RECORDS

Applicant/Plaintiff	**Floreen Rooks**		
Case No.	SIF7024643, SIF10825285,SIF7024645		
Defendant	Dveal Family & Youth Services		
Date of Injury	11/10/2007		
File/Claim Num	00	Date Published	11/12/2020
Records of	**State Compensation Insurance Fund**		
Location Copied	655 N Central Ave, 4th floor Glendale, CA 91203		
Type of Records	Insurance Claims		

Records delivered to: Control Num 21-21912-8 (203) C1

1 Customer

Natalia Foley, Esq
Workers Defenders Law Group
5753 E Santa Ana Cyn Rd Ste G #616
Anaheim, CA 92807
Attn: Natalia Foley, Esq.

These records were produced under U.S. Patent No. 8,301,611

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Records Excerpt & Outline

(List of injuries, diseases and symptoms)
HIPAA COMPLIANT

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Use this Excerpt & Outline to spot **apportionment issues** and also to reduce or **eliminate the review charges** incurred by treating and reviewing doctors.

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Control No: 21-21912-8

Medical Record Excerpt & Outline

Patient Name	:	Floreen Rooks
WCAB #	:	SIF7024643, SIF10825285,SIF7024645
Social Security No.	:	000-00-0000
Date of Birth	:	06/20/49
Employer	:	Dveal Family & Youth Services
Records of	:	State Compensation Insurance Fund Glendale, CA
Date of Injury	:	11/10/2007

Date of Service	Page No.	Provider	Excerpt
08/09/07	135, 209	Dreamwcaver Med Grp	**Progress Note - Adult** Hx of injury: Patient states, "'Slipped on a piece of cucumber and felt onto concrete ground/pavement. Patient states that this afternoon she slipped and fell onto her left hip from ground level. Patient now states that she has pain in her left hip, left knee, and left ankle. The ankle being the most painful area. She has pain in. BP: 116/78. Wt: 210 lbs. Exam: Extremity: Patient was positive for tenderness at the left hip, left knee, left ankle (medial lateral malleolus). ROM: Active and passive of movement at all limits due to pain. Dx: Left hip, knee, ankle pain. Findings and diagnosis consistent with patient's account of injury or onset of illness. Plan: Naprosyn 500 mg BID PRN pain. Ice packs. X-ray. RTC in 3 days for f/u. Off work until 08/15/07. F/u on 08/14/07.
08/09/07	163	La, Dan, D.O.	**Dr's 1st Rept of Occupational Injury/Illness** DOI: 08/09/07. Hx of injury: Patient states, "'Slipped on a piece of cucumber and felt onto concrete ground/pavement. Patient states that this afternoon she slipped and fell onto her left hip from ground level. Patient now states that she has pain in her left hip, left knee, and left ankle. The ankle being the most painful area. She has pain in. BP: 116/78. Wt: 210 lbs. Exam: Extremity: Patient was positive for tenderness at the left hip, left knee, left ankle (medial lateral malleolus). ROM: Active and passive of movement at all limits due to pain. Dx: Left hip, knee, ankle pain. Findings and diagnosis

			consistent with patient's account of injury or onset of illness. Plan: Naprosyn 500 mg BID PRN pain. Ice packs. RTC in 3 days for f/u. RTW/modified duty from 08/08/07.
08/10/07	194- 199	Pacific Med Imaging and Oncology Ctr	**Radiology/Diagnostics** X-rays of Left Knee, Ankle, Hip and Pelvis. X-ray of Left Knee. Impression: 1) Generalized demineralization. 2) Suspect small loose body within the central joint. 3) No acute fracture or subluxation is demonstrated. X-ray of Left Ankle. Impression: 1) Old post-traumatic changes of the malleoli s/p prior ORIF. 2) There is secondary deformity and secondary osteoarthritic changes at the distal tibia and talus. X-ray of Left Hip and Pelvis. Impression: Negative study.
08/14/07	134, 165, 208	Dreamwcaver Med Grp	**Progress Note - Adult** Patient presents for f/u. Patient states she is feeling moderately better. Still swollen left ankle. Patient states she is just lying in bed for 4 days. Naproxen showed relief. Shoulder is better. BP: 130/80. Wt: 210 lbs. Exam: Left ankle, left knee and left hip and gait with cane. Tenderness noted while walking. OA of left knee and left ankle. STS of left ankle. S/p fracture and fixation of left ankle. Assessment and Plan: Left ankle sprain. Ultram 25 mg. PT because of old fracture. Left knee pain. Left hip pain. Naprosyn. Ultram. PT for 2 weeks and MRI of left knee. Wear splint and use cane. RTC in 2 weeks. RTW/modified duty. Restrictions: Sitting mostly. Limited driving to and from work. No continuous walking or prolonged standing. Must be sitting the majority of the shift. F/u on 08/27/07.
08/27/07	133, 164, 180, 207	Dreamwcaver Med Grp	**Progress Note - Adult** Patient presents for f/u. Patient presents with left knee/ankle/hip injury. Patient has taken only 2 Naproxen and patient has relief. Patient was bedridden for 2 days. X-rays show small loose body with the central joint line, left knee. Still has pain and swelling in left knee. Right knee also weird feeling for 1-1/2 weeks. BP: 140/80. Wt: 214 lbs. Exam: General: Overweight. Mildly edematous left knee and ankle. Assessment and Plan: Left knee sprain with swelling. MRI of left knee to r/o meniscal tear. PT of right knee/ankle. RTC 1 week for f/u. PT for 1 week and MRI of left knee. RTC in 2 weeks. Off work until 09/04/07. F/u on 09/04/07.
08/30/07	23		**WC Claim Form (DWC 1)** DOI: 08/09/07. Hx of injury: Employee slipped on a piece of cucumber and fell into concrete pavement.
09/04/07	147- 151, 175- 178, 181	Jung, Kenneth, M.D.-Kerlan – Jobe Ortho Clinic	**Initial Orthopedic Consultation** DOI: 08/09/07. CC: Condition in left ankle. HPI: Patient presents for evaluation of left ankle injury sustained on 08/09/07. Patient reports slipping on a piece of cucumber and

			falling. She injured her knee and ankle. She was initially seen and given a cane and a prescription for Naprosyn. She has been using an elastic ankle brace and taking anti-inflammatories as needed. She reports sharp, achy, cramping, incapacitating pain. It bothers her all day. It hurts her most of the day. There is swelling, tenderness, and giving way. It hurts her when she does exercises such as driving and walking. Her history is significant for a left ankle fracture sustained about 14 years ago. She underwent an open reduction and internal fixation. This injury did not occur at work. It occurred after she fell down some stairs. Exam: Examination of the left ankle and foot reveals well-healed incision. She has limited ankle dorsiflexion and plantar flexion. She is hesitant due to pain. She also is hesitant to inversion and eversion on examination. She also reports pain to palpation over the midfoot and forefoot. Patient has brought in outside films obtained on 08/10/07. Radiographs show hardware in the ankle. There appears to be extensive degenerative changes including anterior osteophytes of the tibia and talus. At KJOC Pasadena I ordered and interpreted AP, lateral, and oblique views of the left foot as well as a mortise ankle view. Radiographs show extensive degenerative changes in the ankle joint Intact hardware. There is extensive anterior spurring. No fractures are seen in the foot or midfoot. Physician's review of medical records. Dx: 1) Left ankle posttraumatic arthritis, s/p open reduction and internal fixation ankle fracture. 2) Industrial injury secondary to fall. 3) Ankle pain after industrial fall. Plan: This patient does not appear to have any acute injuries after her most recent fall. She most likely exacerbated a pre-existing condition, posttraumatic arthritis. She is currently wearing an elastic ankle sleeve. I would recommend the use of a lace-up ankle brace that provides further support. She has been provided with one today. She can be weightbearing as tolerated. She reports she is scheduled to see Dr. Ralph Gambardella with regards to her left knee on 09/10/07. Work Status: I would keep this patient temporarily totally disabled until her office visit with Dr. Ralph Gambardella on 09/10/07. After that point patient is cleared for sedentary work.
09/10/07	152- 162, 166- 174, 179	Gambardella, Ralph, M.D.	**Comprehensive Orthopedic Evaluation** Patient presents here today for comprehensive orthopedic evaluation or treatment regarding an injury to her left knee that she sustained on 08/09/07. History is obtained today from direct interview of patient as well as review of records that are available. These are records from Dr. Jung. Patient

			was employed by D'Veal Family and Youth Svcs and states that she slipped on a piece of a cucumber, falling. Patient at the time felt that she fell on her entire Left side, the ankle being the most painful. When asked today, there is no h/o direct blow. Patient again is unsure, but she thinks she just landed on her left side. Patient, however, has persisted with some discomfort in the left knee, some overall irritability and had onset of swelling. She c/o the swelling with activities and the pain pattern which is diffuse as tenderness more on the medial side than on the lateral side. ROM: Flexion: Left: 125 degrees. Inspection/Palpation: Left knee: Distal quadriceps tenderness. Medial and lateral patellar facet tenderness. Patellar tendon tenderness. Medial epicondylar tenderness. Medial joint line tenderness. Medial tibia tenderness. Lateral joint line tenderness. Effusion. Patellar crepitus in right and left. X-rays: We have outside x-rays available for review, AP and lateral. It is unclear if this is a weightbearing view, which shows no specific joint space non-owing with very minimal osteophyte formation in the medial compartment. An AP of right and left knees and a sunrise of right and left knee is ordered, seen and interpreted here today by me at the Kerlan-Jobe Clinic in Pasadena, show first of all in the sunrise view there is some increased patellar tilt bilaterally with narrowing of the lateral facet space consistent with early chondromalacia patellofemoral joint right and left knees. Then on the AP standing views, there is some early osteophyte formation of both left and right knees. The left knee shows 1-mm joint space narrowing with also some intercondylar notch spur formation and also mild lateral compartment spur formation consistent with early degenerative osteoarthritis of left and right knee, left worse than right. Impression: 1) Synovitis of the left knee with underlying early degenerative osteoarthritis of left knee including patellofemoral early arthrosis with mild patellofemoral malalignment, left and right knees. 2) Pes bursitis, left knee. Recommendations and discussion: This patient at this time has evidence of underlying pre-existing early degenerative osteoarthritis on the left knee and has then had a work-related injury that has resulted in a flare-up of her arthritic condition. Patient has outlined to me that she had not had any symptoms prior to the work injury from a clinical standpoint. However, clearly with the x-ray evidence there was pie-existing disease present. At this time there is not a good h/o a twist injury and with patient's mild hypersensitivity and diffuse tenderness I would not recommend any diagnostic testing which most likely would

			be positive. However, I would recommend a comprehensive PT program on a twice-a-week basis for 6 weeks and to f/u in 6 weeks for repeat evaluation. In addition, patient appears to be not seeing any symptomatic improvement with the Naprosyn. We therefore will switch her to Voltaren XR. Drug warning given relative to the medication. Patient did note that prior to the work injury she was using 2-3 Advil in the morning for her ankle. I would defer relative to her ankle to Dr. Jung. We have recommended that she should however maintain some ankle exercise program and also some intermittent elevation to help decrease the chance of blood clot in the LLE. On today's examination, there is no evidence to suggest a clot or dye. Work restrictions: At this time I would also recommend that patient should have work restrictions relative to the left knee. These work restrictions would consist of sedentary type of work activities, no climbing, a lifting restriction of 10 lbs, no squatting or kneeling activities, and standing and walking limited to no more than 15 minutes per hour. If these restrictions are not available, patient will remain temporarily totally disabled pending f/u evaluation in 6 weeks. Authorization requested for Transfer of care to Dr Kenneth Jung.
11/20/07	139- 140	Hadley. Michael, M.D.	**Dr's 1st Rept of Occupational Injury/Illness** DOI: 11/20/17. Hx of injury: Patient fell on the ground and fractured right foot her left ankle and also her right foot. Because of these injuries, patient developed pain mostly in her right foot. As a result, she went to the Kaiser ER for evaluation and treatment. CC: While at Kaiser ER she was told that she had a fracture of the right foot, sprain to the left ankle and a bruise to the left knee, She was given an ortho shoe and was told to report this to her employer as a job-related injury. Patient did so and she was referred here by her Workers Compensation insurance carrier for evaluation and treatment. Today is her initial visit at this facility. Patient does complain of mild discomfort in her left ankle and her left knee. However, she does complain of significant discomfort in her right foot. BP: 156/98. PMH: Patient states that she has a heart valve problem for many years and does use prophylactic antibiotics for dental work. She has had a fracture of her left ankle in 1992 that was treated operatively. Allergies: She is allergic to Penicillin. She denies any h/o diabetes, HTN, ulcer disease or asthma. Social habits: Patient occasionally smokes. Exam: Ecchymosis. Patient does have impaired weightbearing secondary to pain and altered gait secondary to pain. Patient is ambulating with the aid of a cane. Examination of the left ankle reveals that there is a

			healed surgical scar. There is trace tenderness and edema. Examination of the left knee reveals vague tenderness present anteriorly, trace edema. There is full flexion with pain. Preliminary reading of the right foot reveals that there is a fracture involving the fourth and fifth metatarsals with angulation present in the fourth metatarsal head. Final report is pending. X-ray exam of the left ankle reveals the presence of hardware, no acute finding seen. X-ray of the left knee is unremarkable except for degenerative changes. Final report is pending. Dx: Contusion of left knee. Fracture of right foot. Sprain, left ankle. Findings and diagnosis consistent with patient's account of injury or onset of illness. Plan: Tylenol. X-ray. Dispensed walker boot/cam walker. Referral to orthopedic surgeon for evaluation and treatment. RTW/modified duty. Restrictions: No driving vehicle during working hours, no walking or standing for more than one hour, sitting work only.
11/26/07	141- 143, 182- 185	Gambardella, Ralph A., M.D.	**P and S Rept** DOI: 08/09/07. Patient was initially seen by me on 09/10/07, relative to a work injury. At the time, patient was 58 years of age and had sustained an injury to her left knee on 08/09/07. This had occurred when she had slipped on a piece of cucumber and falling. Patient had injured her left knee as well as her ankle for which she had been under the care of Dr. Jung. Dr. Jung had referred patient here for an evaluation regarding her left knee. At the time of her evaluation, she was found to have a synovitis of the left knee with a mild pes bursitis with underlying early degenerative osteoarthritis and patellofemoral arthrosis with mild patellofemoral malalignment. We recommended a comprehensive PT program. Patient is here today. She has returned and states that she did undergo her PT program and with PT did see improvement of her knee condition. Patient states that she is no longer having any type of significant discomfort with the knee. She still gets some aches and minimal irritability. There has not been any recurrent swelling but has been still occasional swelling. Patient feels that her knee condition is improved to the point that she is capable of returning back to her regular employment. Patient, however, in the interim has also had a new work injury which occurred to her RLE resulting in a fracture in her right foot and today is ambulatory with the assistance of a cane and in a Moon boot. Patient is aware of the fact that she is being seen separately for her RLE injury. We have asked patient again and she has agreed and is comfortable with the fact that in the absence of her present right foot condition, that she would be able to

			return back to regular work relative to her left knee and her left knee has overall been significantly improved with only the occasional remaining symptomatology as outlined above. Exam: Physical examination today of the left knee, there is mild crepitance with ranging patellofemoral joint. ROM is 0-130 degrees. Dx: Underlying degenerative osteoarthritis including patellofemoral arthrosis and mild patellofemoral mal-alignment, left knee s/p posttraumatic synovitis and pes bursitis, left knee. Recommendations: This patient is in a P and S position for rating. Subjective factors: The permanent subjective factors to be considered are the occasional minimal pain with ADLs increasing to occasional to intermittent, minimal-to-slight pain with heavier squatting, kneeling, or lifting activities. Objective factors: The objective factors to be considered are the radiographic evidence of the patellofemoral joint space narrowing and degenerative osteoarthritis joint space narrowing noted radiographically. There are no other objective factors to be considered. Permanent work restrictions: None indicated. This patient can be released to her regular work activities effective 11/26/07. Future Medical Care requirements: In the future, this patient may have a flare-up of her condition that may require the use of oral anti-inflammatory medications, PT, and/or cortisone injection and/or arthroscopic surgical intervention. Causation: Based upon the history, this patient's condition is directly attributed to the work injury. Apportionment: There is no apportionment indicated as there is no residual disability. There was definite evidence of a pre-existing osteoarthritis as was outlined from my original report. However, at this time, there is no residual disability and therefore there does not appear to be a need for apportionment. Impairment rating: Using the AMA Guidelines to the Evaluation of Permanent Impairment, chapter 17, this patient using the radiographic table 17-31 had 1-mm joint space narrowing of the knee which is a 7% lower extremity impairment rating to that which would be added a 10% lower extremity impairment razing for the patellofemoral joint. This would combine to a 17% lower extremity impairment rating which then using table 17-3 translates into a 7% whole person impairment rating.
11/29/07	144- 146	Saucedo, Thomas, M.D.	**Consultation** DOI: 11/10/07. Patient sustained an injury to her right foot on the above-mentioned date. At that time, she indicates that while working, she apparently parked on a gravel road and when the car apparently started rolling without her in it, she ran towards the oar, got into the oar to put the emergency

			parking brake on and in that process twisted her right foot, fractured the fourth and fifth metatarsal, injured her left knee as well as her left ankle. She was seen at Kaiser initially and subsequently by Dr. Hadley. She has been treated with a Cam walker for the right foot and indicates that the pain has improved significantly however, she continues to have discomfort especially of the left ankle to a lesser extent the left knee. She has been on medication. She has been in a Cam walker and has been off of work. PMH: Hypertension. Past surgeries: Include left ankle surgery 14 years ago still has the plate and screws in place), left knee injury as well. Meds: Include Tylenol as well as Motrin. Allergies: Penicillin - develops a rash. Exam: Right foot pain. Right foot: Exam reveals of notable tenderness over the fourth and fifth metatarsal area. There is notable swelling. Left ankle: Exam reveals evidence of diffuse tenderness over the anterior as well as the lateral and anterior aspect of the ankle, She dorsiflexes to 5 degrees, plantar flexes to 15 degrees. Left knee: Exam reveals evidence of mild tenderness, mild swelling. X-rays of the right foot reveal evidence of a fracture of the fourth and fifth metatarsals overall well aligned. X-rays of the left knee reveal evidence of an old avulsion fracture with no acute fractures noted. X-rays of the left ankle reveal evidence of a healed medial and lateral malleolus fracture with retained plate and screws; however, there is evidence of extensive degenerative osteoarthritis of the tibiotalar articulation. Impression: Right foot fourth and fifth metatarsal fracture. Left ankle posttraumatic degenerative osteoarthritis. Left knee sprain. Discussion: I will recommend that patient continue the use of a Cam walker for her right foot. I will also recommend she continue off of work until further progress is made. She will continue the use of Motrin for pain and inflammation and I would like to reexamine her in three weeks time, at which time x-rays will be taken to assess the healing process or the fractures of the right foot.
12/20/07	186- 187	Saucedo, Thomas, M.D.	**Orthopedic Supplemental Rept (PR-2)** Patient has been under our care with a diagnosis of a fracture of her right fourth and fifth metatarsal. She has been using a Cars walker and indicates that her pain has steadily improved. Patient has also complained of pain and discomfort of her left knee and her left ankle, which she indicates has been improving subjectively since her last visit. Exam: Right foot: There is evidence of mild tenderness. There is mild swelling. Left knee: Reveals evidence of mild tenderness. Left ankle: Reveals evidence of mild tenderness

			in the anterolateral aspect of the ankle. X-rays of the right foot reveal evidence of a healing fourth and fifth metatarsal fracture, overall good position. Dx: Healing right fourth and fifth metatarsal fracture. Left knee sprain. Left ankle sprain. Discussion: I will recommend that patient at this time continue off of work. I will encourage her to continue the use of a Cam walker to allow the fractures to heal. A knee immobilizer will be provided for her left knee and I will recommend that she weight bear as tolerated with the assistive devices. I will maintain her off of work and I would like to see her back for fallow-up in four weeks' time, at which time x-rays will be taken to assess the healing fractures.
03/19/08	190- 193	HealthCare Partners	**Radiology/Diagnostics** MRI of Left Knee. Clinical indications: Rule out internal derangement. No known surgery. Impression: 1) Tear, posterior born, medial meniscus (Grade III). 2) Early osteoarthritic changes of the medial compartment of the knee joint. 3) Knee joint effusion.
05/09/08	206	Associated Sports Therapy	Dx: Left knee internal derangement. Plan: PT, 3 x/week x 4 weeks.
07/18/08	201, 204-206	Associated Sports Therapy	Patient participated in PT sessions from 05/09/18 to 07/18/08 in an effort to decrease pain and tenderness and to increase ROM and strength.
01/26/11	136- 138		**Orthopedic Supplemental Rept** Patient has been under our care having previously undergone arthroscopic surgery of her knee. Surgery was performed on 04/24/08. She indicates that she did well, however, she did have some residual soreness, this soreness has steadily become more pronounced. She denies any new injuries to her left knee. She denies any other problem to her left knee and indicates that she has continued to work with D'Veal Family Youth Svcs performing her work related activities. However, she does complain of increased pain of her left knee especially over the last few months. BP: 206/100. Exam: Lower extremities: On physical examination of the left knee there is evidence of notable medial joint line tenderness, there is notable swelling. There is an effusion. She has a positive McMurray sign and positive grind sign. There is notable pain and discomfort especially of the medial compartment of the knee. No gross laxity is noted. Motor and sensory function is intact distally. Diagnostic studies: X-rays of the left knee reveals evidence of Grade III medial compartment narrowing of the left knee with osteophyte formation noted primarily in the medial compartment. Impression: Left knee evidence of medial compartment

			degenerative osteoarthritis. Discussion: Given patient's clinical findings as well as the results of her x-rays it appears that she has extensive degenerative changes of the medial compartment of her left knee. This has progressively gotten worse since she had surgery three years ago and at this point in time it appears that the pain is quite unrelenting. I will recommend that she be treated conservatively at this point in time with the use of an anti-inflammatory medication as well as an intra-articular cortisone injection to minimize her pain and discomfort, this was provided. Patient noted immediate improvement of the pain and discomfort of the left knee. I will see her back for f/u in four weeks time. Should this patient's symptoms not improve or resolve significantly, she may require further intervention. This would entail a knee arthroplasty of her left knee. At this point in time I have discussed this in detail with patient and I will see her back for f/u to assess her progress in four weeks time. She will continue to work with no restrictions. I will keep you informed as noted.

Records Categories

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STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

WORKERS' COMPENSATION APPEALS BOARD

Floreen Rooks
DOB: 06/20/49
AKA:
File: CLA: 05124168; DOL: 08/09/2007

Claimant/Applicant,

vs.

Dveal Family & Youth Services

Employer/Insurance Carrier/Defendant.

Case No. SIF7024643, SIF10825285,SIF7024645
(IF APPLICATION HAS BEEN FILED, CASE NUMBER MUST BE INDICATED REGARDLESS OF DATE OF INJURY)

SUBPOENA DUCES TECUM

(When records are mailed, identify them by using above case number or attaching a copy of subpoena)

Where no application has been filed for injuries on or after January 1, 1990 and before January 1, 1994, subpoena will be valid without a case number, but subpoena must be served on claimant and employer and/or insurance carrier.

See instructions below.*

The People of the State of California Send Greetings to: State Compensation Insurance Fund

WE COMMAND YOU to appear before A Deposition Officer – Med-Legal, LLC

at 955 Overland Ct, Suite 200, San Dimas, CA 91773,Phone 800-244-3495

on the 09/14/20 day of __________, at 10:00 o'clock AM., to testify in the above-entitled matter and to bring with you and produce the following described documents, papers, books and records.

See Attachment for a list of records to be produced subject to this subpoena, to make available for inspection and copying or transmit/transfer electronically.

(Do not produce X-rays unless specifically mentioned above.)

For failure to attend as required, you may be deemed guilty of a contempt and liable to pay to the parties aggrieved all losses and damages sustained thereby and forfeit one hundred dollars in addition thereto.

This subpoena is issued at the request of the person making the declaration on the reverse hereof, or on the copy which is served herewith.

Date 08/25/20

WORKERS' COMPENSATION APPEALS BOARD
OF THE STATE OF CALIFORNIA

Secretary, Assistant Secretary, Workers' Compensation Judge

***FOR INJURIES OCCURING ON OR AFTER JANUARY 1, 1990, AND BEFORE JANUARY 1, 1994**

If no Application for Adjudication of Claim has been filed, a declaration under penalty of perjury that the Employee's Claim for Workers' Compensation Benefits (Form DWC-1) has been filed pursuant to Labor Code Section 5401 must be executed properly.

SEE REVERSE SIDE
[SUBPOENA INVALID WITHOUT DECLARATION]

You may fully comply with this subpoena by mailing the records described (or authenticated copies, Evid. Code 1561) to the person and place stated above within ten (10) days of the date of service of this subpoena.

This subpoena does not apply to any member of the Highway Patrol, Sheriff's Office or city Police Department unless accompanied by notice from this Board that deposit of the witness fee has been made in accordance with Government Code 68097.2, et seq.

DWC WCAB 32 (Side 1) (REV. 06/18)

HIPAA Compliant Request Control #: **21-21912-5**

Do <u>not</u> appear! Simply call (800) 244-3495 and somebody will copy the records for you at your office.

DECLARATION FOR SUBPOENA DUCES TECUM

Case No. SIF7024643, SIF10825285,SIF7024645

STATE OF CALIFORNIA, County of Los Angeles

The undersigned states: That Med-Legal, LLC has been authorized to obtain records by

Natalia Foley, Esq Workers Defenders Law Group
That he /she is (one of) the attorney(s) of record / representative(s) for the applicant/defendant in the action captioned on the reverse hereof. That State Compensation Insurance Fund
has in his/her possession or under his/her control the documents described on the reverse hereof. That said documents are material to the issues involved in the case for the following reasons:
Based on the information and belief to resolve any dispute in the above referenced case.

