr's 1st Rpt by Gayle Windman, Ph.D/Clinical Psychologist at Hamlin Psyche Ctr. DOI: CT: 04/18/19-10/10/19. Due to an attack by a patient, pt c/o stress, anxiety, flashbacks, HA, sleep loss, neck/shoulder/low back tension/pain, TMJ/dental reaction, nausea, chest pain, shortness of breath and high BP. Dx: 1) MDD, single episode. 2) GAD. 3) Psychological factors affecting other medical conditions. Rx: Wellbutrin 100 mg, Buspar 10 mg and Ambien 5 mg. Plan: Requested CBT sessions. TTD.

11/25/19 – PTP's F/u Report by Eric E. Gofnung, DC/Mayya Kravchenko, DC. Pt is undergoing chiropractic manipulations and adjunctive multimodality physiotherapy. Feeling improvement with treatment, however, remains symptomatic. C/o frequent and moderate neck, L shoulder and mid back pain. Has frequent and moderate-to-severe LBP. C/o nausea, difficulty concentrating, dizziness, HAs, numbness in left side of face, anxiety, depression and sleep difficulty. PE: Tenderness at left occipital region. Shoulder depression test was positive on L. Hawkins test was positive at L shoulder. L deltoid 4/5, L wrist extensor 4/5, L wrist flexor 4/5, all other myotomes 5/5. Dysesthesia at L C6-C7 dermatomal levels. L/S: Milgram's test was positive. SLR (supine) elicited increased LBP with radiculopathy to LLE. Right at 55 degrees, left at 45 degrees. Squatting is positive for back pain. Heel and toe walking difficulty and positive for back pain. Dx remains unchanged. Modified duty.

12/09/19 – PTP's Initial Rpt by Gayle Windman, Ph.D. DOI: CT: 04/18/19-10/10/19. Pt began her employment at Star View Adolescent Center on 12/10/18. Her last day of work there was on 10/25/19. On 04/19/19, pt completed her rounds which included room and bed checks for at risk youths on probation. As she walked down the corridor, she passed two youths. Without warning, one of the youths, Savannah, forcefully grabbed her hair. Savannah pulled her down to the floor and dragged her about 15 feet. She viciously punched her face. Savannah struck her head and face over and over. A client and colleague intervened. She was rushed out of the facility and into the open courtyard. Pt passed out. Savannah once told pt that she reminded her of a mother figure. Savannah's mother committed suicide. Pt filed a police report. Pt was referred to the company doctor. Diagnosed with bruises and contusions. Followed up with Kaiser. Continued to work. Pt was demoted to youth counselor. She could no longer work in the unit where the trauma had transpired. She experienced post-traumatic stress reactions including fear. Pt returned to her job as shift lead. On one occasion, a youth began to bang on the plastic partition. He was in a rage. He attempted to strangle himself. He began to punch pt in the stomach. He was restrained. A co-worker accused pt of instigating the outburst. Pt was accused of making a clinical error. Placed on suspension pending an investigation. She was given the choice to either resign or be

