STATE OF CALIFORNIA

Claim #

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the 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 the 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.

1. INSURER NAME AND ADDRESS: Sedgwick, P.O. Box 14188 — PLEASE DO NOT USE THIS COLUMN
2. EMPLOYER NAME: Kaisser permanente Downey Medical Center — Case No.
3. Address: No. and Street: 9333 Imperial Hwy. City: Downey. Zip: 90242 — 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): Darlene Walls — 6. Sex: ☐ Male ☒ Female — 7. Date of Birth: Mo. Day Yr. 3-23-67 — Age
8. Address: No. and Street: 16323 Cornuta Ave. City: Bellflower. Zip: 90706 — 9. Telephone number: 213 401-8827 — Hazard
10. Occupation (Specific job title): Nurse Assistant — 11. Social Security Number: 558-37-5679 — Disease
12. Injured at: No. and Street: 9333 Imperial Hwy. City: Downey County: LA — Hospitalization
13. Date and hour of injury or onset of illness: Mo. Day Yr. CT: 7/1/18 - 12/31/18 Hour ____ a.m. ____ p.m. — 14. Date last worked: Mo. Day Yr. — Occupation
15. Date and hour of first examination or treatment: Mo. Day Yr. 8-12-19 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.) Retaliation from filing complaints from injuries causing stress, sadness, harassment, worked 11 days w/out being written up. Chronic lower back, neck, wrist pain from repetitive work

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use reverse side if more space is required.) Feels sad, little motivation, fatigue, can't sleep due to work related stress, difficulty concentrating

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.) Clinical Interview: Pt. appeared casually dressed, tearful, cries easily, depressive symptoms, disrupted sleep. Is fearful of others due to being harassed from co-workers.

B. X-ray and laboratory results (State if non or pending.)

20. **DIAGNOSIS** (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? ☐ Yes ☒ No
Depressive Disorder F32.9 Insomnia F51.01 ICD-10 Code ___ ___ ___ - ___ ___

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.)
Initial Evaluation

24. If further treatment required, specify treatment plan/estimated duration.
1. BIOFEEDBACK, 2. OUT PATIENT PSYCHOTHERAPY 2-3x A MONTH FOR 3 MONTHS.

25. If hospitalized as inpatient, give hospital name and location — Date admitted: Mo. Day Yr. — Estimated stay

26. WORK STATUS -- Is patient able to perform usual work? ☐ Yes ☒ No
If "no", date when patient can return to: Regular work ___/___/___ Modified work ___/___/___ Specify restrictions ____

Doctor's Signature: Julie Goalwin, PhD — CA License Number: PSY14146

Doctor Name and Degree (please type): JULIE GOALWIN, PHD — IRS Number: 45-3803261

Address: 115 PINE AVE. #640 LONG BEACH CA 90802 — Telephone Number: (562) 364-8587

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.