Declaration for Injuries on or After January 1, 1990 and Before January 1, 1994

☐ That an Employee's Claim for Workers' Compensation Benefits (DWC Form 1) has been filed in accordance with Labor Code Section 5401 by the alleged injured worker whose records are sought, or if the worker is deceased, by the dependent(s) of the decedent, and that a true copy of the form filed is attached hereto. *(Check box if applicable and part of declaration below. See instructions on front of subpoena.)*

I declare under penalty of perjury that the foregoing is true and correct

Executed on 08/25/20 , at San Dimas, California.

Signature	Address	Telephone
[signature]	955 Overland Court, Suite 200, San Dimas, CA 91773	(626) 653-5160

Victor Landero, Operations

DECLARATION OF SERVICE

STATE OF CALIFORNIA, County of Los Angeles

I, the undersigned, state that I served the foregoing subpoena by showing the original and delivering a true copy thereof, together with a copy of the Declaration in support thereof, to each of the following named persons, personally, at the date and place set forth opposite each name.

Name of Person Served	Date	Place

I declare under penalty of perjury that the foregoing is true and correct

Executed on________________, at____________________, California.

____
Signature

Control #: **21-21912-5**

DWC WCAB 32 (Side 2) (REV. 06/18)

Attachment

Re:

Patient/Applicant: Floreen Rooks　　Social Security #: 000-00-0000
AKA:　　D.O.B.: 06/20/49

Ordered By:

Natalia Foley, Esq
Workers Defenders Law Group
5753 E Santa Ana Cyn Rd Ste G #616
Anaheim, CA 92807

Records to produce:

Deponent's file #: CLA: 05124168; DOL: 08/09/2007
Exclusions (if any):

Date Range (if any):

For each injury alleged by the Applicant named on the Subpoena, produce the following:

A signed "Declaration of Custodian of Records" must accompany the records.

This notice of deposition includes a demand for all documents under your custody and control regarding the above claim number as described below for the applicant, herein claimant, listed on the notice of deposition.

This demand does not include privileged documents defined as:

1. Any documentation or correspondence between an attorney representing the deponent and any employee of the deponent.
2. Any documentation or correspondence between the designated spokesperson representing the employer and an attorney who represents that employer unless that documentation has been disclosed to a third party or an insurance company.
3. Any documents prepared by any attorney that are the attorney's impressions, conclusions, opinions or legal research or theories.
4. That portion of a report prepared by an investigator at the request of an attorney that contains the investigator's impressions, conclusions, opinions or theories.
5. Any surveillance video of claimant where the claimant's deposition has not been taken and the deponent intends to take the deposition of the claimant and that surveillance video has not been disclose to a third party or physician.

This demand includes:

1. The Employee's Claim for Workers' Compensation Benefits, DWC Form 1, showing the employer's date of knowledge of injury, the date the employer provided the form to the employee and the date the employer received the completed form from the employee.
2. All documentation of the date the employer provided a claim form to the employee or that the administrator has provided the claim form to the employee.
3. All Employer's Report of Occupational Injury or Illness, DLSR Forma 5020, or documentation of reasonable attempts to obtain it.

Notice: For Subpoenas of claim files, you are to send the claim file directly to Med-Legal only. Sending the claim file to other than Med-Legal will be considered to be in non-compliance of the subpoena.

If any of the documents described above that are in your possession or control are not being produced then a detailed list of each withheld document must be included with the records production or listed on your declaration.

Where used, the terms "writing", "record", "document" and other words of similar meaning include (but are not limited to) electronically maintained image files, documents, notes, faxes, emails and other similar types of electronically held information. If the subpoenaed records exist in paper they are to be provided for inspection and copying. If the subpoenaed records exist electronically then they are to be provided either electronically through our Internet portal at upload.getrecords.com or on CD.

4. All Doctor's First Report of Occupational Injury or Illness, DLSR From 5021, or documentation of reasonable attempts to obtain them.
5. All medical reports pertaining to the claim, or documentation of reasonable attempts to obtain them.
6. All orders or awards of the Workers' Compensation Appeals Board or the Rehabilitation Unit pertaining to the claim.
7. The application(s) for adjudication of claim filed with the Workers' Compensation Appeals Board.
8. All notices and correspondence related to the Qualified Medical Evaluation process required by Labor Code Section 4061 and 4062.
9. All documentation regarding the injured workers earnings and of reasonable attempts to obtain this information.
10. All documentation regarding the claimant's earning capacity, including documentation of any increase in earnings likely to have occurred but for the injury (such as periodic salary increases or increased earnings upon completion of training status) and of reasonable attempts to determine this information.
11. All notes (including email and computer notes) describing telephone conversations relating to the claim including the dates of calls, substance of calls, and identification of parties to the calls.
12. All correspondence (including Email) to and from all medical providers and medical examiners regarding all injuries or illnesses affecting this claim.
13. A copy of any and all records regarding applicant. All summaries or analysis of medical records prepared by any person other than attorneys.
14. All employment records, including personnel records, in all files wherever located, including supervisor files, accident or injury investigation files, personnel files, disciplinary files, and all employment records as defined by Labor Code section I198.5 in your possession or under your control.
15. All documents evidencing that claimant has chosen a pre-designated treating physician(s) before the occurrence of the injuries alleged in this matter.
16. All documents showing the employer has contracted with health care organizations to provide services and medical treatment to injured employees that include claimant.
17. All statements by any person whether a percipient witness to any alleged injuries or with any knowledge regarding any accidents or injuries to claimant whether written recorded or notes of the conversation.
18. All investigation reports involving any known, alleged or reported injuries by claimant.
19. All photographs or images of any scenes or locations or of any objects or equipment regarding any accident or know, alleged and reported injury to claimant.
20. All ergonomic studies of claimant's work area during the period of the alleged injury to claimant.
21. All photographs or images of claimant, including, but not limited to, those depicting any possible visible signs of injuries or disabilities or the lack thereof.
22. All films, movies, motion pictures, video tapes in any format or form purporting to depict claimant in any manner or activity whether depicting disability or lack of disability taken at anytime in the possession of deponent or under the control of deponent including any agent or investigators hired by deponent.
23. All documents including billing statements and reports regarding any surveillance of claimant by any agent or investigator hired by deponent, employer, insurance company or any agent of deponent, employer or insurance company. The documents are to show the name of the person conducting the surveillance, his or her employer, address of his or her employer, date, starting time of surveillance, and ending time of surveillance, minutes of filming or video taping, and any written notes or reports regarding the surveillance.
24. Any documents or records from any index, EDEX, or database of accidents, injuries, or workers' compensation claims attributed to or claimed by claimant, at any time.
25. All vocational rehabilitation documents or reports including job descriptions and job analysis prepared by any Qualified Rehabilitation Representative or vocational rehabilitation expert or nurse.
26. All documents, notes and reports by medical case managers involving this claim.
27. All documents showing proof of compliance with Title 8, California Code of Regulations section 9792.6 for any Utilization Review of any medical request by a physician in this matter.
28. If liability for the claim has not been accepted a copy of all investigation and medical evidence considered or relied upon as the basis for not accepting liability.
29. All documents showing all efforts by the employer to find modified or alternative work for the claimant.

Notice: For Subpoenas of claim files, you are to send the claim file directly to Med-Legal only. Sending the claim file to other than Med-Legal will be considered to be in non-compliance of the subpoena.

If any of the documents described above that are in your possession or control are not being produced then a detailed list of each withheld document must be included with the records production or listed on your declaration.

Where used, the terms "writing", "record", "document" and other words of similar meaning include (but are not limited to) electronically maintained image files, documents, notes, faxes, emails and other similar types of electronically held information. If the subpoenaed records exist in paper they are to be provided for inspection and copying. If the subpoenaed records exist electronically then they are to be provided either electronically through our Internet portal at upload.getrecords.com or on CD.

30. All documents showing all efforts by the employer to make reasonable accommodation for claimant's physical or mental disability.

Notice: For Subpoenas of claim files, you are to send the claim file directly to Med-Legal only. Sending the claim file to other than Med-Legal will be considered to be in non-compliance of the subpoena.

If any of the documents described above that are in your possession or control are not being produced then a detailed list of each withheld document must be included with the records production or listed on your declaration.

Where used, the terms "writing", "record", "document" and other words of similar meaning include (but are not limited to) electronically maintained image files, documents, notes, faxes, emails and other similar types of electronically held information. If the subpoenaed records exist in paper they are to be provided for inspection and copying. If the subpoenaed records exist electronically then they are to be provided either electronically through our Internet portal at upload.getrecords.com or on CD.

Case Name: Floreen Rooks v. Dveal Family & Youth Services

Case Number: SIF7024643, SIF10825285,SIF7024645

PROOF OF SERVICE BY MAIL

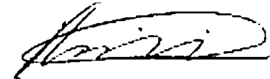
Notice of Copying , Deposition Notice

I declare that I am employed in the County of Los Angeles, over the age of 18 years and not a party to this action. My business address is: 955 Overland Court, Ste. 200 San Dimas, California 91773.

On 8/26/2020 I caused to be served, at my direction and following ordinary business practices, true copies of the document(s) referenced above for collection and mailing in a sealed envelope and addressed to the parties listed below. I am readily familiar with the business practices of Med-Legal, LLC for collection and processing of correspondence for mailing. The document was set for same day mail processing and collection, with postage fully paid, for delivery by the United States Postal Service or private delivery service following ordinary business practices.

SIBTF SACRAMENTO
160 PROMENADE CIRCLE, SUITE 350
SACRAMENTO CA 95834

I declare under penalty under the penalty of perjury under the laws of the State of California, the foregoing is a true and correct statement. Executed on 8/26/2020 at San Dimas, California.



/s/ Roderic B. Davis
Business Document Manager
Med-Legal, LLC
21-21912-5

APPLICANT/PLAINTIFF/PETITIONER: **Floreen Rooks** DEFENDANT/RESPONDENT: Dveal Family & Youth Services	CASE NUMBER: SIF7024643, SIF10825285,SIF7024645

PROOF OF SERVICE OF DEPOSITION SUBPOENA FOR PRODUCTION OF BUSINESS RECORDS

1. I served this *Deposition Subpoena for Production of Business Records* by delivering a copy to the person served as follows:

   ____Personal Delivery ____Certified Mail ____Regular Mail __X__Via Facsimile

   a. Person served (name): State Compensation Insurance Fund Email to CentralizedSDT@scif.com

   b. Address where served: 655 N Central Ave, 4th floor Glendale, CA 91203

   c. Date of delivery: 09/09/20 Time of delivery: 4:19pm

   d. Deposition date is: ☐ ________ ☒ 09/14/20

   e. (1) ☐ Witness fees were paid.
      Amount: ________ $________ Check Number : 0

      (2) ☐ Copying fees were paid.
      Amount: ________ $________

   f. Fee for service: ________ $________

2. I received this subpoena for service on (date): 09/09/20
3. Person serving:
   a. ☐ Not a registered California process server.
   b. ☐ California sheriff or marshal
   c. ☐ Registered California process server.
   d. ☒ Employee or independent contractor of a registered California process server.
   e. ☐ Exempt from registration under Business and Professions Code Section 22350(b).
   f. ☐ Registered professional photocopier.
   g. ☐ Exempt from registration under Business and Professions Code section 22451.
4. Name, address, telephone number, and, if applicable, county of registration and number:
   Vanessa Lopez
   955 Overland Ct, Suite 200, San Dimas, CA 91773,Phone 800-244-3495

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

Date: 09/09/20

► Vanessa Lopez LACO#7235

(SIGNATURE)

(For California sheriff or marshal use only)
I **certify** that the foregoing is true and correct.

Date: ________

► ________

(SIGNATURE)

PROOF OF SERVICE
DEPOSITION SUBPOENA FOR PRODUCTION OF BUSINESS RECORDS

Control Number: 21-21912-5

Records Order Form

08/25/20

Notice of Copying to:

SIBTF SACRAMENTO
160 PROMENADE CIRCLE, SUITE
350
SACRAMENTO, CA 95834

Case Information

Applicant: Floreen Rooks
Employer: Dveal Family & Youth Services
Case #: SIF7024643, SIF10825285,SIF7024645
DOI: 11/10/07 **SS#**: 000-00-0000
Claim #: Not Supplied by Carrier
Ordering party: Natalia Foley, Esq

Record Location: State Compensation Insurance Fund

Records of the Injured Worker are being produced at the above record location and delivered to the opposing party. You may receive copies of the records by selecting one of the following;

Title 8, CCR § 9982 Allowable Services. (A)... services for records relevant to an injured worker's claim, except services under a contract between the employer and the copy service provider.

☐ Electronic Set per Billing Codes WC026 or WC027
Fees set by § 9983 *Fees for Copy and Related Services (f)(2)*
Number of Sets ____

☐ CD Set per Billing Codes WC026 or WC027
Fees set by § 9983 *Fees for Copy and Related Services (f)(2)*
Number of Sets ____

Send records:

☐ Same as above

E-mail addresses required for the electronic sets:
____________________@_______________
____________________@_______________

☐ **Bill to My Office** (*Invoice will be sent to the address on this notice.*)

☐ **Bill to the Insurance Carrier**

______________________________ (Print your name)

______________________________ (Sign your name) **Control #: 21-21912-5**
(Signature required)

Med-Legal, LLC
Photocopy Reg #/County x-423/Los Angeles
Tax ID # 45-4424177
955 Overland Court, Suite 200, San Dimas, CA 91773, (800) 244-3495 FAX (800) 962-4896

There was no violation of California Labor Code Section 139.32 with respect to the services described herein.

Start of Records

Claims

October 30, 2020

Med Legal, Llc
955 Overland Ct
Ste 200
San Dimas CA 91773 1747

Claim Number: 05124168
Employee: Floreen Rooks
Date of Injury: 08/09/2007

02 318168 000000001 001 195 05124168

Subpoena Reference Number : 21 21912 5

Enclosed please find the documents subject to your subpoena.

State Compensation Insurance Fund.

8083

02 318168 000000001 002 195 05124168

INJURED NAME: Floreen Rooks CLAIM NUMBER: 05124168

DECLARATION

I hereby declare under penalty of perjury that the following statements are true, to the best of my knowledge and belief.

I am the custodian of records for State Compensation Insurance Fund. The records made available are all records called for in the attached Subpoena which State Compensation Insurance Fund is legally obligated to produce. All other records in State Compensation Insurance Fund's possession are privileged information.

SA Admin Support

Signature

October 30, 2020

Date

SCIF RECD DTE 09/21/2007 BKSCAN 5 09/21/2007 09:04 AM 023037 9 6

02 318168 000000001 040 195 05124168

McKESSON

SunMark® Performance

Limited Warranty

CANES

16-7710	16-7714	16-7727	16-7730	16-7742
16-7712	16-7726	16-7728	16-7735	16-7745

WALKERS

16-7531	16-7534	16-7535	16-7536	16-7539
16-7533				

BATH AIDS

16-7801	16-7811	16-7818	16-7841	16-7846
16-7807	16-7812	16-7823	16-7842	16-7847
16-7808	16-7815	16-7824	16-7843	16-7848
16-7809	16-7816	16-7831	16-7844	16-7849
16-7810	16-7817	16-7832	16-7845	

Marketed By
McKesson Corporation
McKesson Medical-Surgical
Richmond, VA 23228

LW-3279-1003

claim#-05124168

SCIF RECD DTE 09/10/2007 BKSCAN 6 09/10/2007 03:01 PM 023726 24 9

STATE COMPENSATION INSURANCE FUND

Case No. 05124168

REPORT OF EMPLOYEE'S PRESENT WORK STATUS

IMPORTANT: Immediate completion and return of this form will assure prompt payment of compensation due you.

STATEMENT OF INJURED

I returned to work on ______________ (Date)

Name of present employer ______________

Wages now received ______________ per ______________ (Day, week or month) for ______________ days per week

— OR —

I will be unable to work until FYI / FURTHER NOTICE (Date)

Remarks As of 8/28/07 I was emailed a directory of State Comp. INS. Fund MPN directories, and scheduled an appt with Dr. E. Gambardella @ ~~Kerian Jobe Ortho. Clinic on 9/4/07.~~ AS such, AT THIS TIME I'm not sure when I will return to work.

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Injured's Signature [signature] Date 8/30/07

Address 1315 S. Gladys Ave, San Gabriel, CA Zip 91776

IF YOU HAVE NOT RETURNED TO WORK
HAVE YOUR ATTENDING DOCTOR COMPLETE THE LOWER PORTION

STATEMENT OF ATTENDING DOCTOR

Injured able to return to work on ______________ (Date) SEE ATTACHED WORK STATUS REPORT DATED 8/27/07

Have you discharged injured? ______________ If so, give date ______________

Probable duration of further disability ______________

Remarks ______________

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature of Attending Doctor ______________ Date ______________

SCIF 3089 (REV. 5-95)

1211

8083

02 318168 000000001 063 195 05124168

DREAMWEAVER
MEDICALGROUP

FAX TRANSMITTAL

To: Sherry Chou

Company: State Fund

Phone Number:

Fax Number: (818)662-6341

From: Valerie

Phone Number: (626) 289-8493

Fax Number: (626) 289-8526

Date: 8-28-07

Pages Including Cover Page: 6

Comments:
records as requested for Floreen Books.

Please call, (626) 289-8493 should you have any problems receiving this facsimile.

This message is intended only for the use of the individual or entity to which it is addressed, and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us at the below address via the U.S. Postal service. Thank you.

420 West Las Tunas Drive, San Gabriel, CA 91776

05124168

SHERIE CHOU
AUG 28 2007
LA GLENDALE LOC.

DREAMWEAVER
MEDICALGROUP

FAX TRANSMITTAL

To: Sherry Chou

Company: State Fund

Phone Number:

Fax Number: (818) 662-6741

From: Valerie

Phone Number: (626) 289-8493

Fax Number: (626) 289-8526

Date: 8-28-07

Pages Including Cover Page: 4

Comments:
Xray reports for Florean Books

Please call, (626) 289-8493 should you have any problems receiving this facsimile.

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420 West Las Tunas Drive, San Gabriel, CA 91776

05124168

SHERIE CHOU
AUG 29 2007
LA D.O. GLENDALE LOC.

0512468 TR0 195 00000001 S18168 02

DREAMWEAVER

MEDICALGROUP

FAX TRANSMITTAL

To: Sherry Chou

Company: State Fund

Phone Number:

Fax Number: (818) 662-6741

From: Valerie

Phone Number: (626) 289-8493

Fax Number: (626) 289-8526

Date: 8-28-07

Pages Including Cover Page: 4

Comments:

X-ray reports for Florean Banks

Please call, (626) 289-8493 should you have any problems receiving this facsimile.

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420 West Las Tunas Drive, San Gabriel, CA 91776

05124168

SHERIE CHOU
AUG 2 8 2007
LA D.O. GLENDALE LOC.

02 318168 000000001 082 195 05124168

Page 1 of 2 received on 3/1/2010 1:44:39 PM [Pacific Standard Time] on server FDICRF01 from .

State of California
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT
REQUEST FOR QME PANEL UNDER LABOR CODE § 4062.1
UNREPRESENTED
(Please print or type)

05124168

Request date (Required): 3/1/2010 Date of Injury (Required): 8/9/2007 11/10/2007 Claim Number (Required): 05170360

Specialty Requested *(Required)*: MOS *(use 3 letter code only)*

Requesting party *(Check one box only)*:
- [x] Unrepresented Injured Employee
- [ ] Claims Administrator, if none, Employer
- [ ] Defense Attorney

Reason QME panel is being requested *(Check one box only)*:
- [ ] § 4060 (compensability exam)
- [x] § 4061 (permanent impairment or disability dispute)
- [ ] § 4062 Injured employee only (medical treatment determination, UR dispute or other 4062 reason)
- [ ] § 4062 Claims administrator only (non treatment medical determination or non-UR reason under 4062)
- [ ] §§ 4061 and 4062 dispute (medical treatment and permanent impairment or disability dispute)

If the Claims administrator is requesting a 4062 panel explain the reason for the request:

Answer each question below:

Has this claim been denied? [ ] Yes [x] No

Has any body part in this claim been accepted? [x] Yes [ ] No

If yes, indicate the date of the denial ________

Did notice to injured employee state employer requests an evaluation to determine compensability? *(Attach copy of notice)* [ ] Yes [x] No

Does dispute involve an MPN: [ ] Continuity or Transfer of Care [x] Permanent Disability, Future Medical, UR decision [ ] Diagnosis/Treatment ?

Employee Information

First Name: FLOREEN R. Middle Initial: S. Last Name: ROOKS

Street Address: 1315 S. Gladys Avenue

City: San Gabriel State: CA Zip Code: 91776 Daytime Phone No: (626) 354-4900

If you now live out of state, list the California city and zip code of your residence when injured: N/A

If you never resided in California, list the California zip code in which you would like to be evaluated: N/A

Employer and Claims Administrator Information

Employer: DIVEAL FAMILY & YOUTH SERVICES

Claims Administrator Name: State FUND

Adjustor name: Yolanda L. Nelsen

Street Address or P.O. Box: P.O. Box 92622.

City: Los Angeles State: CA Zip Code: 90009 Phone No. (818) 291-7626

05124168

Claim Number: 05170360

Prior QME Panel Information *(Answer all that apply)*

Has the employee ever received a QME panel before? ☐ Yes ☒ No ☐ Unknown

If yes, did the employee ever see any QME from that panel? ☐ Yes ☐ No ☐ Unknown

If yes, has that claim been settled or resolved? ☐ Yes ☐ No ☐ Unknown

If yes, name of QME seen: ______________________ Specialty: ____________

Date of Injury: __________ Body parts ______________________ Date of Exam: __________

Panel Number (If known): __________ Is that QME available now: ☐ Yes ☐ No ☐ Unknown

The completed form must be mailed to:
Division of Workers' Compensation-Medical Unit
P.O. Box 71010, Oakland, Ca 94612
(510) 286-3700 or (800) 794-6900

Date: March 1, 2010

FLOREEN S. ROOKS

Print Name of Requestor

[signature]

Signature of Injured Employee

Note: Each employer or claims administrator submitting this form to request a QME panel must attach a copy of the correspondence and required notices sent to the injured employee with the panel request form

05124168

Page 1 of 2 received on 3/1/2010 1:44:59 PM [Pacific Standard Time] on server FDICRF01 from .

State of California
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT
REQUEST FOR QME PANEL UNDER LABOR CODE § 4062.1
UNREPRESENTED
(Please print or type)

05124168

Request date (Required): 3/1/2010 Date of Injury (Required): 8/9/2007 11/10/2007 Claim Number (Required): 05170360

Specialty Requested *(Required)*: MOS
(use 3 letter code only)

Requesting party *(Check one box only)*:
☑ Unrepresented Injured Employee
☐ Claims Administrator, if none, Employer
☐ Defense Attorney

Reason QME panel is being requested *(Check one box only)*:
☐ § 4060 (compensability exam)
☑ § 4061 (permanent impairment or disability dispute)
☐ § 4062 Injured employee only (medical treatment determination, UR dispute or other 4062 reason)
☐ § 4062 Claims administrator only (non treatment medical determination or non-UR reason under 4062)
☐ §§ 4061 and 4062 dispute (medical treatment and permanent impairment or disability dispute)

If the Claims administrator is requesting a 4062 panel explain the reason for the request:

Answer each question below:

Has this claim been denied? ☐ Yes ☒ No Has any body part in this claim been accepted? ☒ Yes ☐ No

If yes, indicate the date of the denial ______

Did notice to injured employee state employer requests an evaluation to determine compensability? *(Attach copy of notice)* ☐ Yes ☒ No

Does dispute involve an MPN : ☐ Continuity or Transfer of Care ☒ Permanent Disability, Future Medical, UR decision ☐ Diagnosis/Treatment ?

Employee Information

First Name: FLOREEN R Middle Initial: S. Last Name: ROOKS

Street Address : 1315 S. Gladys Avenue

City: San Gabriel State: CA Zip Code: 91776 Daytime Phone No: (626) 354-4900

If you now live out of state, list the California city and zip code of your residence when injured: N/A

If you never resided in California, list the California zip code in which you would like to be evaluated: N/A

Employer and Claims Administrator Information

Employer: DIVEAL FAMILY & YOUTH SERVICES

Claims Administrator Name: State FUND

Adjustor name: Yolanda L. Nielsen

Street Address or P.O. Box: P.O. Box 92622.

City: Los Angeles State: CA Zip Code: 90009 Phone No. (818) 291-7626

05124168

05124168

Claim Number: 05170360

Prior QME Panel Information *(Answer all that apply)*

Has the employee ever received a QME panel before? ☐ Yes ☒ No ☐ Unknown

If yes, did the employee ever see any QME from that panel? ☐ Yes ☐ No ☐ Unknown

If yes, has that claim been settled or resolved? ☐ Yes ☐ No ☐ Unknown

If yes, name of QME seen: ______________________ Specialty: ______________

Date of Injury: __________ Body parts ______________________ Date of Exam: __________

Panel Number (If known): ______________ Is that QME available now: ☐ Yes ☐ No ☐ Unknown

The completed form must be mailed to:
Division of Workers' Compensation-Medical Unit
P.O. Box 71010, Oakland, Ca 94612
(510) 286-3700 or (800) 794-6900

Date: March 1, 2010

FLOREEN S. ROOKS
Print Name of Requestor

[signature]
Signature of Injured Employee

Note: Each employer or claims administrator submitting this form to request a QME panel must attach a copy of the correspondence and required notices sent to the injured employee with the panel request form

Page 2 of 2 received on 3/1/2010 1:44:59 PM [Pacific Standard Time] on server FDICRF01 from -

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Empleado: Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al (800) 736-7401 para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabajador.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

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.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee - complete this section and see note above. ***Empleado - complete esta sección y note la notación arriba.***

1. Name. *Nombre.* FLOREN ROOKS Today's Date. *Fecha de Hoy.* 8/30/07
2. Home Address. *Dirección Residencial.* 1315 S. Gladys Ave.
3. City. *Ciudad.* San Gabriel State. *Estado.* CA Zip. *Código Postal.* 91776
4. Date of Injury. *Fecha de la lesión (accidente).* August 9, 2007 Time of injury. *Hora en que ocurrió.* ___ a.m. 12:15 p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* 3330 N. LINCOLN AVE, Altadena, CA, (LOMA ALTA PARK).
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* SLIPPED ON A PIECE OF cucumber + fell onto concrete PAVEMENT
7. Social Security Number. *Número de Seguro Social del Empleado.* 130-38-8510
8. Signature of employee. *Firma del empleado.* Floren Rooks

Employer - complete this section and see note below. ***Empleador - complete esta sección y nota la notación abajo.***

9. Name of employer. *Nombre del empleador.* ______
10. Address. *Dirección.* ______
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* ______
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* ______
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* ______
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* **State Compensation Insurance Fund**
15. Insurance Policy Number. *El número de la póliza de Seguro.* ______
16. Signature of employer representative. *Firma del representante del empleador.* ______
17. Title. *Título.* ______ 18. Telephone. *Teléfono* ______

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within one working day of receipt of the form from the employee.