terminated. Pt was referred to Eric Gofnung, D.C. Remained symptomatic. C/o depressive mood, anxiety and unprovoked crying episodes. Experienced stress-intensified medical symptoms with worsened HA, neck/shoulder/low back tension/pain, TMJ/dental reaction, nausea, chest pain, SOB, peptic acid reaction, constipation, abdominal pain/cramping, diarrhea and possible stress-aggravated high BP. Experienced post-concussive symptoms including HA, blurred vision, dizziness, faintness, loss of balance, phobia to bright light and loud noises and ringing in the ears. Due to her mental disorder, experienced impairment in her daily activities. Because of her nervousness, there was increased urinary frequency. There were problems with stress-related constipation and diarrhea. Due to stress-related overeating and depressive inactivity, pt developed a gain of weight of about 70 lbs. Developed decreased sexual interest due to depression, anxiety, withdrawal, irritability, anger and damaged self-esteem. Has difficulty falling and staying asleep due to depression, anxiety, worry and nightmares. Uses Trazodone to fall asleep. Because of her insomnia, pt experienced excessive daytime sleepiness, morning HAs, trouble concentrating and personality change. Because of her cognitive impairment, pt had difficulty communicating her thoughts. Cognitive functioning became impaired such that there was difficulty in her ability to read a magazine or a book and to watch a television show or movie. Ms. Young also had problems remembering where she left things around the house, telephone numbers, appointments, birthdays, directions and what people told her. Due to pt's depression and anxiety, there was psychological fatigue and energy depletion. Medical Hx: Pt was diagnosed with migraine HA, irritable bowel, high BP and chronic fatigue syndrome by Dr. Cho. These conditions may have become aggravated by her work stress, in part, as compensable consequences. Mental status exam was performed. Psychological tests were administered. Dx: 1) MDD, single episode. 2) GAD. 3) Psychological Factors Affecting Medical Condition (stress-intensified HA, neck/shoulder/low back tension/pain, TMJ/dental reaction, nausea, chest pain, shortness of breath, peptic acid reaction, constipation, abdominal pain/cramping, diarrhea and possible stress-aggravated high blood pressure. Plan: Requested CBT sessions. Causation: 100% industrial injury.

12/30/19- PTP' F/u Rpt by Eric E. Gofnung, DC / Mayya Kravchenko, DC. Pt is feeling improvement with treatment. Not returned to work until present. CC: Frequent and moderate neck pain, L shoulder pain, mid back pain, and LBP. Also has nausea, difficulty concentrating, dizziness, HAs, numbness in L side of face, anxiety and depression and sleep difficulty. PE: Tenderness at left occipital region. Shoulder depression test was positive on L. Hawkins test was positive at L shoulder. L deltoid 4/5, L wrist extensor 4/5, L wrist flexor 4/5, all other myotomes 5/5. Dysesthesia at L C6-C7 dermatomal levels. L/S: Milgram's test was positive. SLR (supine) elicited increased LBP with increased radiculopathy to LLE. Right at 60 degrees, left at 50 degrees. Plan: Requested EMG/NCV of UE. Referred Psychiatric consultation with Dr. Musher. Recommended MRI of C/S, L/S and L shoulder. Recommended x-ray of L shoulder and chiro. (Partial document.)

01/10/20 – Orthopedic AME Rpt by Soheil M. Aval, MD/Orthopedic Surgery at West Coast Orthopedics. DOI: 04/18/19. Pt began working for Star View Adolescent Center on 12/10.18, as a shift lead. On 04/18/19, pt was making her rounds and that she was walking by two clients.

One of the clients snatched her by the back of her hair, and dragged her about 15 ft. This individual then beat her with closed fists with impact to her head and face. Another client came to her assistance and got the assailant off her. A colleague dragged her away from the area and that she had lost consciousness. That night she was evaluated at the Concentra Medical Clinic in Torrance and was given medications. Subsequently attended PT for L shoulder and L shoulder blade, L arm, L side of her neck, and low back. In approximately June 2019, pt presented to Kaiser facility on Long Beach and was evaluated by Dr. Cho. She was having difficulty sleeping due to pain. She was provided with medication only. Pt continued working for the above employer until October 25, 2019, when she resigned. In approximately November 2019, pt came under the care of Dr. Eric G. of Los Angeles for neck and low back adjustments. This chiropractor requested an evaluation with a neurologist as she was having ringing in her L ear which was related to the 04/18/19, incident. Has been approved for this and is waiting for an appointment to be scheduled. Current Meds: Amlodipine, Ibuprofen, Trazodone, Zolpidem and Buspirone. C/o constant left-sided C/S pain and radiates to L shoulder and the top of L ear. There is N/T. Has increased pain when she wakes up in the morning. Some relief of pain with use of med. L Shoulder: Constant pain that radiates into top of L ear and down the spine to lower back. Some relief of pain with the use of medication. Intermittent left-sided LBP with radiation to the hip and waistline. There is tingling of her low back. She has increased pain with standing and arising from a seated position. The pain is worse when she wakes up in the morning. There is some relief of pain with the use of medication. Difficulty with ADLs. PE: Wt 145 lbs. BP 180/125. Pt was very guarded in movement today. Unable to obtain reliable ROM. C/S: Spurling, Axial Compression, and Shoulder Abduction tests, negative. B/L shoulders: Neer's, Hawkins, Jobe tests were positive. O'Brien, Speed, and Cross Arm test were negative. The grip JAMAR dynamometer reading on the 2nd notch reveals 5/5/5 on R, per kilograms force. She declined to grasp the Jamar dynamometer on L due to pain. Pinch testing reveals 4/4/4 on R and 2/2/2 on L. Neurological examination reveals the deep tendon reflexes to be symmetrical in the biceps (1+), triceps (1+), and brachioradialis (1+). Sensation utilizing the Wartenberg wheel is intact. Pt walks with a normal gait. L/S: Pt stands with increased lumbar lordosis. Babinski sign, Lasegue sign, Fabere maneuver tests negative. Neurological exam reveals DTRs to be absent in the patellar and Achilles tendons B/L. Imaging Studies: X-ray of C/S reveals degenerative changes with osteophytes and disc changes at C5-6. X-ray exam of B/L shoulders reveals the overall osseous density to be normal. Joint spaces are well maintained. AC joint appears normal. No evidence of fracture, dislocation or subluxation. X-ray of L/S reveals mild diffuse osteopenia. Lumbar lordosis is maintained. Degenerative changes are present. Most notable at L3-4 where there is sclerosis of the superior endplate of L4 and some disc space narrowing. Facet hypertrophic changes are present. Dx: 1) Cervical trapezial strain with degenerative disc disease, per x-rays. 2) L shoulder strain; r/o internal derangement. 3) Lumbosacral s/s with degenerative disc disease, L/S; per x-rays. Discussion: According to submitted correspondence, this is an accepted injury sustained on 04/18/19; however, the nature and extent are at issue. The cover letter has captioned dates of injury which include 04/18/19, through 10/10/19, which appears to be a CT. This examiner recommended she undergo MRI studies of C/S, L shoulder and L/S. Unfortunately, these were not done as pt canceled the appointments and has not responded to re-scheduling of these studies. If she does go on to have MRI studies, will review them and provide

additional commentary in a supplemental report. In addition to orthopedic complaints, pt describes sleep difficulties, issues with sexual function and urination, ringing of L ear, stomach upset. She also states she has had to increase her high BP medication. Her BP readings were elevated and she was advised of this. At this juncture, this examiner has not received any medical records. He is recommending the above-noted MRI studies and would like to review the records before commenting further. Causation and Apportionment: Pt sustained a specific injury on 04/18/19, when she was assaulted by a client. From her hx, the injury involved her C/S, L shoulder and L/S; however, she also describes ringing of her L ear, psychological complaints and other non-orthopedic issues, which are deferred to the appropriate specialists. Pt's C/S, L shoulder and L/S complaints are consistent with industrial injury of 04/18/19, as described by the pt. This date of injury has been accepted, however, it appears that nature and extent are at issue. X-rays show DDD of both C/S and L/S.

02/14/20 – PTP's Rpt by Eric E. Gofnung, DC. Summary: After review of records, it was noted that pt is currently under the care of a psychiatrist and additional treatment is being requested. In addition, Dr. Curtis found pt to be on TTD on combined physical and psychological basis as of his 01/21/20 report for two to three months forward. This examiner is in agreement with all of the above opinions as expressed by Dr. Curtis. All of the opinions remain the same as stated in prior reporting.

Deposition of Benetia Ann Young-James, on 10/09/19 (58 Pages).