Empleador: Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de un día hábil desde el momento de haber sido recibida la forma del empleado.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/*Copia del Empleado* ☒ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

STATE COMPENSATION INSURANCE FUND

SCIF 3301 (REV. 7-04) - DWC Form 1 (REV. 7-04)

1227

8083

SCIF RECD DTE 04/11/2012 VLSCAN 42 04/12/2012 10:12 AM 038861 10 1

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

MINUTES OF HEARING

ADJ 7024643
ADJ 7024645
Case No.

03/12/2012
Date of Hearing (MM/DD/YYYY)

Hearing Information

☐ Before ☒ AT ☐ Trial ☐ Conf ☒ MSC ☐ EXP. HEARING ☐ Lien

Request Date (MM/DD/YYYY) ____________

Applicant

FLOREEN
First Name

MI

ROOKS
Last Name

VS

Defendants

DUBAL FAMILY AND YOUTH SERVICES
Employer Name (Please leave blank spaces between numbers, names or words)

Appearances

Applicant ☐ Present ☒ Not Present

	Attorney	Hearing Rep
Applicant Represented By ____________	☐	☐
Defendant Represented By LENA TSUI FOR STATE FUND	☒	☐
Others Appearing ____________	☐	☐

Interpreter ____________ Cert. No. ____________

Party Making Request

☐ Joint ☐ Applicant ☐ Defendant ☐ Other ____________

Request For: ☐ Continuance ☐ OTOC Request By: ☐ Letter ☐ Telephone

Position of Opposing Party

☐ Agree ☐ Oppose ☐ Unreachable ☐ Unknown

Reason For Request

- [ ] Applicant: Illness
- [ ] Applicant Now Represented
- [ ] Applicant Requests Representation
- [ ] Applicant: Vacation
- [ ] Calendar Conflict: Applicant
- [ ] Calendar Conflict: Defense
- [ ] Celender Conflict: Lien Claimant
- [ ] Change of Circumstances
- [ ] Consolidation
- [ ] Defense: Illness
- [ ] Defense: Vacation
- [ ] Dispute Resolved by Agreement
- [ ] Further Discovery: App Med
- [ ] Further Discovery: Def Med
- [ ] Further Discovery: AME
- [ ] Further Discovery: Depo
- [ ] Improper/Insufficient Notice by Party
- [ ] Joinder
- [ ] New Application
- [ ] No Issues Pending
- [ ] Non Appearance: Applicant
- [ ] Non Appearance: Defense
- [ ] Non Appearance: Lien Claimant
- [ ] Non Appearance: Witness
- [ ] Settlement Pending
- [ ] Unavailability of Witnesses: Applicant
- [ ] Unavailability of Witnesses: Defense
- [ ] Venue

Board Reason

- [ ] Arbitration
- [ ] Bankruptcy Pending
- [ ] Defective Notice
- [ ] Insufficient Time to Start
- [ ] Insufficient Time to Finish
- [ ] Interpreter Not Available
- [ ] Recusal
- [ ] Reporter Not Available
- [ ] Service Defective
- [ ] UEF Issues
- [ ] WCJ Not Available
- [x] Other/ Comments

I + A consulted w/ applicant.

Good Cause Appearing, It Is Ordered That the Request For

- [ ] Continuance Granted
- [ ] Continuance Denied
- [x] DTOC Granted
- [ ] OTOC Denied

_________ Days For
- [ ] C&R
- [ ] STIPS
- [ ] OTOC

Decision

- [x] OTOC
- [ ] C&R / STIPS Submitted for Approval
- [x] C&R / STIPS Approved
- [ ] LIEN STIPS and ORDER Approved
- [ ] N.O.I. to Allow/Disallow Issued

- [ ] MSC
- [ ] CONF
- [ ] TRIAL
- [ ] LIEN TRIAL
- [ ] CONTD TESTIMONY

Set On ________ At ________
MM/DD/YYYY

Location ________

Before Judge ________

- [ ] Supplemental Pages Attached ________ Pages

MAR 1 2 2012
Date - MM/DD/YYYY

Notice To SCIF

[signature]
WORKERS' COMPENSATION ADMINSTRATIVE LAW JUDGE
JUDGE LYNN A. DEVINE

Pursuant to Rule 10500 you are designated to serve this/these document(s) on all parties.

- [x] Served on parties and lien claimants present

REQUEST FOR ASSISTANCE

NAME OF CALLER:

REPRESENTING

DATE: 3/12/2012 TIME: PHONE

( ) TELEPHONED ( ) PLEASE CALL ( ) WAS IN
( ) RETURNED CALL ( ) WILL CALL AGAIN ( ) WANTS TO SEE YOU

NATURE OF CALLER:
A. EMPLOYEE ( )
B. EMPLOYER ( )
C. INS. CARRIER ( )
D. PHYSICIAN ( )
E. APP. ATTORNEY ( )
F. DEF. ATTORNEY ( )
G. UNION REP. ( )
H. LIEN CLAIMANT ( )
J. DIA/WCAB ( )
K. LEGISLATOR ( )
L. OTHER ( )

I&A #:
DEB #:
WCAB # (S): ADJ7246615

EMPLOYEE: Flooreen Rooks
D/I:
ADDRESS:
( ) TELEPHONE

EMPLOYER: Dvere Family Youth Services
ADDRESS:
( ) TELEPHONE

INSURANCE CARRIER: SCIF
ADDRESS:
( ) TELEPHONE

CARRIER CLAIM #:
OTHER CLAIM #:
ATTORNEY:
DOCTOR:

MEMO: I spoke to the applicant on several occasions, she asked questions + did her own research. We also discussed the "medical set aside" which came in lower than the SCIF estimate

Lena W. Tsai
Attorney

MAR 12 2012 claim# 05124168

DIA FORM IAB-4

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF INDUSTRIAL ACCIDENTS
INFORMATION AND ASSISTANCE BUREAU

RESOLUTION
RESOLVED ( )
NOT RESOLVED ( )
DEFERRED ( )

INFORMATION & ASSISTANCE OFFICER

I&A BUREAU (LOCATION)

8083

SCIF RECD DTE 04/11/2012 VLSCAN 42 04/12/2012 10:12 AM 038861 10 5

SCIF INSURED GLENDALE UNIT A
SALLY JACQUELINE G. SMITH
818-291-7270
SJGSMITH@SCIF.COM

SCAN AS ONE DOCUMENT

PROOF OF SERVICE BY MAIL - CCP 1013a, 2015.5

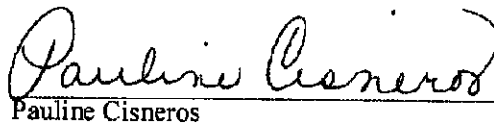
I declare that I am employed in the County of Los Angeles, State of California. I am over the age of eighteen years and not a party to the within entitled cause. My business address is: 655 North Central Avenue, Suite 400, Glendale, California 91203-1400. On April 11, 2012, I served the attached **ORDER APPROVING COMPROMISE & RELEASE WITH C&R PAPERS; MINUTES OF HEARING** on the interested parties in said cause, by placing a true copy thereof, enclosed in an envelope addressed as follows:

COPY TO CLAIMS
APR 10 2012

Floreen Rooks
2374 Olive Avenue
Altadena, CA 91001

I am readily familiar with the firm's practice of collection and processing correspondence for mailing. Under that practice such envelope would be sealed and deposited with U.S. postal service on that same day with postage thereon fully prepaid at Glendale, 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 the date of deposit for mailing in this affidavit.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on April 11, 2012, at Glendale, California.



Pauline Cisneros

Floreen Rooks
05170360
ADJ7024643

8083

SCI000028

02 318168 000000001 093 195 05124168

DIVISION OF WORKERS' COMPENSATION

WORKERS' COMPENSATION APPEALS BOARD

NOTICE OF HEARING

DATE OF SERVICE: 01/09/2012

EAMS CASE NBR(s): ADJ7024645

EMPLOYEE: FLOREEN ROOKS

EMPLOYER: D'VEAL FAMILY & YOUTH SERVICES

INSURER: SCIF INSURED GLENDALE

TYPE OF HEARING: Status Conference

DATE OF HEARING: 02/09/2012 THURSDAY

TIME OF HEARING: 08:30 A.M.

HEARING LENGTH (HOURS):

LOCATION: 320 W. 4TH ST.
#900
LOS ANGELES CA 90013

Map available at: *http://www.dir.ca.gov/dwc/dir2.htm*

JUDGE: Lynn Devine
213 576-7335

SPECIAL COMMENTS/INSTRUCTIONS:

RE: OSA

You are hereby notified that the above entitled case is set for hearing before the Division of Workers' Compensation of the State of California. Continuances are not favored and will be granted only upon clear showing of good cause. Please arrive before scheduled appearance time.

NOTICE TO PARTIES: **Disability Accommodation is available upon request.** Individuals with a disability requiring a reasonable accommodation (such as an auxiliary aid or service or a modification of policies or procedures) to ensure effective communication and access to the programs of the Division of Workers' Compensation, should contact the **Disability Accommodation Coordinator** at the local District Office of the DWC, or the **Statewide Disability Accommodation Coordinator at 1-866-681-1459 (toll free) or through the California Relay Service, by dialing 711 or 1-800-735-2929 (TTY) or 1-800-855-3000 (TTY-Spanish).**

Accommodations can include reasonable modifications of procedures or the provision of auxiliary aids or services including, but not limited to, assistive listening devices (ALD), Computer-Aided Realtime Translation (CART), sign language interpreters, documents in alternative formats, magnifiers, and audio cassette recordings. **Accommodation requests should be made as soon as possible and at least five (5) days before the hearing, especially for requests for an ALD, a sign language interpreter, or CART.**

NOTICE TO INSURER : The employer will not receive Notice of Hearing.

WC01

SCIFRec 01/11/2012 FRSCAN25 01/11/2012 08:34 AM 040002 31B

LAO-ADJ
320 W. 4TH ST.
#900
LOS ANGELES CA 90013

02 318168 000000001 094 195 05124168

SCIF INSURED GLENDALE
PO BOX 65005
PINEDALE CA 93650

02 318168 000000001 095 195 05124168

DIVISION OF WORKERS' COMPENSATION

WORKERS' COMPENSATION APPEALS BOARD

NOTICE OF HEARING

DATE OF SERVICE: 01/09/2012

EAMS CASE NBR(s): ADJ7024643

EMPLOYEE: FLOREEN ROOKS

EMPLOYER: D'VEAL FAMILY & YOUTH SERVICES

INSURER: SCIF INSURED GLENDALE

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LOS ANGELES CA 90013

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NOTICE TO INSURER : The employer will not receive Notice of Hearing.

WC01

LAO-ADJ
320 W. 4TH ST.
#900
LOS ANGELES CA 90013

02 318168 000000001 096 195 05124168

SCIF INSURED GLENDALE
PO BOX 65005
PINEDALE CA 93650

SCIF RECD DTE 03/13/2012 VLSCAN 45 03/14/2012 08:03 AM 040114 11 1

05124168

02 318168 000000001 097 195 05124168

STATE OF CALIFORNIA
WORKERS' COMPENSATION APPEALS BOARD

FLOREEN ROOKS Applicant,

vs.

D'VEAL FAMILY & YOUTH SERVICES; STATE COMPENSATION INSURANCE FUND
Defendants.

Case No(s): ADJ7024643
ADJ7024645

ORDER APPROVING COMPROMISE AND RELEASE And AWARD

☒ JOINT ORDER APPROVING C&R

The parties have filed a Compromise and Release in the above-entitled action together with the entire medical record, which is admitted into evidence and have waived the provisions of Labor Code § 5313. For the reasons set forth in the Compromise and Release and based upon an evaluation of the entire record, the settlement appears adequate and should be approved.

☒ The court has considered the release of applicant's dependents' rights to death benefits in determining the adequacy of the Compromise and Release. Sumner v. WCAB, 48 CCC 369.

☒ The court has considered the applicant's release of Supplemental Job Displacement Benefits in the Compromise and Release.

☐ In view of the contested issues as set forth in the offer of proof, there are good faith issues, which, if resolved against the employee, would defeat the employee's right to compensation.

☐ The parties have filed a Medicare Set Aside as part of the Compromise and Release.

Now therefore, IT IS ORDERED that said Compromise and Release is approved. ☑ Addendums attached are side agreements that do not require judicial approval or exceed jurisdiction.

AWARD is made in favor of FLOREEN ROOKS and against STATE COMPENSATION INSURANCE FUND in the sum of $ 62,000

less the sum of $ Ø

payable to N/A as reasonable attorney's fees,

☒ and less permanent disability advances, according to proof, of $16435.14

O and less ______ of $______

☒ leaving a balance payable to applicant of $ 45,564.86

The Board retains jurisdiction over liens filed to date and penalties and interest thereon.

Dated: MAR 1 2 2012

LYNN A. DEVINE
Workers' Compensation Judge

☑ Defendant/ ~~applicant~~ Ordered to serve
☐ Service on Official Address Record: By:______ Date:______

8083

02 318168 000000001 098 195 05124168

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
COMPROMISE AND RELEASE

ADJ7024643
Case Number 1

Case Number 4

ADJ 7024645
Case Number 2

Case Number 5

Case Number 3

130-38-8570
SSN (Numbers Only)

Venue Choice is based upon: (Completion of this section is required)

[X] County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

[ ] County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

[ ] County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

LAO
Select 3 Letter Office Code For Place/Venue of Hearing (From Document Cover Sheet)

Employee(Completion of this section is required)

FLOREEN
First Name

MI

ROOKS
Last Name

2374 OLIVE AVE
Address/PO Box (Please leave blank spaces between numbers, names or words)

ALTADENA
City

CA
State

91001
Zip Code

Employer Information (Completion of this section is required)

[X] Insured [ ] Self-Insured [ ] Legally Uninsured [ ] Uninsured

D'VEAL FAMILY & YOUTH SERVICES
Employer Name (Please leave blank spaces between numbers, names or words)

PO BOX 40255
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

PASADENA
City

CA
State

91114
Zip Code

ADJUSTER: YOLANDA NIELSEN GLENDALE (SA)

Tracking Id: 12369162

02 318168 000000001 099 195 05124168

Applicant's Attorney or Authorized Representative:

[ ] Law Firm/Attorney [ ] Non Attorney Representative

First Name

Last Name

Law Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

Defendant's Attorney or Authorized Representative:

[X] Law Firm/Attorney [ ] Non Attorney Representative

LENA
First Name

TSUI
Last Name

5225007
Law Firm Number

SCIF INSURED GLENDALE UNIT A
Law Firm Name

PO BOX 65005
Address/PO Box (Please leave blank spaces between numbers, names or words)

PINEDALE | CA | 93650
City | State | Zip Code

Insurance Carrier Information (If known and if applicable - include even if carrier is adjusted by claims administrator)

STATE COMPENSATION INSURANCE FUND
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

PO BOX 65005
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

PINEDALE | CA | 93650
City | State | Zip Code

02 318168 000000001 100 195 05124168

Claims Administrator Information (if known and if applicable)

SCIF INSURED GLENDALE
Name (Please leave blank spaces between numbers, names or words)

PO BOX 65005
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

PINEDALE	CA	93650
City	State	Zip Code

IT IS CLAIMED THAT:

1. The injured employee, born 06/20/1949 (DATE OF BIRTH MM/DD/YYYY), alleges that while employed as a(n)

THERAPIST (OCCUPATION AT THE TIME OF INJURY), sustained injury arising out of and in the course of employment at the locations and during the dates listed below:

(State with specificity the date(s) of injury(ies) and what part(s) of body, conditions or systems are being settled.)

[X] Specific injury

ADJ7024643
Case Number 1

[ ] Cumulative injury

11/10/2007
(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific injury, use the start date as the specific date of injury)

Body Part 1: 530 FOOT RT   Body Part 2: 513 KNEE LEFT   Body Part 3: 520 RIGHT

Body Part 4: ______   Other Body Parts: ______

The injury occurred at JOBSITE
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

ALTADENA	CA	91001
City	State	Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

Tracking Id: 12369162

02 318168 000000001 101 195 05124168

ADJ 7024645
Case Number 2

[X] Specific Injury
[ ] Cumulative Injury

08/09/2007
(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific injury, use the start date as the specific date of injury)

Body Part 1: 513 KNEE LEFT Body Part 2: 520 ANKLE LEFT Body Part 3: 440 HIP LEFT

Body Part 4: ______ Other Body Parts: ______

The injury occurred at COMPANY OUTING
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

LOS ANGELES, CA 91001
City, State, Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

[ ] Specific Injury

Case Number 3

[ ] Cumulative Injury

(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific injury, use the start date as the specific date of injury)

Body Part 1: ______ Body Part 2: ______ Body Part 3: ______

Body Part 4: ______ Other Body Parts: ______

The Injury occurred at ______
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

City, State, Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

[ ] Specific Injury

Case Number 4

[ ] Cumulative Injury

(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific injury, use the start date as the specific date of injury)

Body Part 1: ______ Body Part 2: ______ Body Part 3: ______

Body Part 4: ______ Other Body Parts: ______

The injury occurred at ______
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

City, State, Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

Tracking Id: 12369162

☐ Specific Injury

Case Number 5 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: ____ Body Part 2: ____ Body Part 3: ____

Body Part 4: ____ Other Body Parts: ____

The injury occurred at ____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

2. Upon approval of this compromise agreement by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge and payment in accordance with the provisions hereof, the employee releases and forever discharges the above-named employer(s) and insurance carrier(s) from all claims and causes of action, whether now known or ascertained or which may hereafter arise or develop as a result of the above-referenced injury(ies), including any and all liability of the employer(s) and the insurance carrier(s) and each of them to the dependents, heirs, executors, representatives, administrators or assigns of the employee. Execution of this form has no effect on claims that are not within the scope of the workers' compensation law or claims that are not subject to the exclusivity provisions of the workers' compensation law, unless otherwise expressly stated.

3. This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury set forth in Paragraph No. 1 and further explained in Paragraph No. 9 despite any language to the contrary elsewhere in this document or any addendum.

4. Unless otherwise expressly stated, approval of this agreement RELEASES ANY AND ALL CLAIMS OF APPLICANTS DEPENDENTS TO DEATH BENEFITS RELATING TO THE INJURY OR INJURIES COVERED BY THIS COMPROMISE AGREEMENT. The parties have considered the release of these benefits in arriving at the sum in Paragraph 7. Any addendum duplicating this language pursuant to Sumner v WCAB (1983) 48 CCC 369 is unnecessary and shall not be attached.

5. Unless otherwise expressly ordered by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge, approval of this agreement does not release any claim applicant may have for vocational rehabilitation benefits or supplemental job displacement benefits.

6. The parties represent that the following facts are true: (If facts are disputed, state what each party contends under Paragraph No. 9.)

EARNINGS AT TIME OF INJURY $ 971.15

TEMPORARY DISABILITY INDEMNITY PAID 30885.53 Weekly Rate $ 647.44

Period(s) Paid 08/22/2007 (Start Date: MM/DD/YYYY) 09/14/2008 (End Date: MM/DD/YYYY)

PERMANENT DISABILITY INDEMNITY PAID ~~14986.14~~ ~~15,515.44~~ 16,435.14 Weekly Rate $ 230.00 + 204.50

Period(s) Paid 09/19/2008 (Start Date: MM/DD/YYYY) End date ~~01/17/2012~~ ~~2/18/2012~~ 2-28-12 (End Date: MM/DD/YYYY)

TOTAL MEDICAL BILLS PAID $ 20836.63 Total Unpaid Medical Expense to be Paid By: DEFENDANTS

Unless otherwise specified herein, the employer will pay no medical expenses incurred after approval of this agreement.

7. The parties agree to settle the above claim(s) on account of the injury(ies) by the payment of the SUM OF

$ 62,000.00
Settlement Amount

The following amounts are to be deducted from the settlement amount:

$ ~~14996.14~~ ~~16,435.14~~ 16,515.14 for permanent disability advances through ~~01/17/2012~~ ~~01/31/2012~~ 2-28-12 AND CONTINUING

$ ______ for temporary disability indemnity overpayment, if any.

$ ______ payable to ______

$ ______ payable to ______

$ ______ payable to ______

$ ______ payable to ______

$ ______ requested as applicant's attorney's fee.

LEAVING A BALANCE OF $ 45,564.86, after deducting the amounts set forth above and less further permanent disability advances made after the date set forth above. Interest under Labor Code section 5800 is included if the sums set forth herein are paid within 30 days after the date of approval of this agreement.

8. Liens not mentioned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary):

THIS COMPROMISE & RELEASE (C&R) INCLUDES RESOLUTION OF ALL ISSUES, ALL DATES OF INJURIES, ALL BODY PARTS INDICATED IN THE CLAIM FORM INCLUDING RIGHT FOOT, LEFT ANKLE, RIGHT ANKLE LEFT KNEE; AND OTHER BODY PARTS MENTIONED IN ANY MEDICAL REPORT(S).

THIS C&R INCLUDES ALL TEMPORARY DISABILITY (TD), RETRO TD, PERMANENT DISABILITY (PD), RETRO PD, VOCATIONAL REHABILITATION MAINTENANCE ALLOWANCE (VRMA), RETRO VRMA, SUPPLEMENTAL JOB DISPLACEMENT BENEFIT (SJDB), RETRO MEDICAL BENEFITS, FUTURE MEDICAL BENEFITS, MILEAGE, OUT OF POCKET MEDICAL EXPENSES, PENALTIES, AND INTERESTS (P&I).

PENALITES AND INTEREST WILL BE WAIVED WHEN C&R AWARD IS PAID WITHIN 30 DAYS FROM DATE OF RECEIPT OF STATE FUND.

ALL MED LEGAL FEES WILL BE PAID BY STATE FUND.

STATE FUND WILL ADDRESS ALL LIENS.

9. The parties wish to settle these matters to avoid the costs, hazards and delays of further litigation, and agree that a serious dispute exists as to the following issues (initial only those that apply). ONLY ISSUES INITIALED BY THE APPLICANT OR HIS/HER REPRESENTATIVE AND DEFENDANTS OR THEIR REPRESENTATIVES ARE INCLUDED WITHIN THIS SETTLEMENT.

Applicant	Defendant	
[initialed]	[initialed]	earnings
[initialed]	[initialed]	temporary disability
[initialed]	[initialed]	jurisdiction
[initialed]	[initialed]	apportionment
[initialed]	[initialed]	employment
[initialed]	[initialed]	injury AOE/COE
[initialed]	[initialed]	serious and willful misconduct
[initialed]	[initialed]	discrimination (Labor Code §132a)
[initialed]	[initialed]	statute of limitations
[initialed]	[initialed]	future medical treatment
[initialed]	[initialed]	other ALL ISSUES
[initialed]	[initialed]	permanent disability 24% LT ANKLE/LT KNEE
[initialed]	[initialed]	self-procured medical treatment, except as provided in Paragraph 7
[initialed]	[initialed]	vocational rehabilitation benefits/supplemental job displacement benefits

COMMENTS:

INJURED WORKER IS NOT RECEIVING MEDICARE BENEFITS AT THIS TIME AND IS CURRENTLY CONTINUALLY WORKING FULL TIME WITH DVEAL FAMILY & YOUTH SERVICES SO THERE IS NO NEED FOR A MEDICARE SET ASIDE ALLOCATION REPORT AT THIS TIME.
SETTLEMENT BASED ON PANEL QME REPORT OF DR. THOMAS FELL DATED 3/17/2011 AND INCLUDES ADDENDA "A to B".

Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded

10. It is agreed by all parties hereto that the filing of this document is the filing of an Application, and that the workers' compensation administrative law judge may in its discretion set the matter for hearing as a regular application, reserving to the parties the right to put in issue any of the facts admitted herein and that if hearing is held with this document used as an application, the defendants shall have available to them all defenses that were available as of the date of filing of this document, and that the workers' compensation administrative law judge may thereafter either approve this Compromise and Release or disapprove it and issue Findings and Award after hearing has been held and the matter regularly submitted for decision.

11. WARNING TO EMPLOYEE: SETTLEMENT OF YOUR WORKERS' COMPENSATION CLAIM BY COMPROMISE AND RELEASE MAY AFFECT OTHER BENEFITS YOU ARE RECEIVING TO WHICH YOU BECOME ENTITLED TO RECEIVE IN THE FUTURE FROM SOURCES OTHER THAN WORKERS' COMPENSATION, INCLUDING BUT NOT LIMITED TO SOCIAL SECURITY, MEDICARE AND LONG-TERM DISABILITY BENEFITS.

THE APPLICANT'S (EMPLOYEE'S) SIGNATURE MUST BE ATTESTED TO BY TWO DISINTERESTED PERSONS OR ACKNOWLEDGED BEFORE A NOTARY PUBLIC

By signing this agreement, applicant (employee) acknowledges that he/she has read and understands this agreement and has had any questions he/she may have had about this agreement answered to his/her satisfaction.