Pages 7, 8 – Pt took Amlodipine for hypertension, prescribed by PCP Dr. Chu from a Kaiser in Long Beach. Dr. Chu had been her PCP for about 6 months. She got dry mouth from the hypertension meds. First time he had BP in 2018. Pt felt that medication controlled her hypertension. Pages 9, 10 – Pt also took Trazodone for sleep issues. Pt reported PCP about sleep issues on 04/18/19 and he prescribed medication. Pt spent about 30 minutes with attorney regarding deposition via conference call. Pages 13, 14 – Pt would wear glasses only while doing documentation. As per license, pt's weight was 145 and now it 165 lbs. She stated that she gained little weight with the medication and incident. Currently having pain in right cheek and neck on left side. Pages 15-20 – Pt drove to deposition. Pt would drive 2015 Camry and also owned 2019 Dodge Daytona. She stated that previously scheduled for deposition, but it was cancelled. After currently deposition, she was scheduled to start work by 3 o'clock. Pt previously filed a claim for work compensation case against Kedren Community Los Angeles Youth Network. She first started working for them on 11/18/2015 or 2016 as a case manager in office for 5 or 6 years. Stopped work in 2016 and off work for 2 years. Kedren did a layoff around 2016. Pages 22, 23 – Filed a claim for low back issues at Kedren. Pt stated that she sat all day at work and that caused symptoms. She also had symptoms under bra line. Case was settled. Pages 25-29 – Pt is currently working for Star View Adolescents on regular duties. Pt applied for unemployment benefits regarding lay off in 2016. Pt was hired by Stars on 12/10/18 as a youth counselor. Pt worked at the adolescent center. Pt's supervisor is Johnny George. Pt had been employed at Early Strides Child Development Center from August of 2018 until the present. Pt was hospitalized overnight when she had a baby around 25 years ago. Pages 31-35 - Dr. Chu also

prescribed pain medication. Pt had Kaiser insurance through Stars. At Stars on 04/18/19, while pt was just doing her rounds, going up and down the unit. Before turned back around to do the rounds again to check on all the youth, pt noticed 2 clients on opposite side of her room. At times, a client grabbed the back of pt's hair and dragged her to the ground about 15 feet. Then she turned around to bite and hit her, though other client tried to protect pt. she also struck in pt's face twice on the left side. Employer Imani Ellis witnessed the incident and helped her. Pages 36-39 - Imani carried pt out the back door, and then pt passed out. Then house manager, Michael Trailor asked about her. Pt not continued working that day and filled out incident report. She then went to the company clinic that same day. They gave her pain medicine and sent her to U.S. HealthWorks. Then they changed it to Concentra. She stated that doctor took her off for a couple days and returned on modified duties for 4 months. After that, she returned to full duty around mid/late August or early September. After that client was arrested, they gave her position back. Pages 40-43 – Pt stated that in two-day-ago incident, men were able to get the arms of the client. She wanted to continue working at Stars. Pt stated that she is able to do full duty work, and talked to Dr. Spiteri. Pt admitted that physically she is not capable of restraining right now. Pt is having tingle sensation on left side of her face. Pt had a headache since 04/18/19. Pages 44-46 – Pt had symptoms of upper back and shoulder symptoms on the left side based on activities as well as had symptoms in cheekbones, temple, and back of left neck. She had spasm in mid back around bra line a couple of days ago. Pt would meditate in the morning and do yoga. Pt would get a massage once a week and also water aerobics 4 times a week at Hope. Pages 47-51 – Had seen Dr. Chu twice regarding injury and last visit was 2 months ago. When not working, pt would check on her mother, siblings. Previously, she played racquetball and played golf, but now not able to play at all. She last played racquetball about 3 years ago. Pt did not play golf for about 6 months. Currently, she could not ride bike due to mild fatigue and hypertension. Pt had some memory issues right now. Pt is addressing more emotional issues than memory issues. Pages 53, 54 – Pt started struggling with completing the documentation. Pt felt that pt's documentation speed had gone down.

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: BENETIA YOUNG *(employee name)* v Star View Adolescent Center *(claims administrator name, or if none employer)*

Claim No.: Pending

EAMS or WCAB Case No. (*if any*): ADJ12213522

I, MARIA MORENO *(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 or a regularly utilized drop box of the overnight 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	05/12/21	Subsequent Injury Benefit Trust Fund 1750 Howe Avenue, Suite 370 Sacramento, California 95825-3367
A	05/12/21	WORKERS DEFENDERS LAW GROUP 8018 East Santa Ana Canyon, Suite 100-215 Anaheim Hills, California 92808
A		

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date: 5/12/21

Maria Moreno *(signature of declarant)*

Maria Moreno *(print name)*