Witness the signature hereof this 5 day of March 2012 at Pasadena, CA

Witness 1	(Date)	[signature] Applicant (Employee)	3/5/2012 (Date)
Witness 2	(Date)	[signature] Attorney for Applicant	3-5-12 (Date)
Interpreter	(Date)	YOLANDA NELSON, CLAIMS ADJUSTER Attorney for Defendant	(Date)
		[signature] Attorney for Defendant	3/5/2012 (Date)
		JOE HERRERA, ASSISTANT CLAIMS MANAGER Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)

Tracking Id: 12169162

02 318168 000000001 106 195 05124168

ACKNOWLEDGMENT

State of California
County of ____________________)

On ____________________ before me, ______________________________
(insert name and title of the officer)

personally appeared ______________________________
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature ____________________ (Seal)

Page 2 of 6 received on 3/5/2012 11:15:41 AM [Pacific Standard Time] on server VLICRFZ from 6264058973

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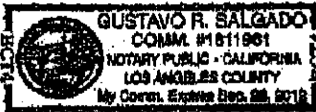
CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT

State of California }
County of Los Angeles }

On MARCH 5, 2012 before me, Gustavo R. Salgado, Notary Public
Date — Here Insert Name and Title of the Officer

personally appeared FLOREEN ROOKS
Name(s) of Signer(s)



who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature [signature]
Signature of Notary Public

Place Notary Seal Above

OPTIONAL

Though the information below is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent removal and reattachment of this form to another document.

Description of Attached Document

Title or Type of Document: COMPROMISE + RELEASE

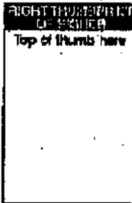
Document Date: 3-5-12 Number of Pages: 9

Signer(s) Other Than Named Above: ____________

Capacity(ies) Claimed by Signer(s)

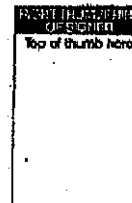
Signer's Name: ____________
- ☐ Individual
- ☐ Corporate Officer — Title(s): ____________
- ☐ Partner — ☐ Limited ☐ General
- ☐ Attorney in Fact
- ☐ Trustee
- ☐ Guardian or Conservator
- ☐ Other: ____________

Signer Is Representing: ____________



Signer's Name: ____________
- ☐ Individual
- ☐ Corporate Officer — Title(s): ____________
- ☐ Partner — ☐ Limited ☐ General
- ☐ Attorney in Fact
- ☐ Trustee
- ☐ Guardian or Conservator
- ☐ Other: ____________

Signer Is Representing: ____________



APPLICANT: FLOREEN ROOKS
WCAB CASE NUMBER(S): ADJ7024643, ADJ 7024645
SCIF CLAIM NUMBER(S): 05170360 AND 05124168

LIEN ADDENDUM

LIENS OF RECORD AND AFFIDAVIT
RE: GOOD FAITH EFFORTS TO RESOLVE LIENS

The following are the liens of record as of the date of this Compromise and Release. Defendants will pay, adjust, or litigate, the following liens, less credit for payments previously made.

Jurisdiction is reserved with the Workers' Compensation Appeals Board as to all issues that may arise regarding disposition of these liens.

Lien Claimant Name & Address	Amount	Description, Date & Result of Lien Resolution Efforts
There are no liens on record for this claim.		

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FREEFORM PARAGRAPH

I declare under penalty of perjury as follows:

I am the representative for defendant State Compensation Insurance Fund. I have made the above-referenced good faith efforts to resolve each of the listed liens.

Y. Niel 1-31-12

State Fund Representative Date

YOLANDA NIELSEN
CLAIMS ADJUSTER

APPLICANT: Floreen Rooks

WCAB NO: ADJ7024643 & ADJ7024645

STATE FUND CLAIM NO: 05170360 & 05124168

SJDB/Rodgers & Carter/Accrued Benefits Addendum A

1. SETTLEMENT OF ACCRUED BENEFITS

The settlement includes any claims for retroactive benefits and reimbursement, including, but not limited to, temporary disability indemnity, mileage reimbursement, out-of-pocket medical expense, and any interest or penalties, including, but not limited to, sanctions and self-imposed penalties, claimed up to the date of the Order Approving Compromise and Release.

2. SUPPLEMENTAL JOB DISPLACEMENT BENEFITS [SELECT ONE]

☑ Applicant is not prevented from returning or has returned to work for the employer; therefore, applicant is not entitled to the supplemental job displacement benefit.

☐ The employer has offered modified or alternative work; therefore, applicant is not entitled to the supplemental job displacement benefit.

☐ As a result of the injury settled herein, applicant is entitled to a SJDB voucher in an amount (select one of the following amounts if entitled to SJDB voucher)

☐ up to $4,000 (PD less than 15%) ☐ up to $6,000 (PD: 15% to 25%)

☐ up to $8,000 (PD: 26% to 49% ☐ up to $10,000 (PD: 50% to 99%)

☐ The settlement amount indicated in paragraph 7 includes consideration to settle the potential eligibility for the SJDB voucher. Therefore, no supplemental job displacement benefit is owed to applicant. [8 CCR 10133.52]

3. RODGERS/CARTER RELEASE – Supplemental Job Displacement Benefits

In the event applicant has participated, is participating, or later participates in an education related re-training or skill enhancement program or plan, pursuant to Labor Code section 4658.5, the following release applies: Applicant has been advised, fully understands, and specifically agrees this settlement agreement releases all liability of the defendants for any workers' compensation benefits including, but not limited to, potential disability benefits and medical benefits, to which applicant may be entitled for any injury or injuries to applicant that may occur or might have occurred during education related re-training or skill enhancement program which are a direct and natural consequence of the original injury or injuries recited in this Compromise and Release. The applicant hereby agrees to waive such potential claim or claims for workers' compensation benefits pursuant to *Rodgers v. Workers' Comp. Appeals Bd. et al.* (1985) 168 Cal.App.3d 567, 50 Cal.Comp.Cases 299, and *Carter et al., v. County of Los Angeles et al.* (1986) 51 Cal.Comp.Cases 255 (*en banc*).

APPLICANT Floreen Cook DATE March 5, 2012

APPLICANT'S ATTORNEY__________ DATE________

DEFENDANT'S ATTORNEY Y [signature] DATE 3-5-12

YOLANDA NELSON.
CLAIMS ADJUSTER

C&R Addendum – (rev. 07/08/2009) Page 2 of 2
DOI on or after 1/1/2004

Page 5 of 6 received on 3/5/2012 11:15:41 AM [Pacific Standard Time] on server VLICRF2 from 6264058973.

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APPLICANT Floreen Rooks

SOCIAL SECURITY NUMBER 130-38-8570

WCAB NUMBER ADJ7024643 & ADJ7024645

CLAIM NUMBER 05170360 & 05124168

ADDENDUM B

MEDICARE ELIGIBILITY VERIFICATION

I, Floreen Rooks, attest that I am not currently receiving, nor have I ever received Medicare benefits at the time of the approval of the Compromise and Release in this matter.

1. I do understand that this Medicare Eligibility Verification is an essential part of the settlement on my workers compensation case by way of a Compromise and Release. I do understand that I have a right to seek the advice of an attorney if I have any questions. I do understand that, under Federal Law: I, as beneficiary am "...responsible for taking whatever action is necessary to obtain any payment that can reasonably be expected under workers compensation"; and that Medicare will not pay benefits until my remedies under workers compensation are exhausted. (Title 42CFR 411.43)

2. I do understand that, in the event that I have ever received, are currently receiving, or have ever applied for Medicare benefits, my failure to advise Medicare of my receipt of benefits under the Workers Compensation System in the State of California may result in Medicare's refusal to pay for any medical services until such time as my medical expenditures have exhausted the amount of this Compromise and Release or the portion of the Compromise and release which clearly relates to medical care.

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☑ A. For Medicare purposes, this Compromise & Release includes an allocation of $21,965.00 in consideration for the applicant's Permanent Disability, estimated to be rated at 24 %, with regard to the industrial injury. The settlement amount also takes into consideration other disputed benefits, such as temporary disability benefits, past and future, non-Medicare covered expenses such as nursing home fees, all or a portion of sums which are claimed as regular non-medical benefits. The balance of settlement proceeds is paid in consideration of potential medical benefits, including pharmacy costs, which is valued at the sum of $ 27,621.00 PER MSA 2-17-12

☐ B. The Applicant and Defendant agree that the settlement sum indicated in Paragraph #7 of this Compromise & Release includes $__________ (*total MSA recommended amount*) in consideration for the Applicant's estimated Medicare-covered future medical expenses due to the industrial injury. A third-party vendor specializing in Medicare allocation and set-aside issues has reviewed the Applicant's history of medical expenses and treatment resulting from the subject industrial injury and made a recommendation for the Medicare Set-Aside. See attached report from ______________________________ (*name of third-party vendor*), which is incorporated herein by reference. The Medicare Set-Aside allocation has been completed but not submitted to the Centers for Medicare and Medicaid Services for approval. A copy of the Medicare Set-Aside allocation has been provided to the Applicant.

Page 2 of 2 received on 3/5/2012 12:49:05 PM [Pacific Standard Time] on server VLICRF2 from 6264058897:

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3. Applicant releases Defendants and State Compensation Insurance Fund from further liability for any claim that applicant may have against Defendants and State Compensation Insurance Fund for, or as a result of, any and all claims against Applicant made by CMS against these settlement proceeds, and for sums which may be paid by Medicare to the applicant in the future for this industrial injury. Applicant releases Defendants and State Compensation Insurance Fund from any liability for any claim made by or against applicant due to loss, either at present or in the future, of Federal Program benefits, including but not limited to: Social Security, the aforementioned Medicare benefits including prescriptions, and possibly other relief and entitlement benefits governed by Federal Statute, to the extent the Applicant would have been entitled to same in the absence of this settlement. Applicant acknowledges and verifies he/she has read (or has had read to him/her) the entire Compromise and Release, including this Addendum. He/She understands and accepts the provisions of these documents. Applicant acknowledges he/she has the right to discuss these documents with legal counsel, and if represented, he/she has had the opportunity to confidentially discuss same with legal counsel so as to fully understand the significance of these documents.

Signed this 5 day of March 2012 at L.A. County, California.

APPLICANT [signature]

APPLICANT'S ATTORNEY ____________________

INTERPRETER ____________________

CERTIFICATION NUMBER ____________________

SCIF RECD DTE 10/26/2009 BKSCAN 3 10/26/2009 02:28 PM 034601 8 12

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
STIPULATIONS WITH REQUEST FOR AWARD

02 318168 000000001 115 195 05124168

05170360
Case No.

Date of Injury 11/10/2007
MM/DD/YYYY

130-38-8570
SSN (Numbers Only)

Venue Choice is based upon: (Completion of this section is required)

[X] County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

[ ] County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

[ ] County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

LAO
Select 3 Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Applicant (Completion of this section is required)

FLOREEN
First Name

MI

ROOKS
Last Name

1315 S GLADYS AVE
Address/PO Box (Please leave blank spaces between numbers, names or words)

SAN GABRIEL	CA	91776
City	State	Zip Code

Employer #1 Information (Completion of this section is required)

[X] Insured [ ] Self-Insured [ ] Legally Uninsured [ ] Uninsured

D'VEAL FAMILY & YOUTH SERVICES
Employar Name (Please leave blank spaces between numbers, names or words)

PO BOX 40255
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

PASADENA	CA	91114
City	State	Zip Code

ADJUSTER: YOLANDA NELSEN GLENDALE (SA)

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Insurance Carrier Information (If known and if applicable - include even if carrier is adjusted by claims administrator)

STATE COMPENSATION INSURANCE FUND
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

PO BOX 92622
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

LOS ANGELES	CA	90009
City	State	Zip Code

Claims Administrator Information (if known and if applicable)

SCIF INSURED GLENDALE
Name (Please leave blank spaces between numbers, names or words)

PO BOX 92622
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

LOS ANGELES	CA	90009
City	State	Zip Code

Employer #2 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City	State	Zip Code

Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City	State	Zip Code

02 318168 000000001 117 195 05124168

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Pleaae leave blank spaces between numbers, names or words)

City | State | Zip Code

Employer #3 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

Insurance Carrier Informetion
(if known end if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Neme (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

Cleims Administrator Information (if known end if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

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Employer #4 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Claims Administrator Information (If known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

The parties hereto stipulate to the issuence of en Award and/or Order, based upon the following facls, and waive the requirements of Labor Code section 5313:

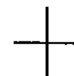
1. FLOREEN
Employees First Name

ROOKS
Employees Lest Name

birth date 06/20/1949
MM/DD/YYYY

while employed at PASADENA, CA
State

as a(n) THERAPIST
Occupation
Group in



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☐ More than 4 Companion Cases

☒ Specific Injury

05170360
Case Number 1

☐ Cumulative Injury

11/10/2007
(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 513 KNEE Body Part 2: ______ Body Part 3: ______

Body Part 4: ______ Other Body Parts: LEFT KNEE

☐ Specific Injury

Case Number 2

☐ Cumulative Injury

(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: ______ Body Part 2: ______ Body Part 3: ______

Body Part 4: ______ Other Body Parts: ______

☐ Specific Injury

Case Number 3

☐ Cumulative Injury

(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: ______ Body Part 2: ______ Body Part 3: ______

Body Part 4: ______ Other Body Parts: ______

☐ Specific Injury

Case Number 4

☐ Cumulative Injury

(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: ______ Body Part 2: ______ Body Part 3: ______

Body Part 4: ______ Other Body Parts: ______

by the employer(s) and their insurer(s) listed above and who sustained injury(ies) arising out of and in the course of employment to

INJURED BODY PART IS THE LEFT KNEE.

(Please list all body parts injured)

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2. The injury (ies) caused temporary disability for the period 11/15/2007 (MM/DD/YYYY) through 09142008 (MM/DD/YYYY) for which indemnity has been paid at $ 647.44 (Indemnity Paid) per week.

2(a). The injury(ies) caused additional temporary disability for the period ______ (MM/DD/YYYY) through ______ (MM/DD/YYYY) at the rate of $ ______ (Rate) in the amount of $ ______ (Indemnity Paid)

3. The injury(ies) caused permanent disability of 1 % for which indemnity is payable at $ 230.00 (Indemnity Rate) per week beginning 09/15/2008 (MM/DD/YYYY) in the sum of $ 690.00, less credit for such payments previously made. ☐ And a life pension of $ ______ (Life Pension) per week thereafter.

Labor Code §4658(d) adjustment:

☐ Increase rate to $ ______ as of ______ (MM/DD/YYYY)

☐ Decrease rate to $ ______ as of ______ (MM/DD/YYYY)

☐ Not Applicable

An informal rating ☐ has / ☒ has not (Select one) been previously issued in case no(s) ______

4. There ☒ is ☐ is Not a need for medical treatment to cure or relieve from the effects of said injury (ies)

5. Medical-legal expenses and/or liens are payable by defendant as follows.

6. Applicant's attorney requests a fee of $ ______

☐ Fees to be commuted as follows.

7. Liens Against compensation are payable as follows:

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8.Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

9.Other stipulations:

INJURED BODY PART IS THE LEFT KNEE.

THIS STIPULATION IS BASED UPON THE PERMANENT AND STATIONARY REPORT OF DR. TOMAS SAUCEDO DATED 12/5/2008 AND THE SUPPLEMENTAL REPORT DATED 1/23/09.

PENALTIES AND INTERESTS WILL BE WAIVED IF THE AWARD IS PAID WITHIN 30 DAYS FROM THE DATE OF RECEIPT OF THE AWARD BY STATE FUND.

Dated Oct. 22, 2009 ______________ Applicant
MM/DD/YYYY

Applicant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☒ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Dated ______________ MM/DD/YYYY ______________ Applicant Attorney Signature

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Defendant's Attorney or Authorizad Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Coda

Dated
MM/DD/YYYY

Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Dated
MM/DD/YYYY

Defense Attorney Signature

SCIF RECD DTE 10/26/2009 BKSCAN 3 10/26/2009 02:29 PM 034601 8 20

02 318168 000000001 123 195 05124168

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

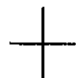
Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Dated MM/DD/YYYY Defense Attorney Signature

Interpreter Licence Number:

Interpreter Name Interpreter License Number



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Dear Floreen Rooks

THIS PAGE MUST BE PLACED ON TOP OF THE DOCUMENT/FORM
YOU ARE RETURNING TO STATE COMPENSATION INSURANCE FUND.

CLAIM NUMBER: 05170360

INJURED'S NAME: FLOREEN ROOKS

ADJUSTER'S NAME: YOLANDA NIELSEN

ADJUSTER'S RETURN ADDRESS:

PO BOX 92622
LOS ANGELES CA 90009

SCIF RECD DTE 10/26/2009 BKSCAN 3 10/26/2009 02:29 PM 034601 8 22

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STATE COMPENSATION INSURANCE FUND

IN REPLY REFER TO

July 21, 2009

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Ms. Rooks:

Enclosed are Stipulations with Request for Award in the above-entitled matter. We ask that you sign the form. Please also sign and date the enclosed Addendum(s) to the form. If you have any questions, you may contact me or a State Information and Assistance Office at 1-800-736-7401 or call your local Information and Assistance Officer at (213)576-7389.

Please complete the form(s) using all **CAPITAL** letters and in **BLACK** ink only. Do not fold, staple or bend any of the pages of the forms and return the form(s) in the enclosed envelope.

Please return the executed Stipulations with Request for Award to this office. I will then complete and submit it to the assigned Workers' Compensation Appeals Board for approval and will return an executed copy to you.

Sincerely

Yolanda L. Nielsen
Yolanda L. Nielsen
Adjuster
(818)291-7626

Enc: Business Reply Envelope (SCIF 19619)
Stipulation with Request for Awards (DWC-CA Form 10214(a)

Mailing Address: P.O. Box 92622 • Los Angeles, CA 90009-2622

SCIF 19180

8083

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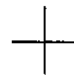
STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
STIPULATIONS WITH REQUEST FOR AWARD



05124168
Case No.

Date of Injury 08/09/2007
MM/DD/YYYY

130-38-8510
SSN (Numbers Only)

Venue Choice is based upon: (Completion of this section is required)

[X] County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

[ ] County where injury occurred (Labor Code section 5501.5(a)(2) or (d))

[ ] County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

LAO
Select 3 Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Applicant (Completion of this section is required)

FLOREEN
First Name

MI

ROOKS
Last Name

1315 S GLADYS AVE
Address/PO Box (Please leave blank spaces between numbers, names or words)

SAN GABRIEL	CA	91776
City	State	Zip Code

Employer #1 Information (Completion of this section is required)

[X] Insured [ ] Self-Insured [ ] Legally Uninsured [ ] Uninsured

D'VEAL FAMILY & YOUTH SERVICES
Employer Name (Please leave blank spaces between numbers, names or words)

PO BOX 40255
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

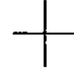
PASADENA	CA	91114
City	State	Zip Code

ADJUSTER YOLANDA NELSEN GLENDALE (SA)

02 318168 000000001 127 195 05124168

Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)

STATE COMPENSATION INSURANCE FUND
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)



PO BOX 92622
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

LOS ANGELES	CA	90009
City	State	Zip Code

Claims Administrator Information (if known and if applicable)

SCIF INSURED GLENDALE
Name (Please leave blank spaces between numbers, names or words)

PO BOX 92622
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

LOS ANGELES	CA	90009
City	State	Zip Code

Employer #2 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

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Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Employer #3 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Insurance Carrier Information
(If known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

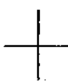
City State Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code



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Employer #4 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces betwaen numbers, names or words)

City State Zip Code

Claims Administrator Information (if known and if applicable)

Name (Plaase leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

The parties hereto stipulate to the issuance of an Award and/or Order, based upon the following facts, and waive the requirements of Labor Code section 5313

1. FLOREEN
Employees First Name

ROOKS
Employees Last Name

birth date 06/20/1949
MM/DD/YYYY

while employed at PADADENA, CA
State

as a(n) THERAPIST in
Occupation Group

☐ More than 4 Companion Cases

[X] Specific Injury

05124168
Case Number 1

☐ Cumulative Injury

08/09/2007
(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 520 ANKLE Body Part 2: 513 KNEE Body Part 3:

Body Part 4: Other Body Parts: LEFT KNEE AND ANKLE

☐ Specific Injury

Case Number 2 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: Body Part 2. Body Part 3:

Body Part 4: Other Body Parts:

☐ Specific Injury

Case Number 3 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: Body Part 2. Body Part 3:

Body Part 4: Other Body Parts:

☐ Specific Injury

Case Number 4 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

by the employer(s) and their insurer(s) listed above and who sustained injury(ies) arising out of and in the course of employment to

INJURED BODY PARTS ARE LEFT KNEE AND LEFT ANKLE.

(Please list all body parts injured)

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2 The injury (ies) caused temporary disability for the period 08/22/2007 (MM/DD/YYYY) through 09162007 (MM/DD/YYYY) for which indemnity has been paid al $ 645.66 (Indemnity Paid) per week.

2(a). The injury(ies) caused additional temporary disability for the period ________ (MM/DD/YYYY)

through ________ (MM/DD/YYYY) at the rate of $ ________ (Rate) in the amount of $ ________ (Indemnity Paid)

3. The injury(ies) caused permanent disability of 6% % for which indemnity is payable at $ 230.00 (Indemnity Rate) per week beginning 09/17/2007 (MM/DD/YYYY) in the sum of $ 4,140.00, less credit for such payments previously made ☐ And a life pension of $ ________ (Life Pension) per week thereafter.

Labor Code §4658(d) adjustment:

☐ Increase rate to $ ________ as of ________ (MM/DD/YYYY)

☐ Decrease rate to $ ________ as of ________ (MM/DD/YYYY)

☐ Not Applicable

An informal rating ☐ has / ☒ has not (Select one) been previously issued in case no(s) ________

4. There ☒ is ☐ is Not a need for medical treatment to cure or relieve from the effects of said injury (ies).

5. Medical-legal expenses and/or liens are payable by defendant as follows:

6. Applicant's attorney requests a fee of $ ________

☐ Fees to be commuted as follows:

7. Liens Against compensation are payable as follows.

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8 Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded

9.Other stipulations:

INJURED BODY PARTS ARE LEFT KNEE AND LEFT ANKLE.

THIS STIPULATION IS BASED UPON THE PERMANENT AND STATIONARY REPORT OF DR. RALPH GAMBARDELLA DATED 11/26/07.

PENALTIES AND INTERESTS ARE WAIVED IF AWARD IS PAID WITHIN 30 DAYS FROM DATE OF RECEIPT BY STATE FUND.

Dated Oct 22, 2009 MM/DD/YYYY

Applicant

Applicant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☒ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Dated MM/DD/YYYY

Applicant Attorney Signature

SCIF RECD DTE 10/26/2009 BKSCAN 3 10/26/2009 02:28 PM 034601 8 8

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Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Dated
MM/DD/YYYY

Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Dated
MM/DD/YYYY

Defense Attorney Signature

02 318168 000000001 134 195 05124168

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Neme

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

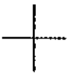
Dated ______________ MM/DD/YYYY

Defense Attorney Signature

Interpreter Licence Number:

Interpreter Name

Interpreter License Number



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Dear Floreen Rooks

THIS PAGE MUST BE PLACED ON TOP OF THE DOCUMENT/FORM YOU ARE RETURNING TO STATE COMPENSATION INSURANCE FUND.

CLAIM NUMBER: 05124168

INJURED'S NAME: FLOREEN ROOKS

ADJUSTER'S NAME: YOLANDA NIELSEN

ADJUSTER'S RETURN ADDRESS:

PO BOX 92622
LOS ANGELES CA 90009

8083

SCIF RECD DTE 10/26/2009 BKSCAN 3 10/26/2009 02:28 PM 034601 8 11

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STATE
COMPENSATION
INSURANCE
FUND

IN REPLY REFER TO

July 21, 2009

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05124168
Employee: Floreen Rooks
Date of Injury: 08/09/2007

Dear Ms. Rooks:

Enclosed are Stipulations with Request for Award in the above-entitled matter. We ask that you sign the form. Please also sign and date the enclosed Addendum(s) to the form. If you have any questions, you may contact me or a State Information and Assistance Office at 1-800-736-7401 or call your local Information and Assistance Officer at (213)576-7389.

Please complete the form(s) using all **CAPITAL** letters and in **BLACK** ink only. Do not fold, staple or bend any of the pages of the forms and return the form(s) in the enclosed envelope.

Please return the executed Stipulations with Request for Award to this office. I will then complete and submit it to the assigned Workers' Compensation Appeals Board for approval and will return an executed copy to you.

Sincerely

Yolanda L. Nielsen

Yolanda L. Nielsen
Adjuster
(818)291-7626

Enc: Business Reply Envelope (SCIF 19619)
Stipulation with Request for Awards (DWC-CA Form 10214(a)

Mailing Address: P.O. Box 92622 • Los Angeles, CA 90009-2622

SCIF 19180

SCIF RECD DTE 11/17/2009 BKSCAN 6 11/18/2009 10:36 AM 042792 14 1

STATE COMPENSATION INSURANCE FUND

COPY TO CLAIMS
NOV 06 2009

November 6, 2009

IN REPLY REFER TO:
05124168

Ms. Floreen Rooks
1315 South Gladys Avenue
San Gabriel, CA 91776-3623

Re: Floreen Rooks v. D'Veal Family & Youth Services
WCAB Case No. Unassigned

Dear Ms. Rooks:

The Glendale - A Legal Department and the undersigned have been assigned the legal defense of the above-captioned case.

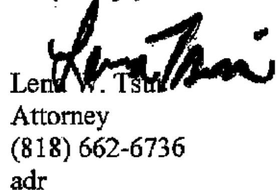
Please send all notices, pleadings and correspondence addressed to State Compensation Insurance Fund, Legal Department, at the address shown below. Be further advised that notices of hearings or depositions served on any other address may not be legally effective under the doctrine stated in *Hartford Accident and Indemnity Co. v. WCAB (Phillips),* 86 Cal. App. 3d 1, 43 CCC 1193 (1978). Also, please serve a separate copy of any application(s), medical report(s) and any other pleading(s) or document(s) on this office. Pursuant to Labor Code § 4906, please forward the attorney disclosure form to my office.

State Compensation Insurance Fund requests that you comply with Title 8, Section 10418, which requires notice of medical-legal examinations. We will object to any billings and entry into evidence of reports that do not comply with this section.

Please serve any medical reports in your possession or control as prescribed by the Rules of Practice and Procedure.

Defendant State Compensation Insurance Fund will not accept service by facsimile.

Very truly yours,



Lena W. Tsui
Attorney
(818) 662-6736
adr

cc: D'Veal Family & Youth Services, Post Office Box 40255, Pasadena, CA 91114
Yolanda L. Nielsen, Glendale Unit 5 (SA) Claims Department

02 318168 000000001 138 195 05124168

August 29, 2007

Floreen Rooks
1317 1/2 South Gladys Ave
San Gabriel CA 91776

Claim Number: 05124168
Employee: Floreen Rooks
Date of Injury: 08/09/2007
Employer: D'Veal Family & Youth Services

NOTICE REGARDING TEMPORARY DISABILITY BENEFITS

State Compensation Insurance Fund, the claims administrator for D'Veal Family & Youth Services, is handling your workers' compensation claim. This notice is to advise you of the status of temporary disability payments for your workers' compensation injury of August 9, 2007.

Although liability for your workers' compensation injury has been accepted, I cannot pay you temporary disability benefits at this time because we need to obtain all the medical records from your primary treating physician.

In order to reach a decision, I need medical records for your appointment on 9/4/07. I will contact you by September 28, 2007 to advise you of our decision.

We will pay for appropriate medical care and will reimburse you for necessary transportation expenses at the rate of 48.5 cents a mile. If you receive any medical bills, please send them to me.

Please review the enclosed pamphlet for a full explanation of workers' compensation benefits. You may also receive recorded information by calling the State Information and Assistance Officer at 1-800-736-7401 or call your local Information and Assistance Officer at 1-213-576-7389.

If you have any questions, please feel free to call me at the number listed below. However, if you are represented by an attorney, this phone call should be made through your attorney.

Sincerely

Sherie Chou

Sherie Chou
For Yolanda Nielsen, Adjuster of this claim
Adjuster

8083

SCI000074

(818)291−7626
Fax: (707)646−2609

Enc: Your Guide to Workers Compensation (SCIF Form e13699)

cc: D'Veal Family & Youth Services, PO Box 40255 Pasadena, CA 91114

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SCI000076

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August 29, 2007

Floreen Rooks
1317 1/2 South Gladys Ave
San Gabriel CA 91776

Claim Number: 05124168
Employee: Floreen Rooks
Date of Injury: 08/09/2007
Employer: D'Veal Family & Youth Services

NOTICE REGARDING TEMPORARY DISABILITY BENEFITS

State Compensation Insurance Fund, the claims administrator for D'Veal Family & Youth Services, is handling your workers' compensation claim. This notice is to advise you of the status of temporary disability payments for your workers' compensation injury of August 9, 2007.

Although liability for your workers' compensation injury has been accepted, I cannot pay you temporary disability benefits at this time because we need to obtain all the necessary medical records from your primary treating physician.

In order to reach a decision, I need Medical information from your re-directed MPN Dr. for date of services on 9/4/07 and 9/10/07. I will contact you by September 28, 2007 to advise you of our decision.

We will pay for appropriate medical care and will reimburse you for necessary transportation expenses at the rate of 48.5 cents a mile. If you receive any medical bills, please send them to me.

Please review the enclosed pamphlet for a full explanation of workers' compensation benefits. You may also receive recorded information by calling the State Information and Assistance Officer at 1-800-736-7401 or call your local Information and Assistance Officer at 1-213-576-7389.

If you have any questions, please feel free to call me at the number listed below. However, if you are represented by an attorney, this phone call should be made through your attorney.

Sincerely

Sherie Chou

Sherie Chou
For Yolanda Nielsen, Adjuster of this claim

8083

SCI000077

02 318168 000000001 142 195 05124168

Adjuster
(818)291−7626

Enc: Your Guide to Workers Compensation (SCIF Form e13699)

cc: D'Veal Family & Youth Services, PO Box 40255 Pasadena, CA 91114

02 318168 000000001 143 195 05124168

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SCI000079

02 318168 000000001 144 195 05124168

January 3, 2008

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05124168
Employee: Floreen Rooks
Date of Injury: 08/09/2007
Employer: D'Veal Family & Youth Services

NOTICE REGARDING PERMANENT DISABILITY BENEFITS

State Compensation Insurance Fund, the claims administrator for D'Veal Family & Youth Services, is handling your workers' compensation claim. This notice is to advise you of the status of permanent disability payments for your workers' compensation injury of August 9, 2007.

Your treating physician, Dr. Ralph Gambardella, has determined that your injury is permanent and stationary. We do not know if your doctor has determined if your injury has resulted in permanent disability. We expect to have this information by February 26, 2008 and we will notity you of the status of permanent disability at that time.

Dr. Gambardella has determined a permanent disability rating but you are currently receiving Temporary Disability benefits regarding claim number 05170360.As soon as we have received your disability status regarding claim number 05170360, we will start your permanent disability benefits regarding this claim.

The State of California requires this notice to include the following language:

> Please call me if you have questions. If you want further information, you may contact the local State Information and Assistance Office by calling 1-213-576-7389 or you may receive recorded information by calling 1-800-736-7401.
>
> You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

Sincerely

Yolanda L. Nielsen

8083

SCI000080

02 318168 000000001 145 195 05124168

Yolanda L. Nielsen
Adjuster
(818)291−7626

Enc: DWC fact sheet D− Answers to your questions about permanent disability benefits

cc: D'Veal Family & Youth Services, PO Box 40255 Pasadena, CA 91114

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September 7, 2007

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05124168
Employee: Floreen Rooks
Date of Injury: 08/09/2007
Employer: D'Veal Family & Youth Services

NOTICE REGARDING TEMPORARY DISABILITY BENEFITS

State Compensation Insurance Fund, the claims administrator for D'Veal Family & Youth Services, is handling your workers' compensation claim. This notice is to advise you of the status of temporary disability payments for your workers' compensation injury of August 9, 2007.

Payments are beginning for temporary disability for the period from August 22, 2007 through September 7, 2007.

The payment in the amount of $1568.03 is enclosed. Your temporary total disability payment is based on two-thirds of your average weekly wage at the time of injury and is subject to maximum and minimum rates which are set by state law depending on the date of injury. No payments will be paid to you for the first three days of disability unless you were hospitalized or are disabled for more than 14 days. For injuries occurring on or after April 19, 2004, it is also subject to a maximum of 104 compensable weeks within two years from the date of initial payment; or if the injury involves pulmonary fibrosis, chronic lung disease, chemical burns to the eyes, human immunodeficiency virus (HIV), severe burns, amputations, or high velocity eye injuries - a maximum of 240 compensable weeks within five years from the date of injury. Your weekly compensation rate is $645.66 based on your earnings of $968.49 per week.

Payments will be sent every two weeks on Friday until you are able to return to work, your medical condition becomes permanent and stationary, or you have been paid the maximum number of benefit weeks allowed by law, whichever occurs first.

If you believe your average weekly wages noted above are inaccurate, please provide us with additional earnings documentation from any employment so that we may make the appropriate adjustment to your temporary disability rate. The rate noted above may change pending additional earnings information.

We will also pay for appropriate medical care and will reimburse you for necessary transportation expenses at the rate of 48.5 cents a mile. If you receive any medical bills, please send them to me.

You may also receive recorded information by calling the state Information and Assistance Officer at 1-800-736-7401 or you may call your local Information and Assistance Officer at 1-213-576-7389.

If you have moved, or are moving soon, or want to know the status of your benefit check, please call our toll free number 1-888-222-3211, Monday through Friday, between 7:00 a.m. and 5:00 p.m. PST.

If you have any questions, please feel free to call me at the number listed below. However, if you are represented by an attorney, this phone call should be made through your attorney.

Sincerely

Peter Cross

Peter Cross
For Yolanda Nielsen, Adjuster of this claim
Adjuster
(818)291-7626

Enc: Check

cc: D'Veal Family & Youth Services, PO Box 40255 Pasadena, CA 91114
Kenneth Jung, Kerlan Jobe Orthopaedic Clinic, 301 N Lake Ave Ste 201 Pasadena, CA 91101-5120

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02 318168 000000001 149 195 05124168

September 18, 2007

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05124168
Employee: Floreen Rooks
Date of Injury: 08/09/2007
Employer: D'Veal Family & Youth Services

NOTICE REGARDING TEMPORARY DISABILITY BENEFITS

State Compensation Insurance Fund, the claims administrator for D'Veal Family & Youth Services, is handling your workers' compensation claim. This notice is to advise you of the status of temporary disability payments for your workers' compensation injury of August 9, 2007.

Your final payment of temporary disability was sent separately. Payments are ending because you have returned to modified work on September 17, 2007.

Temporary disability benefits paid to you total $2398.16. This amount covers the following period(s) at the following rate(s) per week: from August 22, 2007 through September 16, 2007 at $645.66 per week.

While temporary disability benefits are ending, you may be entitled to other workers' compensation benefits. We will advise you if additional benefits are due.

We will continue to pay for appropriate medical care and will reimburse you for necessary transportation expenses at the rate of 48.5 cents a mile. If you receive any medical bills, please send them to me.

The State of California requires that you be given the following information:

> If you disagree with the decision, you may consult with a state Information and Assistance Officer at 1-800-736-7401 or call your local Information and Assistance Officer at 1-213-576-7389. You may also consult with and be represented by an attorney, and/or apply to have your case heard by the Workers' Compensation Appeals Board.

The law limits the time period within which you may collect benefits. Should you disagree with any action taken by State Fund, in order to protect your rights, you must commence proceedings before the Workers' Compensation Appeals Board by filing an Application for Adjudication of Claim within one year of the date of your injury, or one year from the last

furnishing of indemnity or medical treatment benefits by your employer or State Fund. If you do not do so, your right to benefits may be lost.

If you have moved, or are moving soon, or want to know the status of your benefit check, please call our toll free number 1−888−222−3211, Monday through Friday, between 7:00 a.m. and 5:00 p.m. PST.

If you have any questions, please feel free to call me at the number listed below. However, if you are represented by an attorney, this phone call should be made through your attorney.

Sincerely

Peter Cross

Peter Cross
For Yolanda Nielsen, Adjuster of this claim
Adjuster
(818)291−7626

Enc:

cc: D'Veal Family & Youth Services, PO Box 40255 Pasadena, CA 91114

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02 318168 000000001 151 195 05124168

August 29, 2007

Floreen Rooks
1317 1/2 South Gladys Ave
San Gabriel CA 91776

Claim Number: 05124168
Employee: Floreen Rooks
Date of Injury: 08/09/2007
Employer: D'Veal Family & Youth Services

NOTICE REGARDING SALARY CONTINUATION BENEFITS

State Compensation Insurance Fund, the claims administrator for D'Veal Family & Youth Services, is handling your workers' compensation claim. This notice is to advise you of the status of salary continuation in lieu of temporary disability payments for your workers' compensation injury of August 9, 2007.

Salary continuation benefits being paid by your employer in the amount of $645.66 include temporary disability benefits from August 9, 2007 through August 15, 2007 at $645.66 per week.

Your employer's salary continuation plan was provided by your employer.

Salary continuation is ending because you were released to return to modified work by Dreamweaver Medical Group and modified work was available with your employer starting on August 16, 2007. If you have not yet returned to work, contact your employer.

While salary continuation benefits are ending, you may be entitled to other workers' compensation benefits. We will advise you if additional benefits are due.

We will continue to pay for appropriate medical care and will reimburse you for necessary transportation expenses at the rate of 48.5 cents a mile. If you receive any medical bills, please send them to me.

The California State Legislature has issued this warning:

> Warning: Acceptance of employment with a different employer that requires performance of activities that you have stated that you cannot perform because of the injury for which you are receiving temporary disability benefits could constitute fraud and could result in criminal prosecution. If convicted, you could lose your rights to workers' compensation benefits and face imprisonment for up to 5 years and a fine of up to fifty thousand dollars ($50,000), or double the amount of the fraud, whichever is greater.

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This warning notice is sent by State Fund to all injured workers who are receiving salary continuation in lieu of temporary disability. Your employer is paying you salary continuation benefits because the doctor reports you are unable to work full time due to the injury or injuries you sustained on the job. If you become employed by anyone or become self employed or your earnings change in any way while you are still receiving salary continuation payments, State Fund should be notified immediately as salary continuation payments may need to be changed or stopped. Failure to notify State Compensation Insurance Fund about your earnings, your employment status or your self-employment while you are receiving salary continuation payments, could be a crime.

The State of California requires that you be given the following information:

> If you disagree with the decision, you may consult with a state Information and Assistance Officer at 1-800-736-7401 or call your local Information and Assistance Officer at 1-213-576-7389. You may also consult with and be represented by an attorney, and/or apply to have your case heard by the Workers' Compensation Appeals Board.

The law limits the time period within which you may collect benefits. Should you disagree with any action taken by State Fund, in order to protect your rights, you must commence proceedings before the Workers' Compensation Appeals Board by filing an Application for Adjudication of Claim within one year of the date of your injury, or one year from the last furnishing of indemnity or medical treatment benefits by your employer or State Fund. If you do not do so, your right to benefits may be lost.

If you have any questions, please feel free to call me at the number listed below. However, if you are represented by an attorney, this phone call should be made through your attorney.

Sincerely

Sherie Chou

Sherie Chou
For Yolanda Nielsen, Adjuster of this claim
Adjuster
(818)291-7626
Fax: (707)646-2609

cc: D'Veal Family & Youth Services, PO Box 40255 Pasadena, CA 91114

02 318168 000000001 153 195 05124168

September 18, 2007

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05124168
Employee: Floreen Rooks
Date of Injury: 08/09/2007
Employer: D'Veal Family & Youth Services

NOTICE REGARDING PERMANENT DISABILITY BENEFITS

State Compensation Insurance Fund, the claims administrator for D'Veal Family & Youth Services, is handling your workers' compensation claim. This notice is to advise you of the status of permanent disability payments for your workers' compensation claim for your injury of August 9, 2007.

It is too soon to tell if you will have any permanent disability from your injury. We will monitor your medical condition until it is permanent and stationary. At that time, a medical evaluation will be performed to determine the existence and extent of permanent disability and the need for continuing medical care. We expect to have this information by December 15, 2007 and we will notify you of the status of permanent disability at that time.

The State of California requires this notice to include the following language:

> Please call me if you have questions. If you want further information, you may contact the local State Information and Assistance Office by calling 1-213-576-7389 or you may receive recorded information by calling 1-800-736-7401.
>
> You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

Sincerely

Peter Cross

Peter Cross
For Yolanda Nielsen, Adjuster of this claim
Adjuster
(818)291-7626

8083

Enc: DWC fact sheet D– Answers to your questions about permanent disability benefits

cc: D'Veal Family & Youth Services, PO Box 40255 Pasadena, CA 91114

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**You may lose important rights if you do not take certain actions within 10 days.
Read this letter and any enclosed fact sheets very carefully.**

February 23, 2010

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05124168
Employee: Floreen Rooks
Date of Injury: 08/09/2007
Employer: D'Veal Family & Youth Services

NOTICE REGARDING PERMANENT DISABILITY BENEFITS

State Compensation Insurance Fund, the claims administrator for D'Veal Family & Youth Services, is handling your workers' compensation claim. This notice is to advise you of the status of permanent disability payments for your workers' compensation injury of August 9, 2007.

Your treating physician, Dr. Ralph A Gambardella, has determined that your injury is permanent and stationary. Your doctor indicates that your injury has resulted in permanent disability, which we estimate is 6%. This rating is equivalent to $4,140.00. Your doctor indicates that you are in need of continuing medical care.

For dates of injury on or after January 1, 2005, the law provides that if your employer has 50 or more employees and, within 60 days of your disability becoming permanent and stationary, offers you regular, alternative, or modified work for a period of at least 12 months, each of your remaining permanent disability payments shall be reduced by 15% from the date of such offer. If your employer does not make an offer meeting these requirements, each of your remaining permanent disability payments shall be increased by 15% from the date of the end of the 60-day period.

The payment in the amount of $4,554.00 was sent separately. Your weekly compensation rate is $230.00 based on your earnings of $968.49 per week. Additionally, this check includes a 10% self-imposed increase in the amount of $414.00.

We have paid you a total amount of $4,140.00 in permanent disability benefits. We have determined the total amount of permanent disability payable based on permanent and stationary report of Dr. Ralph Gambardella dated 11/26/07. These benefits are ending because your permanent disability benefit has been paid in full.

Benefits were paid to you from September 17, 2007 through January 20, 2008. This amount will be deducted from any award you may receive.

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You have the right to disagree with our decision(s).

Our records indicate that you have not participated in a comprehensive medical evaluation. Please be advised that both you and State Compensation Insurance Fund have the right to disagree with the treating doctor's findings regarding your permanent disability status. The Workers' Compensation Laws of California under Labor Codes §§ 4062 and 4062.1 provide a process to follow when such a disagreement arises. Either you or State Fund may request and obtain (at no cost to you) a comprehensive medical evaluation prepared by a physician selected from a panel of Qualified Medical Evaluators to help resolve the dispute. These medical evaluators are physicians certified by the Administrative Director of the Division of Workers' Compensation specifically for these purposes.

Enclosed is a "Request for Qualified Medical Evaluator," the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators. If you disagree with State Fund's decision or the findings of the treating physician, you may request assignment of a panel of Qualified Medical Evaluators by submitting this form to the DWC Medical Unit. If State Fund disagrees with the findings of the treating physician, you have 10 days to submit the form to the DWC Medical Unit otherwise, Labor Code 4062.1 allows State Fund to submit the panel request.

We agree with the findings of your treating physician.

When the Administrative Director sends you the panel, you are responsible for selecting one of the physicians on the panel, making the appointment and providing us this information. You have up to 10 days from receipt of the panel to do this. Please complete the attached form (Panel QME Appointment Notice SCIF Form 3051) to notify us of the name of the doctor you have chosen and the date of the appointment. We are required to send you money for mileage and any other allowed expenses. When scheduling an appointment, please allow at least 20 days for State Fund to send your medical file to the physician before the examination date. If you do not select the physician from the panel within 10 days, Labor Code § 4062.1 allows State Fund to select the physician.

We will not request a rating of the physician's report from the State of California Disability Evaluation Unit. However, you may contact an Information and Assistance Officer to have the report reviewed and rated by the Disability Evaluation Unit.

The State of California, Division of Workers' Compensation requires that you be provided with the following:

> You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call Yolanda Nielsen at (818)291-7626. However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights

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to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (213)576-7389.

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at:

http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to the Workers' Compensation Appeals Board or the Administrative Director.

The law limits the time period within which you may collect benefits. Should you disagree with any action taken by State Fund, in order to protect your rights, you must commence proceedings before the Workers' Compensation Appeals Board by filing an Application for Adjudication of Claim within one year of the date of your injury, or one year from the last furnishing of indemnity or medical treatment benefits by your employer or State Fund. If you do not do so, your right to benefits may be lost.

If you have moved, or are moving soon, or want to know the status of your benefit check, please call our toll free number (888) 222-3211, Monday through Friday, between 7:00 a.m. and 5:00 p.m. PST.

Sincerely

Yolanda L. Nielsen

Yolanda L. Nielsen
Adjuster
(818)291-7626

Enc: How to Request a Qualified Medical Evaluator (Rev 02/09) (SCIF e3475)
QME Form 105 (Rev. 02/09) (SCIF e3131-Unrepresented)
QME Panel Appointment Notice (SCIF 3051)
Business Reply Envelope
DWC Fact Sheet C (Rev. 2/08)
DWC Fact Sheet E (Rev. 12/05)

cc: D'Veal Family & Youth Services, PO Box 40255, Pasadena, CA 91114

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PLEASE RETURN IN THE ENCLOSED ENVELOPE

Claim #: 05124168

Claimant: Floreen Rooks

Adjuster: ____________________

I have made an appointment with the following Qualified Medical Evaluator:

DOCTOR: ______________________________

ADDRESS: ______________________________

CITY/ZIP: ______________________________ PHONE: (_____)____________

DATE OF APPT:____________________________TIME OF APPT:____________

____
Signature

QME Panel Appointment Notice (SCIF 3051)

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**You may lose important rights if you do not take certain actions within 10 days.
Read this letter and any enclosed fact sheets very carefully.**

September 22, 2008

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05124168
Employee: Floreen Rooks
Date of Injury: 08/09/2007
Employer: D'Veal Family & Youth Services

NOTICE REGARDING PERMANENT DISABILITY BENEFITS

State Compensation Insurance Fund, the claims administrator for D'Veal Family & Youth Services, is handling your workers' compensation claim. This notice is to advise you of the status of permanent disability payments for your workers' compensation injury of August 9, 2007.

Your treating physician, Dr. Ralph A Gambardella, has determined that your injury is permanent and stationary. Your doctor indicates that your injury has resulted in permanent disability, which we estimate is 6%. This rating is equivalent to $4,140.00. Your doctor indicates that you are in need of continuing medical care.

For dates of injury on or after January 1, 2005, the law provides that if your employer has 50 or more employees and, within 60 days of your disability becoming permanent and stationary, offers you regular, alternative, or modified work for a period of at least 12 months, each of your remaining permanent disability payments shall be reduced by 15% from the date of such offer. If your employer does not make an offer meeting these requirements, each of your remaining permanent disability payments shall be increased by 15% from the date of the end of the 60-day period.

The payment in the amount of $4,554.00 was sent separately. Your weekly compensation rate is $230.00 based on your earnings of $968.49 per week. Additionally, this check includes a 10% self-imposed increase in the amount of $414.00.

We have paid you a total amount of $4,140.00 in permanent disability benefits. We have determined the total amount of permanent disability payable based on permanent and stationary report of Dr. Ralph Gambardella dated 11/26/07. These benefits are ending because your permanent disability benefit has been paid in full.

Benefits were paid to you from September 17, 2007 through January 20, 2008. This amount will be deducted from any award you may receive.

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You have the right to disagree with our decision(s).

Our records indicate you have had a prior comprehensive medical evaluation. Both you and State Compensation Insurance Fund have the right to dispute the comprehensive medical evaluation doctor's findings. You may be requested to return to that physician for a new evaluation to resolve the dispute. We accept the findings of your treating physician.

Since you have not filed a Workers' Compensation Claim Form (DWC−1), you are not entitled to participate in the panel Qualified Medical Evaluation process. If you wish to be evaluated by a Qualified Medical Evaluator, you must first submit a properly completed claim form. For your convenience, we have enclosed a Workers' Compensation Claim Form (DWC−1) for you to complete. Please complete the employee's section of the form and then forward the form to your employer so they can complete their section of the form. Once we receive the completed DWC−1 form, you may proceed with requesting a panel from the DWC Medical Unit.

We will not request a rating of the physician's report from the State of California Disability Evaluation Unit. However, you may contact an Information and Assistance Officer to have the report reviewed and rated by the Disability Evaluation Unit.

The State of California, Division of Workers' Compensation requires that you be provided with the following:

> You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call Yolanda Nielsen at (818)291−7626. However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (213)576−7389.
>
> For recorded information and a list of offices, call (800)736−7401. You may also visit the DWC website at:
>
> http://www.dir.ca.gov/DWC/dwc_home_page.htm
>
> You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

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To resolve a dispute, you may apply to the Workers' Compensation Appeals Board or the Administrative Director.

The law limits the time period within which you may collect benefits. Should you disagree with any action taken by State Fund, in order to protect your rights, you must commence proceedings before the Workers' Compensation Appeals Board by filing an Application for Adjudication of Claim within one year of the date of your injury, or one year from the last furnishing of indemnity or medical treatment benefits by your employer or State Fund. If you do not do so, your right to benefits may be lost.

If you have moved, or are moving soon, or want to know the status of your benefit check, please call our toll free number (888) 222-3211, Monday through Friday, between 7:00 a.m. and 5:00 p.m. PST.

Sincerely

Yolanda L. Nielsen

Yolanda L. Nielsen
Adjuster
(818)291-7626

Enc: Workers' Compensation Claim Form (SCIF e3301) (Rev. 7/04) [DWC-1 (Rev. 7/04)]
Business Reply Envelope
DWC Fact Sheet C (Rev. 2/08)
DWC Fact Sheet E (Rev. 12/05)

cc: D'Veal Family & Youth Services, PO Box 40255, Pasadena, CA 91114

CERTIFIED MAIL

September 18, 2007

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05124168
Employee: Floreen Rooks
Date of Injury: 08/09/2007
Employer: D'Veal Family & Youth Services

NOTICE OF POTENTIAL RIGHT TO SUPPLEMENTAL JOB DISPLACEMENT BENEFIT FORM

If your injury causes permanent partial disability, which prevented you from returning to work within 60 days of the last payment of temporary disability, and the claims administrator has not provided you with a Form DWC-AD 10133.53 "Notice of Offer of Modified or Alternative Work," you may be eligible for a supplemental job displacement benefit in the form of a nontransferable voucher for education-related retraining or skill enhancement, or both, at state approved or accredited schools.

The amount of the voucher for the supplemental job displacement benefit will be as follows:

Up to four thousand dollars ($4,000) for a permanent partial disability award of less than 15%.

Up to six thousand dollars ($6,000) for a permanent partial disability award between 15 and 25 %.

Up to eight thousand dollars ($8,000) for a permanent partial disability award between 26 and 49 %.

Up to ten thousand dollars ($10,000) for a permanent partial disability award between 50 and 99 %.

A permanent partial disability award is issued by a Workers' Compensation Administrative Law Judge or the Workers' Compensation Appeals Board. You may also settle your potential eligibility for a voucher as part of a compromise and release settlement for a lump sum payment. Any settlement must be reviewed and approved by a Workers' Compensation Administrative Law Judge.

The voucher may be used for payment of tuition, fees, books, and other expenses required by the school for retraining or skill enhancement. Not more than 10 percent of the voucher

moneys may be used for vocational or return to work counseling. A list of vocational return to work counselors is available on the Division of Workers' Compensation's website www.dir.ca.gov or upon request.

If you are eligible, and you have not already settled the benefit, you will receive the voucher from the claims administrator within 25 calendar days from the date the permanent partial disability award is issued by the Workers' Compensation Administrative Law Judge or the Workers' Compensation Appeals Board.

If modified or alternative work is available, you will receive a Form DWC-AD 10133.53 "Notice of Offer of Modified or Alternative Work" from the claims administrator within 30 days of the termination of temporary disability indemnity payments. The claims administrator will not be required to pay for supplemental job displacement benefits if the offer for modified or alternative work meets the following conditions:

(1) You have the ability to perform the essential functions of the job provided;
(2) The job provided is in a regular position lasting at least 12 months;
(3) The job provided offers wages and compensation that are at least 85 percent of those paid to you at the time of the injury; and
(4) The job is located within reasonable commuting distance of your residence at the time of injury.

If there is a dispute regarding the Supplemental Job Displacement Benefit, the employee or claims administrator may file Form DWC-AD 10133.55 "Request for Dispute Resolution before the Administrative Director."

If you have a question or need more information, you can contact your employer or the claims administrator listed below. You can also contact a State Division of Workers' Compensation Information and Assistance Officer.

Sincerely

Peter Cross

Peter Cross
For Yolanda Nielsen, Adjuster of this claim
Adjuster
(818)291-7626

cc: D'Veal Family & Youth Services, PO Box 40255 Pasadena, CA 91114

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August 29, 2007

Floreen Rooks
1317 1/2 South Gladys Ave
San Gabriel CA 91776

Claim Number: 05124168
Employee: Floreen Rooks
Date of Injury: 08/09/2007

Dear Floreen Rooks

There is additional information that we need from you regarding your workers' compensation claim. The enclosed material will help us to provide accurate and timely benefits.

Enclosed is an *EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS (SCIF 3301-DWC 1)*. If you have not already completed one of these, please complete the top section and return this form to your employer. Do not send it to State Compensation Insurance Fund. Your employer must complete the bottom section and provide you with a copy. It is your employer's responsibility to return the form to our office. If you do not give your employer the completed claim form, it may result in your loss of some benefits or rights.

Enclosed is an *EMPLOYEE'S REPORT OF INJURY (SCIF 3048)*. The information on this form is important in the adjustment of your claim. Please complete and sign the form and return it in the enclosed business reply envelope.

Enclosed is a *MEDICAL MILEAGE FORM (SCIF 3065)* to be used for the reimbursement of travel expense. Please complete and return the form in the enclosed business reply envelope and keep a copy for your record. Contact me if you need more mileage forms.

Enclosed is an *EMPLOYEE'S STATEMENT OF EARNINGS (SCIF 3282)* to be completed with your total earnings for **one full year** prior to your date of injury. Attach copies of W-2(s) or check stubs showing year-to-date earnings. You may be entitled to more benefits, but without this information we are unable to revise your compensation rate.

Enclosed is an *EMPLOYEE'S WORK STATUS (SCIF 3069)* form. Please complete the top section and return it in the enclosed business reply envelope if you have returned to work. If you have not returned to work, please have your primary treating physician complete the bottom section and return it to us.

If you have any questions regarding the completion of these forms or questions regarding your benefits, please call me.

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It is a felony for any person to knowingly misrepresent any fact in order to obtain workers' compensation benefits.

PLEASE NOTE THE ABOVE CLAIM NUMBER ON ALL CORRESPONDENCE.

Sincerely

Sherie Chou

Sherie Chou
For Yolanda Nielsen, Adjuster of this claim
Adjuster
(818)291-7626

Enc: Employees Claim for Workers Compensation Benefits (SCIF Form 3301) [DWC Form 1]
Employees Report of Injury (SCIF Form 3048)
Medical Mileage Expense Form (SCIF e3065 Form)
Employees Statement of Earnings (SCIF Form 3282)
Employees Work Status (SCIF Form 3069)
Business Reply Envelope

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02 318168 000000001 167 195 05124168

STATE

FUND

Floreen Rooks
Injured's Name / Nombre de la Persona Lesionada

05124168
Claim Number / Numero de Reclamo

Medical Mileage Expense Form
Forma de Gastos por Distancia Recorrida por Visitas Medica

You are entitled to reimbursement of medical travel expense incurred because of your industrial injury at the rate of 48.5 ¢ per mile. Mileage for reasonable travel to the pharmacy, parking, bridge tolls, public transportation costs are also included. Complete this form, attach receipts and send the original to State Compensation Insurance Fund. Keep a copy for your records.

Usted tiene derecho a recibir reembolso de 48.5 ¢ por milla por gastos de viaje por visitas medicas incurridos debido a la lesion sufrida en el trabajo. Millas por un viaje de distancia razonable a la farmacia, estacionamiento, pago de peaje, transporte publico tambien son incluidos. Complete esta forma y adjunte los recibos y envie la forma original a State Compensation Insurance Fund. Conserve la copia para su archivo.

Date/ Fecha	Traveled from (include address) Viaje desde (incluya direccion)	Traveled to (include name and address of doctor, hospital, therapist, etc.) Viaje a (incluya nombre y direccion del medico, hospital, terapeuta, etc.)	Round trip mileage/ Millaje viaje redondto	Parking/ Estacion?amiento	Toll/Public Trans/Other Peaje/Transporte Publico/Otros
Sample: 7/1/05	Sample: 1515 Maple, San Francisco	Sample: Dr. Sherman, 190 Oak, San Francisco	Sample: 14rmi	Sample: $2.50	Sample: $10.00

California law requires the following to appear on this from: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and my be subject to fines and confinement in state prison.	Total miles		x $ 0.485 / mile =	$
	ADJUSTER'S STAMP		Total parking	$
			Total tolls	$
		Total reimbursment requests $		
Las Leyes de California establecen que la siguiente redaracion aparezca en este formulario: Cualquier persona que a sabiendas presente reclames falsos o fraudulentos para el pago de una perdida, sera culpabli de un delito y se le podria multar y encarceiar en la "Penitenciaria estatal.	Signature / Firma			
	Printed name & Date Imprima su nombre & Fecha			

SCIF e3065 (REV 1−07)

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So that we can compute your compensation rate, we need your help.
Please answer the questions as completely as possible.

05124168
CLAIM NUMBER

PLEASE COMPLETE AND RETURN THIS FORM TODAY

Please list your past earnings from August 9, 2006 to August 9, 2007

INSTRUCTIONS:

1. List all periods of unemployment and state why you were not working. If due to illness or disability, please state the nature of the illness.
2. List gross wages before deductions under "total amount earned".
3. List all benefits received in addition to wages. State what they were (such as room, board, tips) and show their weekly value.

EMPLOYERS	DATES STARTED WORK	DATES LEFT WORK	TOTAL AMOUNT EARNED	Additional Benefits	COMMENTS (Reason unemployed ... why left work)
NAME ADDRESS CITY					
NAME ADDRESS CITY					
NAME ADDRESS CITY					
NAME ADDRESS CITY					
NAME ADDRESS CITY					
NAME ADDRESS CITY					

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and maybe subjected to fines and confinement in state prison.

Signature______________________________**Date**____________________

SCIF 3282 (REV. 5–96)

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August 29, 2007

Floreen Rooks
1317 1/2 South Gladys Ave
San Gabriel CA 91776

Claim Number: 05124168
Employee: Floreen Rooks
Date of Injury: 08/09/2007

Dear Floreen Rooks

Pursuant to Labor Code section 4663(d), we hereby request disclosure of **ALL permanent disabilities or physical impairments that existed prior to the injury.**

As provided in Labor Code section 4664, the employer is only liable for the portion of permanent disability directly caused by the work related injury. If applicable, an apportionment determination will be made by determining what approximate percentage of the permanent disability was caused by the work related injury, and what portion was caused by other factors, including prior industrial injuries.

Please list all previous permanent disabilities or physical impairments. If there are none, please advise. You may use the attached form and return using the enclosed business reply envelope.

Sincerely

Sherie Chou

Sherie Chou
For Yolanda Nielsen, Adjuster of this claim
Adjuster
(818)291-7626
Fax: (707)646-2609

Enc: Business Reply Envelope

cc: D'Veal Family & Youth Services, PO Box 40255 Pasadena, CA 91114

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Disclosure of Previous Permanent Disabilities or Physical Impairments pursuant to Labor Code Section 4663(d)

Pursuant to the requirements of Labor Code section 4663(d), I represent and disclose that the following is a complete list of permanent disabilities, physical impairments and awards for permanent disability that existed before the presently pending industrial injury.

Nature of permanent disability, physical impairment or disability award.

Add additional pages if necessary.

If applicable, please check the following box:
No prior permanent disabilities or physical impairments.

Dated: ____________________ Signed: ________________________

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SCI000106

02 318168 000000001 171 195 05124168

August 29, 2007

Floreen Rooks
1317 1/2 South Gladys Ave
San Gabriel CA 91776

Claim Number: 05124168
Employee: Floreen Rooks
Date of Injury: 08/09/2007

Dear Floreen Rooks

State Compensation Insurance Fund, the claims administrator for D'Veal Family & Youth Services, is handling your workers' compensation claim.

Effective April 19, 2004, California law requires your employer to authorize medical treatment for workers' compensation injuries or illnesses within one working day after you have filed a claim form (DWC−1). Medical treatment will be provided for your injury or illness until your claim is accepted or rejected up to a limit of $10,000 in total as required by law (L.C. §5402). You will also be reimbursed for reasonable transportation expenses based on current law. If you receive any medical bills for your workers' compensation injury or illness, please send them to me. Any treatment provided while your claim is on delay does not mean that your employer is accepting your claim. Any request for medical treatment authorization is subject to the medical treatment utilization schedule established by California law (L.C. §5307.27), the American College of Occupational and Environmental Medicine's (ACOEM) Occupational Medicine Practice Guidelines, or other evidence−based medical treatment guidelines, as appropriate.

The State Fund Medical Provider Network (MPN) will provide authorized medical treatment. Enclosed is a brochure outlining your rights and responsibilities as a covered employee in the State Fund MPN. The brochure explains how to obtain medical treatment for your injury or illness, how to select a primary treating physician, how to obtain a referral to a specialist, steps to take if you disagree with your physician's diagnosis or treatment, transfer of care, and continuity of care. If you have predesignated a personal physician prior to your injury or illness, you may obtain medical treatment from your personal physician.

We have not received a workers' compensation claim form (DWC−1) for your injury on August 9, 2007. If you have not already completed a claim form, please complete the top section of the enclosed claim form and return it to your employer. Do not send it to State Compensation Insurance Fund. Your employer must complete the bottom section and provide you with a copy. It is your employer's responsibility to return the form to our office. Once we have received your claim form, medical treatment will be provided for your injury or illness until your claim is accepted or rejected up to a limit of $10,000. Failure to file the claim form with your employer may preclude your entitlement to some benefits or rights.

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If you have any questions regarding the information above or the enclosed brochures, please feel free to contact me at the phone number listed below. However, if you are represented by an attorney, this phone call should be made through your attorney.

PLEASE NOTE THE ABOVE CLAIM NUMBER ON ALL CORRESPONDENCE.

Sincerely

Sherie Chou

Sherie Chou
For Yolanda Nielsen, Adjuster of this claim
Adjuster
(818)291−7626

Enc: Your Guide to Workers Compensation (SCIF Form e13699)
Employees Claim for Workers Compensation Benefits (SCIF Form 3301) [DWC Form 1]
Employee's Guide to the State Fund Medical Provider Network (SCIF Form 13176)

cc: D'Veal Family & Youth Services, PO Box 40255 Pasadena, CA 91114

02 318168 000000001 173 195 05124168

FLOREEN ROOKS
1315 S GLADYS AVE
SAN GABRIEL CA 91776-3623

8083

July 21, 2009

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05124168
Employee: Floreen Rooks
Date of Injury: 08/09/2007

Dear Ms. Rooks:

Enclosed are Stipulations with Request for Award in the above-entitled matter. We ask that you sign the form. Please also sign and date the enclosed Addendum(s) to the form. If you have any questions, you may contact me or a State Information and Assistance Office at 1-800-736-7401 or call your local Information and Assistance Officer at (213)576-7389.

Please complete the form(s) using all **CAPITAL** letters and in **BLACK** ink only. Do not fold, staple or bend any of the pages of the forms and return the form(s) in the enclosed envelope.

Please return the executed Stipulations with Request for Award to this office. I will then complete and submit it to the assigned Workers' Compensation Appeals Board for approval and will return an executed copy to you.

Sincerely

Yolanda L. Nielsen

Yolanda L. Nielsen
Adjuster
(818)291-7626

Enc: Business Reply Envelope (SCIF 19619)
Stipulation with Request for Awards (DWC-CA Form 10214(a)

Dear Floreen Rooks

THIS PAGE MUST BE PLACED ON TOP OF THE DOCUMENT/FORM YOU ARE RETURNING TO STATE COMPENSATION INSURANCE FUND.

CLAIM NUMBER: 05124168

INJURED'S NAME: FLOREEN ROOKS

ADJUSTER'S NAME: YOLANDA NIELSEN

ADJUSTER'S RETURN ADDRESS:

PO BOX 92622
LOS ANGELES CA 90009

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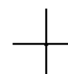
02 318168 000000001 175 195 05124168

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
STIPULATIONS WITH REQUEST FOR AWARD



05124168
Case No.

Date of Injury 08/09/2007
MM/DD/YYYY

130-38-8510
SSN (Numbers Only)

Venue Choice is based upon: (Completion of this section is required)

[X] County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

[ ] County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

[ ] County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

LAO
Select 3 Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Applicant (Completion of this section is required)

FLOREEN
First Name

MI

ROOKS
Last Name

1315 S GLADYS AVE
Address/PO Box (Please leave blank spaces between numbers, names or words)

SAN GABRIEL | CA | 91776
City | State | Zip Code

Employer #1 Information (Completion of this section is required)

[X] Insured [ ] Self-Insured [ ] Legally Uninsured [ ] Uninsured

D'VEAL FAMILY & YOUTH SERVICES
Employer Name (Please leave blank spaces between numbers, names or words)

PO BOX 40255
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

PASADENA | CA | 91114
City | State | Zip Code

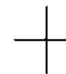
ADJUSTER: YOLANDA NIELSEN GLENDALE (SA)

8083

05124168 195 176 000000001 3501 05124168 318168 02 012 004 000000001 1386443 2

Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)

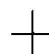
STATE COMPENSATION INSURANCE FUND
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)



PO BOX 92622
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

LOS ANGELES — CA — 90009
City — State — Zip Code

Claims Administrator Information (if known and if applicable)



SCIF INSURED GLENDALE
Name (Please leave blank spaces between numbers, names or words)

PO BOX 92622
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

LOS ANGELES — CA — 90009
City — State — Zip Code

Employer #2 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

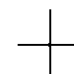
City — State — Zip Code

Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

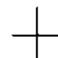
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City — State — Zip Code



2 1386443 000000001 005 012 05124168 3501 05124168 177 195 000000001 318168 02

Claims Administrator Information (if known and if applicable)



Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

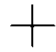
Employer #3 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code



Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

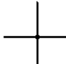
City | State | Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code



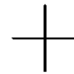
8083

2 1386443 000000001 006 012 05124168 3501 000000001 178 195 05124168 02 318168

05124168 195 179 000000001 3501 05124168 318168 02 012 007 000000001 1386443 2

Employer #4 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured



Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

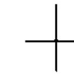
Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

The parties hereto stipulate to the issuance of an Award and/or Order, based upon the following facts, and waive the requirements of Labor Code section 5313:



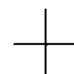
1. FLOREEN
Employees First Name

ROOKS ,
Employees Last Name

birth date 06/20/1949 ,
MM/DD/YYYY

while employed at PADADENA , CA
State

as a(n) THERAPIST , in
Occupation Group



☐ More than 4 Companion Cases

☒ Specific Injury

05124168 — Case Number 1

☐ Cumulative Injury

08/09/2007 (Start Date: MM/DD/YYYY) — (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 520 ANKLE Body Part 2: 513 KNEE Body Part 3:

Body Part 4: Other Body Parts: LEFT KNEE AND ANKLE

☐ Specific Injury

Case Number 2

☐ Cumulative Injury

(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

☐ Specific Injury

Case Number 3

☐ Cumulative Injury

(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

☐ Specific Injury

Case Number 4

☐ Cumulative Injury

(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

by the employer(s) and their insurer(s) listed above and who sustained injury(ies) arising out of and in the course of employment to

INJURED BODY PARTS ARE LEFT KNEE AND LEFT ANKLE.

(Please list all body parts injured)

05124168 195 180 000000001 3501 05124168 318168 02 012 008 000000001 1386443 2

2. The injury (ies) caused temporary disability for the period 08/22/2007 (MM/DD/YYYY) through 09162007 (MM/DD/YYYY) for which indemnity has been paid at $ 645.66 (Indemnity Paid) per week.

2(a).The injury(ies) caused additional temporary disability for the period ________ (MM/DD/YYYY)

through ________ (MM/DD/YYYY) at the rate of $ ________ (Rate) in the amount of $ ________ (Indemnity Paid)

3. The injury(ies) caused permanent disability of 6% % for which indemnity is payable at $ 230.00 (Indemnity Rate)

per week beginning 09/17/2007 (MM/DD/YYYY) in the sum of $ 4,140.00 , less credit for such payments

previously made. ☐ And a life pension of $ ________ (Life Pension) per week thereafter.

Labor Code §4658(d) adjustment:

☐ Increase rate to $ ________ as of ________ (MM/DD/YYYY)

☐ Decrease rate to $ ________ as of ________ (MM/DD/YYYY)

☐ Not Applicable

An informal rating ☐ has / ☒ has not (Select one)been previously issued in case no(s) ________ .

4.There ☒ is ☐ is Not a need for medical treatment to cure or relieve from the effects of said injury (ies).

5. Medical-legal expenses and/or liens are payable by defendant as follows:

6. Applicant's attorney requests a fee of $ ________

☐ Fees to be commuted as follows:

7. Liens Against compensation are payable as follows:

05124168 195 181 000000001 3501 05124168 318168 02 012 009 000000001 1386443 2

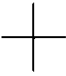
8.Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

9.Other stipulations:

INJURED BODY PARTS ARE LEFT KNEE AND LEFT ANKLE.

THIS STIPULATION IS BASED UPON THE PERMANENT AND STATIONARY REPORT OF DR. RALPH GAMBARDELLA DATED 11/26/07.

PENALTIES AND INTERESTS ARE WAIVED IF AWARD IS PAID WITHIN 30 DAYS FROM DATE OF RECEIPT BY STATE FUND.

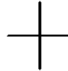


Dated ______________________ MM/DD/YYYY

______________________ Applicant

Applicant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☒ Non Attorney Representative



First Name

Last Name

Firm Number

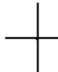
Law Firm name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Dated ______________________ MM/DD/YYYY

______________________ Applicant Attorney Signature



2 1386443 000000001 010 012 05124168 3501 02 318168 000000001 182 195 05124168

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Dated MM/DD/YYYY

Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

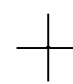
Dated MM/DD/YYYY

Defense Attorney Signature

2 1386443 000000001 011 012 05124168 3501
02 318168 000000001 183 195 05124168

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative



First Name

Last Name

Firm Number

Law Firm Name

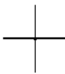
Address/PO Box (Please leave blank spaces between numbers, names or words)

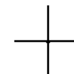
City State Zip Code

Dated MM/DD/YYYY Defense Attorney Signature

Interpreter Licence Number:

Interpreter Name Interpreter License Number





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02 318168 000000001 185 195 05124168

September 19, 2011

Nuquest / Bridge Pointe
PO Box 915619
Longwood FL 32791-5619

Claim Number: 05124168
Employee: Floreen Rooks
Date of Injury: 08/09/2007
Employer: D'Veal Family & Youth Services

Dear Gentlepersons

In response to your written request, dated September 19, 2011, enclosed are copies of the medical records we have on file for Floreen Rooks.

Sincerely

Yolanda L. Nielsen

Yolanda L. Nielsen
Adjuster
(818)291-7626

Enc: Medical File

8083

02 318168 000000001 186 195 05124168

List of Medical Reports

ATTENTION : STATE FUND
If records are returned, do not reimage.

Name	Date
Dr. Saucedo	01/26/2011
Associated Sports Therapy	05/22/2008
Associated Sports Therapy	05/09/2008
Anthony Bledin Md	03/19/2008
Anthony Bledin, Md	03/19/2008
Thomas Saucedo,Md	12/20/2007
Thomas Saucedo, Md	11/29/2007
Dr. Gambardella	11/26/2007
Ralph A. Gambardella, Md	11/26/2007
Michael Hadley, Md	11/10/2007
*State Fund	10/01/2007
Cal Osha	09/21/2007
Kerlan Jobe	09/10/2007
Ralph A. Gambardella, Md	09/10/2007
Ralph A. Gambardella, Md	09/10/2007
Ralph Gambardela, Md	09/10/2007
Ralph Gambardella, Md	09/10/2007
Kenneth Jung, Md	09/04/2007
Kenneth Jung, Md	09/04/2007
Kerlan Jobe	09/04/2007
Kerlan Jobe Ortho Clinic	09/04/2007
Dreamweaver Medical Group	08/27/2007
Dreamweaver Medical Group	08/27/2007
Dreamweaver Medical Group	08/27/2007
Drewamweaver Medical Group	08/27/2007
Dreamweaver Medical Group	08/14/2007
Richard Chao, Md	08/10/2007
Richard Chao, Md	08/10/2007
Kenneth Jung, Md	08/09/2007

November 23, 2010

Thomas Fell, Jr., M.D.
4940 Van Nuys Blvd Ste 302
Sherman Oaks CA 91403

Claim Number: 05124168
Employee: Floreen Rooks
Date of Injury: 08/09/2007
Employer: D'Veal Family & Youth Services

Dear Gentlepersons

In response to your written request, dated November 23, 2010, enclosed are copies of the medical records we have on file for Floreen Rooks.

These records are pertaining to the PQME appointment on 1/06/11.

Sincerely

Yolanda L. Nielsen
Yolanda L. Nielsen
Adjuster
(818)291-7626

Enc: Employee Claim Form of 08/30/2007
Medical File

cc: Floreen Rooks, 1315 S Gladys Ave, San Gabriel, CA 91776-3623

02 318168 000000001 187 195 05124168

8083

List of Medical Reports

ATTENTION : STATE FUND
If records are returned, do not reimage.

Name	Date
Associated Sports Therapy	05/22/2008
Associated Sports Therapy	05/09/2008
Anthony Bledin Md	03/19/2008
Anthony Bledin, Md	03/19/2008
Thomas Saucedo,Md	12/20/2007
Thomas Saucedo, Md	11/29/2007
Dr. Gambardella	11/26/2007
Ralph A. Gambardella, Md	11/26/2007
Michael Hadley, Md	11/10/2007
*State Fund	10/01/2007
Cal Osha	09/21/2007
Kerlan Jobe	09/10/2007
Ralph A. Gambardella, Md	09/10/2007
Ralph A. Gambardella, Md	09/10/2007
Ralph Gambardela, Md	09/10/2007
Ralph Gambardella, Md	09/10/2007
Kenneth Jung, Md	09/04/2007
Kenneth Jung, Md	09/04/2007
Kerlan Jobe	09/04/2007
Kerlan Jobe Ortho Clinic	09/04/2007
Dreamweaver Medical Group	08/27/2007
Dreamweaver Medical Group	08/27/2007
Dreamweaver Medical Group	08/27/2007
Drewamweaver Medical Group	08/27/2007
Dreamweaver Medical Group	08/14/2007
Richard Chao, Md	08/10/2007
Richard Chao, Md	08/10/2007
Kenneth Jung, Md	08/09/2007

02 318168 000000001 188 195 05124168

8083

SCI000124

02 318168 000000001 189 195 05124168

January 31, 2010

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05124168
Employee: Floreen Rooks
Date of Injury: 08/09/2007
Employer: D'Veal Family & Youth Services

MEDICARE QUESTIONNAIRE

We are writing to inform you of a new Federal law that requires insurers such as State Fund to obtain Medicare Beneficiary Status information from claimants.

As of January 1, 2009, a Federal law (Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007) mandates that insurers such as State Fund collect CMS Medicare Beneficiary Status information from their claimants for Medicare Quarterly Reporting (MQR). The Centers for Medicare and Medicaid Services (CMS) oversees the Medicare program and coordinates benefit payments to ensure that proper and timely payment is made.

Enclosed is a two-page Medicare Questionnaire along with a self-addressed stamped envelope. We ask that you complete and return the questionnaire within 10 days of receipt of this letter.

Please be advised that all information collected in this questionnaire will be used by CMS to accurately coordinate benefits with Medicare. State Fund recognizes the importance of respecting the privacy of our customers and is committed to providing the highest level of security and privacy regarding the collection and use of personal information.

This letter is being sent to you to meet federal reporting requirements and does not constitute acceptance of liability for your workers' compensation claim.

If you have any questions, please feel free to call me at the number listed below. However, if an attorney represents you, this phone call should be made through your attorney.

Sincerely

Yolanda L. Nielsen

Yolanda L. Nielsen
Adjuster
(818)291-7626

Enc: Medicare Questionnaire Form
Business Reply Envelope

8083

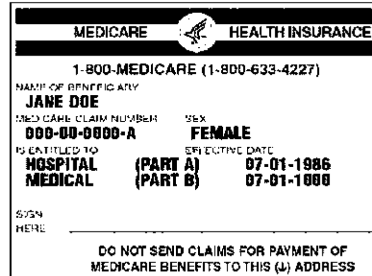
SCI000125

02 318168 000000001 190 195 05124168

For Internal Use: CPC Indexers-Please index this document to document type " Medicare Form"
Employee: Floreen Rooks Claim #: 05124168

MEDICARE QUESTIONNAIRE FORM

Please review this picture of the Medicare card to determine if you have, or have ever had a similar Medicare card and answer the following questions.



SECTION I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?	[ ] YES	[ ] NO
If yes, please complete the following. If no, proceed to Section II.		
Full Name: *(Please print the name* ***exactly*** *as it appears on your SSN or Medicare card if available.)*		
Medicare Claim Number:	**Date of Birth** *(Mo/Day/Year)*	_ _ – _ _ – _ _ _ _
Social Security Number: *(If Medicare Claim Number is Unavailable)* _ _ _ – _ _ – _ _ _ _	**Sex**	[ ]Female [ ] Male

SECTION II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

____
Employee Name *(Please print)*

____
Name of Person Completing This Form If Employee is Unable *(Please print)*

____
Signature of Person Completing this Form **Date**

For Internal Use: CPC Indexers-Please index this document to document type " Medicare Form"
Employee: Floreen Rooks Claim #: 05124168

02 318168 000000001 191 195 05124168

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

SECTION III

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

____

____

____

____

____

____

____
Employee Name *(Please print)*

____
Name of Person Completing This Form If Employee is Unable *(Please print)*

____
Signature of Person Completing this Form

____
Date

PD Rating Report

Date Requested: 09/10/2020

Claim 05124168 **Claimant** FLOREEN ROOKS

Trans Num	Date of Rating	Final PD %	Formula String
2	03/21/2012	8	APP FRAC FAC DIS NUM RTG OCC DIS MOD AGE SUBJECT FINAL C&R PD for this claim.
1	02/04/2008	8	APP FRAC FAC DIS NUM RTG OCC DIS MOD AGE SUBJECT FINAL Per PTP Dr. Gambardella 11/26/07: [17.05-7(2)8-110D-6-8] IW is receiving TD benefits under 05170360

-- End of Report --

02 318168 000000001 192 195 05124168

Wage Calculation Report

Claim Num: 05124168 | Claimant: FLOREEN ROOKS

Date of Calculation	AWW	TD Rate	Selected Flag
8/27/07, 3:07 PM	$ 968.49	$ 645.66	YES

Wage Component

Wage Type		
Rate Wage		
Start Date	End Date	Period
		7
Gross Wages	Hours a Day	Days a Week
$ 968.49		
Seasonal Amount		
0.0		

Description

02 318168 000000001 193 195 05124168

Date Requested: September 10, 2020

8083

SCI000129

Claim Num: 05124168 Claimant FLOREEN ROOKS

02 318168 000000001 194 195 05124168

Room and Board

Start Date	End Date
Weekly Rent Value	**Weekly Board**
0.0	0.0
Weekly Utility	**Weekly Other Value**
0.0	0.0

Description

Wage Summary

Date Requested: September 10, 2020

Claim Num: 05124168 Claimant FLOREEN ROOKS

02 318168 000000001 195 195 05124168

Wage Summary

Wages Earned from (calculated date)	to (calculated date)		Weeks and	Days
null	null	=	null	null

Gross Wages from all Employment	divided by (weeks)		Result
0	0	=	null

Room and Board Weekly Amount if any	Bonus if any	Average Weekly Wage	Multiplied by	TD Rate
0.0	0.0	$ 0.0	.66667	$ 0.0

Date Requested: September 10, 2020

Doctor's Notes

02 318168 0000000001 003 195 0124168

WORK STATUS REPORT

Date of Injury: 8-9-07 | Today's Date: 8-27-07

Employer: Dread Family Youth Services

Diagnosis:
(L) ankle sprain
(L) knee sprain

WORK STATUS

- ☐ Return to usual and customary work with no limitations.
- ☐ Off work balance of current work shift and return to work on ____________.
  - ☐ with NO limitations
  - ☐ with the limitations listed below.
- ☐ Return to temporary alternate work with the following limitations:
  - ☐ no continuous walking or prolonged standing
  - ☐ no lifting, pushing, or pulling over ________ pounds.
  - ☐ no repetitive bending or stooping.
  - ☐ limited use of the ☐ RIGHT ☐ LEFT ☐ HAND ☐ ARM
  - ☐ no use of the ☐ RIGHT ☐ LEFT ☐ HAND ☐ ARM
  - ☐ no repetitive kneeling or squatting.
  - ☐ no work above shoulder level.
  - ☐ must be sitting the majority of work shift.
  - ☐ sitting work only.
  - ☐ must keep the ☐ RIGHT ☐ LEFT ☐ FOOT ☐ LEG elevated major of work shift.
  - ☐ no driving commercial vehicle.
  - ☐ no operation of machinery.
  - ☐ Other: ____________
- ☒ Off work (TTD) until 9/4/07.
- ☐ Off work (TTD) because no temporary alternative work is available until ____________.
- ☐ Return to work on ____________ with NO LIMITATIONS.

Listed limitations apply to all non-work related activities (home, sports, hobbies, etc.)

INSTRUCTIONS TO EMPLOYEE:

- ☐ Keep wound bandage clean and dry.
- ☐ Wear ☐ SPLINT ☐ ARM SLING ☐ SUPPORT during working shift.
- ☐ Use ☐ CANE ☐ CRUTCHES during working hours.

Dispensed medications that can be taken during working shift:
1. ____________
2. ____________

Dispensed medications that MUST NOT be taken during work shift:
1. ____________
2. ____________

- ☐ Employee advised to see his/her private physician because his/her medical condition is **NOT WORK RELATED** (non-industrial).
- ☐ Employee referred for specialty evaluation. Type: Physical Therapy & MRI of (L) knee

Estimated Length of Treatment ____________ days ____ weeks.
Estimated Length of Disability ____________ days ____ weeks.

- ☐ There is no permanent disability expected.
- ☐ Employee's medical condition is permanent and stationary.
- ☐ Employee is released from further medical care.

RETURN APPOINTMENT: Date 9-4-07 Time: 10:30 (AM) PM

Provider signature: [signature] | Date: 8-27-07

DREAMWEAVER MEDICAL GROUP
420 W. Las Tunas Drive
San Gabriel, CA 91776
(626) 289-8493

Patient Name: Floreen Books
Date of Birth: 6-20-49
SSN #: 130-56-8610
MR #:

WORK STATUS REPORT

02 318168 000000001 004 195 05124168

WORK STATUS REPORT

Date of Injury: 8-9-07 | Today's Date: 8-14-07

Employer: D'Veal Family Youth Services

Diagnosis:
(1.) (L) ankle sprain (3) (L) hip pain
(2.) (L) knee pain

WORK STATUS

- ☐ Return to usual and customary work with no limitations.
- ☐ Off work balance of current work shift and return to work on ______.
  - ☐ with NO limitations
  - ☐ with the limitations listed below.
- ☒ Return to temporary alternate work with the following limitations: — on 8/16/2007.
  - ☒ no continuous walking or prolonged standing
  - ☒ no lifting, pushing, or pulling over 10 lbs pounds. SNowacore
  - ☒ no repetitive bending or stooping.
  - ☐ limited use of the ☐ RIGHT ☐ LEFT ☐ HAND ☐ ARM
  - ☐ no use of the ☐ RIGHT ☐ LEFT ☐ HAND ☐ ARM
  - ☒ no repetitive kneeling or squatting.
  - ☐ no work above shoulder level.
  - ☒ must be sitting the majority of work shift.
  - ☒ sitting work only.
  - ☒ must keep the ☐ RIGHT ☒ LEFT ☒ FOOT ☐ LEG elevated major of work shift.
  - ☒ no driving commercial vehicle.
  - ☐ no operation of machinery.
  - ☒ Other: Limited driving (to & from work), no stairs or climbing up

SNowacore 8/9/07

SNowacore 8/9/07

- ☐ Off work (TTD) until ______.
- ☐ Off work (TTD) because no temporary alternative work is available until ______.
- ☐ Return to work on ______ with NO LIMITATIONS.

Listed limitations apply to all non-work related activities (home, sports, hobbies, etc.)

INSTRUCTIONS TO EMPLOYEE:

- ☐ Keep wound bandage clean and dry.
- ☒ Wear ☒ SPLINT ☐ ARM SLING ☐ SUPPORT during working shift.
- ☒ Use ☒ CANE ☐ CRUTCHES during working hours.
- ☒ Dispensed medications that can be taken during working shift:
  1. Cane D/C. SNowacore 8/16/2007
  (Ent) Naprosyn 500 mg PO. BID.

Dispensed medications that MUST NOT be taken during work shift:
1. ______
2. ______

- ☐ Employee advised to see his/her private physician because his/her medical condition is NOT WORK RELATED (non-industrial).
- ☒ Employee referred for specialty evaluation. Type: Physical therapy and MRI of (L) knee

Estimated Length of Treatment ______ days 2 weeks.
Estimated Length of Disability ______ days ______ weeks.

- ☐ There is no permanent disability expected.
- ☐ Employee's medical condition is permanent and stationary.
- ☐ Employee is released from further medical care.

RETURN APPOINTMENT: Date 8-21-07 Time: 11:00 (AM) PM

Provider signature: [signature] | Date: 8-14-07

DREAMWEAVER MEDICAL GROUP
420 W. Las Tunas Drive
San Gabriel, CA 91776
(626) 289-8493

Patient Name: Florecen Books
Date of Birth: 6-20-49
SSN #: 130-38-3610
MR #:

WORK STATUS REPORT

02 318168 000000001 005 195 05124168

Date of Injury: 8-9-07 | Today's Date: 8-9-07

Employer: Dveal Family Youth Services

Diagnosis:
(1) (L) ankle pain (2) (L) knee pain (3) (L) hip pain

WORK STATUS

- ☐ Return to usual and customary work with no limitations.
- ☐ Off work balance of current work shift and return to work on ________.
  - ☐ with NO limitations
  - ☐ with the limitations listed below.
- ☐ Return to temporary alternate work with the following limitations:
  - ☐ no continuous walking or prolonged standing
  - ☐ no lifting, pushing, or pulling over ________ pounds.
  - ☐ no repetitive bending or stooping.
  - ☐ limited use of the ☐ RIGHT ☐ LEFT ☐ HAND ☐ ARM
  - ☐ no use of the ☐ RIGHT ☐ LEFT ☐ HAND ☐ ARM
  - ☐ no repetitive kneeling or squatting.
  - ☐ no work above shoulder level.
  - ☐ must be sitting the majority of work shift.
  - ☐ sitting work only.
  - ☐ must keep the ☐ RIGHT ☐ LEFT ☐ FOOT ☐ LEG elevated major of work shift.
  - ☐ no driving commercial vehicle.
  - ☐ no operation of machinery.
  - ☐ Other: ________
- ☒ Off work (TTD) until 8/15/07
- ☐ Off work (TTD) because no temporary alternative work is available until ________.
- ☐ Return to work on ________ with NO LIMITATIONS.

Listed limitations apply to all non-work related activities (home, sports, hobbies, etc.)

INSTRUCTIONS TO EMPLOYEE:

- ☐ Keep wound bandage clean and dry.
- ☒ Wear ☒ SPLINT ☐ ARM SLING ☐ SUPPORT during working shift.
- ☒ Use ☒ CANE ☐ CRUTCHES during working hours.

Dispensed medications that can be taken during working shift:
1. Naprosyn 500 mg BID.
2. ________

Dispensed medications that **MUST NOT** be taken during work shift:
1. ________
2. ________

- ☐ Employee advised to see his/her private physician because his/her medical condition is **NOT WORK RELATED** (non-industrial).
- ☒ Employee referred for specialty evaluation. Type: X-ray

Estimated Length of Treatment ________ days ________ weeks.
Estimated Length of Disability ________ days ________ weeks.

- ☒ There is no permanent disability expected.
- ☐ Employee's medical condition is permanent and stationary. 8/14/07
- ☐ Employee is released from further medical care.

RETURN APPOINTMENT: Date 8-14-07 Time: 1:30 AM (PM)

Provider signature: [signature] | Date: 8-9-07

DREAMWEAVER MEDICAL GROUP
420 W. Las Tunas Drive
San Gabriel, CA 91776
(626) 289-8493

Patient Name: Floreen Books
Date of Birth: 6-20-49
SSN #: 130-38-8510
MR #: ________

WORK STATUS REPORT

8083

SCIF RECD DTE 02/07/2011 BKSCAN 6 02/07/2011 08:53 AM 052139 31 1

02 318168 000000001 006 195 05124168

EOMA

Eastside Orthopedic Medical Associates

Diplomates of the American Board of Orthopedic Surgeons
Fellows of the American Academy of Orthopedic Surgeons
Qualified Medical Examiners

Total Joints Arthroplasty
Industrial Medicine
Sports Medicine

Richard Zapanta, M.D., Inc.
Tomas Saucedo, M.D., Inc.
Dana J. Primo, P.A.C.

Associated Physicians
Luigi Gallioni, M.D., Inc.

ORTHOPEDIC SUPPLEMENTAL REPORT

January 26, 2011

State Compensation Insurance
P.O. Box 92622
Los Angeles, CA 90009-2622

Attention: Worker's Compensation Claims

RE:	**FLOREEN ROOKS**
EMP:	**D'Veal Family Youth Services**
DATE OF INJURY:	**11/10/07**
DATE OF EXAMINATION:	**01/26/11**

Gentleman:

As you are well aware, this patient has been under our care having previously undergone arthroscopic surgery of her knee. Surgery was performed on 04/24/08. She indicates that she did well, however, she did have some residual soreness, this soreness has steadily become more pronounced. She denies any new injuries to her left knee. She denies any other problem to her left knee and indicates that she has continued to work with D'Veal Family Youth Services performing her work related activities. However, she does complain of increased pain of her left knee especially over the last few months.

PHYSICAL EXAMINATION

GENERAL

Vital signs – blood pressure 206/100, pulse is 88, respirations 16.

LOWER EXTREMITIES

On physical examination of the left knee there is evidence of notable medial joint line tenderness, there is notable swelling. There is an effusion. She has a positive

880 South Atlantic Boulevard, Suite 205, Monterey Park, California 91754 • (626) 289-0178 • FAX (626) 308-2083

02 318168 000000001 007 195 05124168

McMurray sign and positive grind sign. There is notable pain and discomfort especially of the medial compartment of the knee. No gross laxity is noted. Motor and sensory function is intact distally.

DIAGNOSTIC STUDIES

X-rays of the left knee reveals evidence of Grade III medial compartment narrowing of the left knee with osteophyte formation noted primarily in the medial compartment.

IMPRESSION

LEFT KNEE EVIDENCE OF MEDIAL COMPARTMENT DEGENERATIVE OSTEOARTHRITIS

DISCUSSION

Given Ms. Rooks clinical findings as well as the results of her x-rays it appears that she has extensive degenerative changes of the medial compartment of her left knee. This has progressively gotten worse since she had surgery three years ago and at this point in time it appears that the pain is quite unrelenting. I will recommend that she be treated conservatively at this point in time with the use of an anti-inflammatory medication as well as an intra-articular cortisone injection to minimize her pain and discomfort, this was provided. The patient noted immediate improvement of the pain and discomfort of the left knee. I will see her back for follow-up in four weeks time. Should this patient's symptoms not improve or resolve significantly, she may require further intervention. This would entail a knee arthroplasty of her left knee. At this point in time I have discussed this in detail with the patient and I will see her back for follow-up to assess her progress in four weeks time. She will continue to work with no restrictions. I will keep you informed as noted.

Should you have any further questions or concerns, please do not hesitate to contact me.

DISCLOSURE

I declare under penalty of perjury that I, the signing physician, have actually performed this examination, and the time spent in performing this evaluation is in compliance with the IMC Guidelines (Section 5307.1 and 5307.6).

SCIF RECD DTE 02/07/2011 BKSCAN 6 02/07/2011 08:53 AM 052139 31 3

02 318168 000000001 008 195 05124168

I declare under penalty of perjury that I have devoted at least one-third of my total practice time to providing medical treatment.

I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under the penalty of perjury.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

There may or may not be other medical information that is protected by special state and federal laws and cannot be released without the subject's specific written authorization, or pursuant to other procedures established by law.

This report was done in the State of California in the County of Los Angeles, in the City of Monterey Park, on the 26th, of January, 2011.

Sincerely,

Tomas Saucedo, M.D.
Diplomate, American Board of
Orthopedic Surgery

TS/mc

SCIF RECD DTE 02/16/2008 BKSCAN 3 02/16/2008 09:18 AM 018884 9 1

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

HealthCare Partners 95-4526112
3144 Santa Anita Avenue
El Monte, CA 91733-

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's worker's compensation insurance carrier or the self-insured employer. Failure to file a timely doctor report may result in assessment of a civil penalty. In 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

1. INSURER
State Comp 92622
P.O. Box 92622
Los Angeles, CA 90009-2622

2. EMPLOYER NAME
D'Veal Family & Youth Services
P.O. Box 40255
Pasadena, CA 91114

PLEASE DO NOT USE THIS COLUMN: Case No | Industry | County | Age | Hazard | Disease | Hospitalization | Occupation | Return Date/Code

4. Nature of Business (e.g., food manufacturing, building construction, retailer of women's clothes)

5. PATIENT NAME: ROOKS, FLOREEN
6. Sex: [ ] Male [X] Female
7. Date of Birth (Mo. Day Year): 06/20/1949

8. Address: 1315 S. GLADYS AVE. City: SAN GABRIEL Zip: 91776
9. Telephone Number: (626) 573-1906

10. Occupation (Specific job title): MARRIAGE FAMILY THERAPIST
11. Social Security Number: 130-38-8510

12. Injured at: WORK PLACE City: County:

13. Date and hour of injury or onset of illness: Mo. Day Year 11/10/2007 Hour 10:30 am
14. Date Last Worked: Mo. Day Year 11/10/2007

15. Date and hour of first examination or treatment: Mo. Day Year 11/20/2007 Hour 11:04 am
16. Have you (or your office) previously treated patient [ ] Yes [X] No

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.)
"Fell ... ground gr el and fr ctu ed ight foo to pr ent from rolling oncoming ffi
In ed ight fo "

18. SUBJECTIVE COMPLAINTS (Describe fully. Use the reverse side if more space is required.)
The pa nt ate at she is employed ma iage and family therapist. On 11/10/2007 whi
... nte ... cle that was mo though ... parked she ipped on the ground nd
f... the hit her left knee and she twisted (continued)

19. OBJECTIVE FINDINGS (Use reverse side if more space is required.)
A. Physical examination
General appearance: No ... di tre... Vital ign BP 156/98, pulse 78, spi ... 16.
Exami ation of the ight fo veals that the... mode ate edema with moderat marked tendernes
pr ... um. The no (c ntinued)

B. X-ray and laboratory results (State if none pending) X-rays were performed and (continued)

20. DIAGNOSIS (if occupational illness, specific etiologic agent and duration of exposure) Chemical or toxic compounds involved? [ ] Yes [X] No
924.11 CONTUSION, LEFT KNEE 825.20 FRACTURE, RIGHT FOOT

21. Are your findings and diagnosis consistent with patient's account of injury or onset [X] Yes [ ] No
If "no" please explain

22. Is there any other current condition that will impede or delay patient's recovery? [X] Yes [ ] No
If "yes" please explain Patient does have (continued)

23. TREATMENT RENDERED (Use reverse side if more space is required.)
(1) Examination. (2) X-ray. (3) Dispensed walke boot/Cam walke (4) Dispens Motrin 800 mg x #30 tablets
(5 Dispe ed strength Tyle ol x #30 table (6) Re ... to orthopedic surgeon aluation and
... tment

If further treatment is required, specify treatment Yes, in the form of treatment (continued) Estimated duration 1 month.

24. If Hospitalized as inpatient, give hospital name and location Date admitted Mo. Day Year Estimated Stay
(continued)

25. WORK STATUS Is patient able to perform usual work? [ ] Yes [X] No
If "no", patient can return to
Regular work ________
Modified work ________ Specify Patient placed on modified duty

I have not violated Labor Code 139.3 and the contents of the report and bill are true and correct to the best of my knowlege. This statement is made under penalty of perjury.

Doctor's signature ________ Date ________ CA License Number G36632
Doctor name and degree (Please print) Michael Hadley, M.D. IRS Number 95-4526112
Case# 80283 Telephone Number (626) 582-7989

ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR PURPOSE OF OBTAINING OR DENYING WORKERS' COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY

8083

02 318168 00000001 016 195 05124168

FIRST REPORT - ADDITIONAL INFORMATION

FLOREEN ROOKS
DOI: 11/10/2007 SSN: 130-38-8510 MR#: 32-295496
Page 2

#18.
her left ankle and also her right foot. Because of these injuries, the patient developed pain mostly in her right foot. As a result, she went to the Kaiser ER for evaluation and treatment.

While at Kaiser ER she was told that she had a fracture of the right foot, sprain to the left ankle and a bruise to the left knee. She was given an ortho shoe and was told to report this to her employer as a job-related injury. The patient did so and she was referred here by her Workers Compensation insurance carrier for evaluation and treatment. Today is her initial visit at this facility.

The patient does complain of mild discomfort in her left ankle and her left knee. However, she does complain of significant discomfort in her right foot.

Pertinent past medical history: The patient states that she has a heart valve problem for many years and does use prophylactic antibiotics for dental work. She has had a fracture of her left ankle in 1992 that was treated operatively. SHE IS ALLERGIC TO PENICILLIN. She denies any history of diabetes, high blood pressure, ulcer disease or asthma.

Social history: The patient occasionally smokes. She does play chess and write poetry.

Review of systems: Denies any chest pain or shortness of breath. Patient denies any abdominal pain, nausea, vomiting, diarrhea or constipation.

#19A.
ecchymosis. The patient does have impaired weight bearing secondary to pain and altered gait secondary to pain. The patient is ambulating with the aid of a cane.

Examination of the left ankle reveals that there is a healed surgical scar. There is trace tenderness and edema.

Examination of the left knee reveals vague tenderness present anteriorly, trace edema. There is full flexion with pain.

#19B.
preliminary reading of the right foot reveals that there is a fracture involving the fourth and fifth metatarsals with angulation present in the fourth metatarsal head. Final report is pending. X-ray exam of the left ankle reveals the presence of hardware, no acute finding seen. X-ray of the left knee is unremarkable except for degenerative changes. Final report is pending.

#20.
1. FRACTURE, RIGHT FOOT.
2. SPRAIN, LEFT ANKLE.
3. CONTUSION, LEFT KNEE.

#22.
hardware in her left ankle and this may impact upon her rate of recovery.

#23.
Further treatment: by the orthopedic surgeon.

#24.
To be determined by the orthopedic surgeon.

#25.
the following restrictions: No driving vehicle during working hours, no walking or standing for more than one hour, sitting work only.

SCIF RECD DTE 12/17/2007 BKSCAN 11 12/17/2007 10:46 AM 023644 16 1

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 11/26/2007 Doctor: RALPH GAMBARDELLA MD

PERMANENT AND STATIONARY REPORT

CASE SUMMARY:

The patient was initially seen by me on September 10, 2007, relative to a work injury. At the time, the patient was 58 years of age and had sustained an injury to her left knee on August 9, 2007. This had occurred when she had slipped on a piece of cucumber and falling. The patient had injured her left knee as well as her ankle for which she had been under the care of Dr. Jung. Dr. Jung had referred the patient here for an evaluation regarding her left knee. At the time of her evaluation, she was found to have a synovitis of the left knee with a mild pes bursitis with underlying early degenerative osteoarthritis and patellofemoral arthrosis with mild patellofemoral malalignment. We recommended a comprehensive physical therapy program. The patient is here today. She has returned and states that she did undergo ber physical therapy program and with pbysical therapy did see improvement of her knee condition. The patient states that she is no longer having any type of significant discomfort with the knee. She still gets some aches and minimal irritability. There has not been any recurrent swelling but bas been still occasional swelling. The patient feels that her knee condition is improved to the point that she is capable of returning back to her regular employment.

The patient, however, in the interim has also had a new work injury which occurred to her right lower extremity resulting in a fracture in her right foot and today is ambulatory with the assistance of a cane and in a Moon boot. The patient is aware of the fact that she is being seen separately for her right lower extremity injury. We have asked the patient again and she has agreed and is comfortable with the fact that in the absence of her present right foot condition, that she would be ahle to return back to regular work relative to her left knee and her left knee has overall been significantly improved with only the occasional remaining symptomatology as outlined above.

PHYSICAL EXAMINATION:

Physical examination today of the left knee, there is mild crepitance with ranging patellofemoral joint. There is no effusion. There is no longer any joint line tenderness, retinacular tenderness, no tenderness over the pes bursal area. Range of motion is 0-130 degrees.

FINAL IMPRESSION:

8083

SCI000141

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 11/26/2007 Doctor: RALPH GAMBARDELLA MD

Underlying degenerative osteoarthritis including patellofemoral arthrosis and mild patellofemoral mal-alignment, left knee status post posttraumatic synovitis and pes bursitis, left knee.

RECOMMENDATIONS:

This patient is in a permanent and stationary position for rating.

SUBJECTIVE FACTORS:

The permanent subjective factors to be considered are the occasional minimal pain with activities of daily living increasing to occasional to intermittent, minimal-to-slight pain with heavier squatting, kneeling, or lifting activities.

OBJECTIVE FACTORS:

The objective factors to be considered are the radiographic evidence of the patellofemoral joint space narrowing and degenerative osteoarthritis joint space narrowing noted radiographically. There are no other objective factors to be considered.

PERMANENT WORK RESTRICTIONS:

None indicated. This patient can be released to her regular work activities effective November 26, 2007.

LOSS OF PRE-INJURY CAPACITY:

None.

FUTURE MEDICAL CARE REQUIREMENTS:

In the future, this patient may have a flare-up of her condition that may require the use of oral anti-inflammatory medications, physical therapy, and/or cortisone injection and/or arthroscopic surgical intervention.

CAUSATION:

Based upon the history, this patient's condition is directly attributed to the work injury.

APPORTIONMENT:

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 11/26/2007 Doctor: RALPH GAMBARDELLA MD

There is no apportionment indicated as there is no residual disability. There was definite evidence of a preexisting osteoarthritis as was outlined from my original report. However, at this time, there is no residual disability and therefore there does not appear to be a need for apportionment.

IMPAIRMENT RATING:

Using the AMA Guidelines to the Evaluation of Permanent Impairment, chapter 17, this patient using the radiographic table 17-31 had 1-mm joint space narrowing of the knee which is a 7% lower extremity impairment rating to that which would be added a 10% lower extremity impairment rating for the patellofemoral joint. This would combine to a 17% lower extremity impairment rating which then using table 17-3 translates into a 7% whole person impairment rating.

DISCLOSURE:

I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that the contents of this report and bill are true and correct to the best of my knowledge.

Ralph A. Gambardella, M.D.
RAG/ Orig Job #: 0001AT-00000LND
D: 11/26/2007 5:14:11PM
T: 11/27/2007 6:56:17AM
ROOKS, FLOREEN

Specialists
3144 Santa Anita Avenue, Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	11/29/2007		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

11/29/2007

State Comp 92622
P.O. Box 92622
Los Angeles, CA 90009-2622

ATTN: Worker's Compensation Claims

RE:	ROOKS, FLOREEN
Age Sex:	58 & F
Occupation:	MARRIAGE FAMILY THERAPIST
Employer:	D'VEAL FAMILY & YOUTH SERVICES
Date of Injury:	11/10/2007
Date of Exam:	11/29/2007

ORTHOPEDIC CONSULTATION

Gentlemen:

Today I had the opportunity to examine the above-named patient, who sustained an injury to her right foot on the above-mentioned date. At that time, she indicates that while working, she apparently parked on a gravel road and when the car apparently started rolling without her in it, she ran towards the car, got into the car to put the emergency parking brake on and in that process twisted her right foot, fractured the fourth and fifth metatarsal, injured her left knee as well as her left ankle. She was seen at Kaiser initially and subsequently by Dr. Hadley. She has been treated with a Cam walker for the right foot and indicates that the pain has improved significantly; however, she continues to have discomfort especially of the left ankle to a lesser extent the left knee. She has been on medication. She has been in a Cam walker and has been off of work.

PAST MEDICAL HISTORY:

SURGERIES: Include left ankle surgery 14 years ago (still has the plate and screws in place), left knee injury as well.

MEDICAL ILLNESSES: Include a history of hypertension.

MEDICATIONS: Include TYLENOL as well as MOTRIN.

ALLERGIES: PENICILLIN - DEVELOPS A RASH.

PRIOR WORK-RELATED INJURIES: Left ankle fracture in 2007. Was off of work for five weeks.

PRIOR MOTOR VEHICLE ACCIDENTS: None.

PRIOR SPORTS INJURIES: None.

SOCIAL HISTORY: She is single. She has one child. She has a Master's degree. She smokes one pack of cigarettes a week and uses alcohol only socially.

Specialists
3144 Santa Anita Avenue. Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	11/29/2007		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

PHYSICAL EXAMINATION:

GENERAL: This is a well-developed, well-nourished woman complaining of right ankle and right foot pain.

VITAL SIGNS She stands 5'6" tall, and weighs 213 pounds. She is right hand dominant.

RIGHT FOOT: Exam reveals of notable tenderness over the fourth and fifth metatarsal area. There is notable swelling. There is notable ecchymosis. Motor and sensory function is intact distally.

LEFT ANKLE: Exam reveals evidence of diffuse tenderness over the anterior as well as the lateral and anterior aspect of the ankle. She dorsiflexes to 5 degrees, plantar flexes to 15 degrees. Motor and sensory function is intact distally.

LEFT KNEE: Exam reveals evidence of mild tenderness, mild swelling. No effusion. No gross laxity is noted. Motor and sensory function is intact distally.

RADIOGRAPHIC FINDINGS:

X-rays of the right foot reveal evidence of a fracture of the fourth and fifth metatarsals overall well aligned. X-rays of the left knee reveal evidence of an old avulsion fracture with no acute fractures noted. X-rays of the left ankle reveal evidence of a healed medial and lateral malleolus fracture with retained plate and screws; however, there is evidence of extensive degenerative osteoarthritis of the tibiotalar articulation.

IMPRESSION:

1. RIGHT FOOT FOURTH AND FIFTH METATARSAL FRACTURE.
2. LEFT ANKLE POSTTRAUMATIC DEGENERATIVE OSTEOARTHRITIS.
3. LEFT KNEE SPRAIN.

DISCUSSION:

I will recommend that Ms. Rooks continue the use of a Cam walker for her right foot. I will also recommend she continue off of work until further progress is made. She will continue the use of MOTRIN for pain and inflammation and I would like to reexamine her in three weeks' time, at which time x-rays will be taken to assess the healing process of the fractures of the right foot.

If you have any questions or concerns please do not hesitate to contact me.

"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge."

"I declare under penalty of perjury that the information contained in this report and its attachments if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true."

SCIF RECD DTE 12/08/2007 BKSCAN 8 12/08/2007 09:24 AM 025192 11 4

Specialists
3144 Santa Anita Avenue. Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	11/29/2007		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

Sincerely Yours,

Thomas Saucedo, M.D. ____________________
DATE

Executed in the County of Los Angeles on 11/29/2007.

TS:pf/tj

02 318168 000000001 022 195 05124168

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/04/2007 Doctor: KENNETH JUNG MD

MEDICAL RECORD REVIEW

The following is a review of medical records provided for this patient's case. Please note 15 minutes were spent organizing and reviewing these records.

1. Doctor's first report of occupational injury or illness. Date of injury August 9, 2007. The patient slipped on a piece of cucumber and fell onto the concrete ground/pavement. She was seen for left hip, knee, and ankle pain. She had tenderness at the left ankle, medial and lateral malleolus. She was given Naprosyn and ice packs.

2. August 9, 2007. Work injury intake form for the patient's initial office visit. The patient had x-rays. She was given Naprosyn. She was held out of work.

3. August 10, 2007. X-ray report of the left ankle shows posttraumatic changes of the malleoli status post ORIF. Secondary deformity and osteophytic changes of the distal tibia and talus.

4. August 10, 2007. Left knee x-rays. Generalized demineralization, suspect a small loose body in the central joint. No acute fracture or subluxation.

5. August 10, 2007. X-rays of the pelvis and left hip. Negative study.

6. August 14, 2007. Work status report and progress note. The patient referred for physical therapy. She was given Ultram for her ankle sprain.

7. August 14, 2007. Physical therapy prescription.

8. August 27, 2007. Followup visit. The patient recommended to continue on physical therapy and have an MRI of her left knee.

That completes review of medical records.

DISCLOSURE:

I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that the contents of this report and bill are true and correct to the best of my knowledge.

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/04/2007 Doctor: KENNETH JUNG MD

Kenneth Jung, M.D.
/ Orig Job #: 0002H9-000003YR
D: 9/04/2007 1:01:29PM
T: 9/05/2007 3:13:36AM
ROOKS, SLOREEN

SCIF RECD DTE 10/02/2007 BKSCAN 9 10/02/2007 09:05 AM 024016 9 4

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/04/2007 Doctor: KENNETH JUNG MD

INITIAL ORTHOPAEDIC CONSULTATION

DATE OF INJURY:

August 9, 2007.

CONDITION:

Left ankle.

HISTORY OF PRESENT ILLNESS:

A 58-year-old female marriage and family therapist presents for evaluation of left ankle injury sustained on August 9, 2007. The patient reports slipping on a piece of cucumber and falling. She injured her knee and ankle. She was initially seen and given a cane and a prescription for Naprosyn. She has been using an elastic ankle brace and taking antiinflammatories as needed. She reports sharp, achy, cramping, incapacitating pain. It bothers her all day. It hurts her most of the day. There is swelling, tenderness, and giving way. It hurts her when she does exercises such as driving and walking.

Her history is significant for a left ankle fracture sustained about 14 years ago. She underwent an open reduction and internal fixation. This injury did not occur at work. It occurred after she fell down some stairs.

Past surgical, medical, family, social histories and review of systems, please refer to the patient questionnaire.

PHYSICAL EXAMINATION:

A pleasant female. In no acute distress. Alert and oriented x3.

Examination of the left ankle and foot reveals well-healed incision. No erythema or signs of infection.

She has limited ankle dorsiflexion and plantar flexion. She is hesitant due to pain. She also is hesitant to inversion and eversion on examination.

Anterior drawer is negative.

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SCI000149

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/04/2007 Doctor: KENNETH JUNG MD

Motor is intact. Capillary refill is brisk. Sensation is grossly intact to light touch.

She also reports pain to palpation over the midfoot and forefoot. No subluxation or crepitus is noted. There is no tenting of the skin. No erythema.

RADIOGRAPHS:

The patient has brought in outside films obtained on August 10, 2007. Radiographs show hardware in the ankle. There appears to be extensive degenerative changes including anterior osteophytes of the tibia and talus.

At KJOC Pasadena I ordered and interpreted AP, lateral, and oblique views of the left foot as well as a mortise ankle view. Radiographs show extensive degenerative changes in the ankle joint. Intact hardware. There is extensive anterior spurring. No fractures are seen in the foot or midfoot.

IMPRESSION:

1. Left ankle posttraumatic arthritis, status post open reduction and internal fixation ankle fracture.
2. Industrial injury secondary to fall.
3. Ankle pain after industrial fall.

PLAN:

This patient does not appear to have any acute injuries after her most recent fall. She most likely exacerbated a pre-existing condition, posttraumatic arthritis. She is currently wearing an elastic ankle sleeve. I would recommend the use of a lace-up ankle brace that provides further support. She has been provided with one today. She can be weightbearing as tolerated.

She reports she is scheduled to see Dr. Ralph Gambardella with regards to her left knee on September 10, 2007.

WORK STATUS:

I would keep this patient temporarily totally disabled until her office visit with Dr. Ralph Gambardella on September 10, 2007. After that point the patient is cleared for sedentary work.

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/04/2007 Doctor: KENNETH JUNG MD

I would like to see this patient in about 4 weeks' time. If she is doing better, I would plan to clear her for a full duty with regards to her left ankle.

DISCLOSURE:

I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that the contents of this report and bill are true and correct to the best of my knowledge.

Kenneth Jung, M.D.
/ Orig Job #: 0002H9-000003YN
D: 9/04/2007 1:01:00PM
T: 9/04/2007 5:44:01PM
ROOKS, SLOREEN

02 318168 000000001 028 195 05124168

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/10/2007 Doctor: RALPH GAMBARDELLA MD

COMPREHENSIVE ORTHOPAEDIC EVALUATION

HISTORY:

A 58-year-old female here today for comprehensive orthopaedic evaluation or treatment regarding an injury to her left knee that she sustained on August 9, 2007. History is obtained today from direct interview of the patient as well as review of records that are available. These are records from Dr. Jung. The patient was employed by D'Veal Family and Youth Services and states that she slipped on a piece of a cucumber, falling. The patient at the time felt that she fell on her entire left side, the ankle being the most painful. When asked today, there is no history of direct blow. The patient again is unsure, but she thinks she just landed on her left side. The patient, however, has persisted with some discomfort in the left knee, some overall irritability and had onset of swelling. She complains of the swelling with activities and the pain pattern which is diffuse as tenderness more on the medial side than on the lateral side.

There is no previous history of injury to the left knee as outlined in Dr. Jung's note. There is previous injury to the left ankle.

PHYSICAL EXAMINATION:

KNEE PHYSICAL EXAMINATION:

GENERAL APPEARANCE OF THE PATIENT:
Normal appearance, well nourished.

MOOD AND AFFECT:
Normal mood and affect, cooperative, no apparent distress, in good spirits.

RANGE OF MOTION

	Right	Left	Normal
Flexion	130	125	135 degrees
Extension	180	180	180 degrees

INSPECTION/PALPATION:

	Right	Left
Distal quadriceps tenderness	no	YES
Distal quadriceps defect	no	no
Medial patellar facet tenderness	no	YES
Lateral patellar facet tenderness	no	YES

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/10/2007 Doctor: RALPH GAMBARDELLA MD

Patellar tendon tenderness	no	YES
Patellar tendon defect	no	no
Medial epicondylar tenderness	no	YES
Medial joint line tenderness	no	YES
Medial tibia tenderness	no	YES
Lateral epicondylar tenderness	no	no
Lateral joint line tenderness	no	YES
Lateral fibula head tenderness	no	no
Effusion	YES	YES
Alignment abnormal	no	no
Ecchymosis	no	no
Scars	no	no
Spasm	no	no
Medial crepitus	no	no
Lateral crepitus	no	no
Patellar crepitus	YES	YES
Atropby	no	no

STABILITY:	Right	Left
Patellar apprehension	no	no
Patellar Subluxation	no	no
Patellar tilt	no	no
Lateral McMurray's sign	no	no
Medial McMurray's sign	no	no
MCL (Valgus)	no	no
LCL (Varus)	no	no
PCL(Posterior drawer)	no	no
Posterolateral rotation	no	no
ACL (Anterior drawer)	no	no
Lachman's test present	no	no
Pivot shift	no	no
General ligamentous laxity	no	no

MUSCLE STRENGTH AND TONE:	Right	Left
Thigh Atrophy	no	no
Calf Atrophy	no	no
Quadriceps muscle strength	5	5
Hamstring muscle strength	5	5

02 318168 000000001 030 195 05124168

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/10/2007 Doctor: RALPH GAMBARDELLA MD

SENSATION/NEUROLOGIC FUNCTION:

	Right	Left
Distal sensation pes	normal	NO hypersensitive
REFLEXES		
Patellar reflex	2+	2+
Achilles reflex	2+	2+

VASCULAR:	Right	Left
Femoral pulse	1	1
Posterior tibialis pulse	1	1
Dorsalis pedis pulse	1	1
Cyanosis	no	no
Calf tenderness	no	no
Edema	no	YES trace pretibial
Homans' sign	no	no

X-RAYS:

We have outside x-rays available for review, AP and lateral. It is unclear if this is a weightbearing view, which shows no specific joint space narrowing with very minimal osteophyte formation in the medial compartment.

An AP of right and left knees and a sunrise of right and left knee is ordered, seen and interpreted here today by me at the Kerlan-Jobe Clinic in Pasadena, show first of all in the sunrise view there is some increased patellar tilt bilaterally with narrowing of the lateral facet space consistent with early chondromalacia patellofemoral joint right and left knees. Then on the AP standing views, there is some early osteophyte formation of both left and right knees. The left knee shows 1-mm joint space narrowing with also some intercondylar notch spur formation and also mild lateral compartment spur formation consistent with early degenerative osteoarthritis of left and right knee, left worse than right.

IMPRESSION:

1. Synovitis of the left knee with underlying early degenerative osteoarthritis of left knee including patellofemoral early arthrosis with mild patellofemoral malalignment, left and right knees.
2. Pes bursitis, left knee.

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/10/2007 Doctor: RALPH GAMBARDELLA MD

RECOMMENDATIONS AND DISCUSSION:

This patient at this time has evidence of underlying pre-existing early degenerative osteoarthritis on the left knee and has then had a work-related injury that has resulted in a flareup of her arthritic condition. The patient has outlined to me that she had not had any symptoms prior to the work injury from a clinical standpoint. However, clearly with the x-ray evidence there was pre-existing disease present.

At this time there is not a good history of a twist injury and with the patient's mild hypersensitivity and diffuse tenderness I would not recommend any diagnostic testing which most likely would be positive. However, I would recommend a comprehensive physical therapy program on a twice-a-week basis for 6 weeks and to follow up in 6 weeks for repeat evaluation. In addition, the patient appears to be not seeing any symptomatic improvement with the Naprosyn. We therefore will switch her to Voltaren XR. Drug warning given relative to the medication. The patient did note that prior to the work injury she was using 2-3 Advil in the morning for her ankle.

I would defer relative to her ankle to Dr. Jung. We have recommended that she should however maintain some ankle exercise program and also some intermittent elevation to help decrease the chance of blood clot in the left lower extremity. On today's examination, there is no evidence to suggest a clot or DVT.

WORK RESTRICTIONS:

At this time I would also recommend that the patient should have work restrictions relative to the left knee. These work restrictions would consist of sedentary type of work activities, no climbing, a lifting restriction of 10 pounds, no squatting or kneeling activities, and standing and walking limited to no more than 15 minutes per hour. If these restrictions are not available, the patient will remain temporarily totally disabled pending follow up evaluation in 6 weeks.

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/10/2007 Doctor: RALPH GAMBARDELLA MD

DISCLOSURE:

I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that the contents of this report and bill are true and correct to the best of my knowledge.

____

Ralph A. Gambardella, M.D.
RAG/ Orig Job #: 0001AT-00000KU4
D: 9/10/2007 1:52:53PM
T: 9/10/2007 2:49:04PM
ROOKS, FLOREEN .
/gtc

SCIF RECD DTE 10/01/2007 BKSCAN 12 10/01/2007 09:39 AM 021773 4 2

02 318168 000000001 033 195 05124168

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/10/2007 Doctor: RALPH GAMBARDELLA MD

COMPREHENSIVE ORTHOPAEDIC EVALUATION

HISTORY:

A 58-year-old female here today for comprehensive orthopaedic evaluation or treatment regarding an injury to her left knee that she sustained on August 9, 2007. History is obtained today from direct interview of the patient as well as review of records that are available. These are records from Dr. Jung. The patient was employed by D'Veal Family and Youth Services and states that she slipped on a piece of a cucumber, falling. The patient at the time felt that she fell on her entire left side, the ankle being the most painful. When asked today, there is no history of direct blow. The patient again is unsure, but she thinks she just landed on her left side. The patient, however, has persisted with some discomfort in the left knee, some overall irritability and had onset of swelling. She complains of the swelling with activities and the pain pattern which is diffuse as tenderness more on the medial side than on the lateral side.

There is no previous history of injury to the left knee as outlined in Dr. Jung's note. There is previous injury to the left ankle.

PHYSICAL EXAMINATION:

KNEE PHYSICAL EXAMINATION:

GENERAL APPEARANCE OF THE PATIENT:
Normal appearance, well nourished.

MOOD AND AFFECT:
Normal mood and affect, cooperative, no apparent distress, in good spirits.

RANGE OF MOTION

	Right	Left	Normal
Flexion	130	125	135 degrees
Extension	180	180	180 degrees

INSPECTION/PALPATION:

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Distal quadriceps defect	no	no
Medial patellar facet tenderness	no	YES
Lateral patellar facet tenderness	no	YES

8083

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Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/10/2007 Doctor: RALPH GAMBARDELLA MD

Patellar tendon tenderness	no	YES
Patellar tendon defect	no	no
Medial epicondylar tenderness	no	YES
Medial joint line tenderness	no	YES
Medial tibia tenderness	no	YES
Lateral epicondylar tenderness	no	no
Lateral joint line tenderness	no	YES
Lateral fibula head tenderness	no	no
Effusion	YES	YES
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Ecchymosis	no	no
Scars	no	no
Spasm	no	no
Medial crepitus	no	no
Lateral crepitus	no	no
Patellar crepitus	YES	YES
Atrophy	no	no

STABILITY:	Right	Left
Patellar apprehension	no	no
Patellar Subluxation	no	no
Patellar tilt	no	no
Lateral McMurray's sign	no	no
Medial McMurray's sign	no	no
MCL (Valgus)	no	no
LCL (Varus)	no	no
PCL(Posterior drawer)	no	no
Posterolateral rotation	no	no
ACL (Anterior drawer)	no	no
Lachman's test present	no	no
Pivot shift	no	no
General ligamentous laxity	no	no

MUSCLE STRENGTH AND TONE:	Right	Left
Thigh Atrophy	no	no
Calf Atrophy	no	no
Quadriceps muscle strength	5	5
Hamstring muscle strength	5	5

02 318168 000000001 036 195 05124168

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/10/2007 Doctor: RALPH GAMBARDELLA MD

SENSATION/NEUROLOGIC FUNCTION:

	Right	Left
Distal sensation	normal	NO hypersensitive
pes		
REFLEXES		
Patellar reflex	2+	2+
Achilles reflex	2+	2+

VASCULAR:	Right	Left
Femoral pulse	1	1
Posterior tibialis pulse	1	1
Dorsalis pedis pulse	1	1
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Calf tenderness	no	no
Edema	no	YES trace pretibial
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IMPRESSION:

1. Synovitis of the left knee with underlying early degenerative osteoarthritis of left knee including patellofemoral early arthrosis with mild patellofemoral malalignment, left and right knees.
2. Pes bursitis, left knee.

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/10/2007 Doctor: RALPH GAMBARDELLA MD

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WORK RESTRICTIONS:

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Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/10/2007 Doctor: RALPH GAMBARDELLA MD

DISCLOSURE:

I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that the contents of this report and bill are true and correct to the best of my knowledge.

Ralph A. Gambardella, M.D.
RAG/ Orig Job #: 0001AT-00000KU4
D: 9/10/2007 1:52:53PM
T: 9/10/2007 2:49:04PM
ROOKS, FLOREEN
/gtc

02 318168 000000001 039 195 05124168

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.

PLEASE DO NOT USE THIS COLUMN: Case No. | Industry | County | Age | Hazard | Disease | Hospitalization | Occupation | Return Date/Code

1. INSURER NAME AND ADDRESS
D'Veal Family & Youth Services, 855 No. Orange Grove Blvd., Pasadena, CA 91103

2. EMPLOYER NAME
D'Veal Family & Youth Services

3. Address — No. and Street: 855 No. Orange Blvd. — City: Pasadena — Zip: 91103

4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes.)
Mental Health Services

5. PATIENT NAME (first name, middle initial, last name): Floreen S. Rooks
6. Sex: ☐ Male ☒ Female
7. Date of Birth: Mo. 06 Day 20 Yr. 49

8. Address — No. and Street: 1317-1/2 So. Gladys Ave. — City: San Gabriel — Zip: 91776
9. Telephone number: (626) 573-1906

10. Occupation (Specific job title): Marriage Family & Therapist Intern
11. Social Security Number: 130 - 38 - 8570

12. Injured at — No. and Street: Sycamores — City: Altadena — County: Los Angeles

13. Date and hour of injury or onset of illness: Date: Mo. 08 Day 09 Yr. 07 Hour 12:15 ☐ a.m. ☒ p.m.
14. Date last worked: Date: Mo. 08 Day 09 Yr. 07

15. Date and hour of first examination or treatment: Date: Mo. 08 Day 09 Yr. 07 Hour 3:30 ☐ a.m. ☒ p.m.
16. Have you (or your office) previously treated patient? ☒ Yes ☐ No

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.)
"Slipped on e piece of cucumber and fell onto concrete ground/pavement."

18. SUBJECTIVE COMPLAINTS (Describe fully. Use reverse side if more space is required.)
The patient states that this afternoon she slipped and fell onto her left hip from ground level. No pop or crack was noted by the patient. The patient now states that she has pain in her left hip, left knee, and left ankle. The ankle being the most painful area. She has pain in

19. OBJECTIVE FINDINGS (Use reverse side if more space is required.)
A. Physical examination
Vital Signs: Stable B/P: 116/78 Pulse: 88 Resp: 16 Temp: 98.0 Weight: 210 lbs. Extremity Examination: Patient was positive for tenderness at the left hip, left knee, left ankle (medial lateral malleolus) ROM: Active and passive of movement of all limbs due to pain.
B. X-ray and laboratory results (State if non or pending.) Ordered

20. DIAGNOSIS (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? ☐ Yes ☒ No
1) Left hip, knee, ankle pain. ICD-9 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.)
1. Nyprosyn 500mg bid prn pain
2. Ice Packs

24. If further treatment required, specify treatment plan/estimated duration.
Return to clinic in three days for follow-up.

25. If hospitalized as inpatient, give hospital name and location.
N/A — 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 08 / 08 / 07 Specify restrictions ___

Doctor's Signature [signature] — CA License Number 20A9597
Doctor Name and Degree (please type) Dan Le, D.O. — IRS Number ___
Address 420 West Las Tunas Drive, San Gabriel, CA 91776 — Telephone Number (626) 296-9500

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.

FORM 5021 (Rev. 4)
1992

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02 318168 000000001 041 195 05124168

WORK STATUS REPORT

Date of Injury: 8-4-07 | Today's Date: 8-27-07

Employer: D'Veal Family Youth Services

Diagnosis:
(L) ankle sprain
(L) knee sprain

WORK STATUS

- ☐ Return to usual and customary work with no limitations.
- ☐ Off work balance of current work shift and return to work on ______.
  - ☐ with NO limitations
  - ☐ with the limitations listed below.
- ☐ Return to temporary alternate work with the following limitations:
  - ☐ no continuous walking or prolonged standing
  - ☐ no lifting, pushing, or pulling over ______ pounds.
  - ☐ no repetitive bending or stooping.
  - ☐ limited use of the ☐ RIGHT ☐ LEFT ☐ HAND ☐ ARM
  - ☐ no use of the ☐ RIGHT ☐ LEFT ☐ HAND ☐ ARM
  - ☐ no repetitive kneeling or squatting.
  - ☐ no work above shoulder level.
  - ☐ must be sitting the majority of work shift.
  - ☐ sitting work only.
  - ☐ must keep the ☐ RIGHT ☐ LEFT ☐ FOOT ☐ LEG elevated major of work shift.
  - ☐ no driving commercial vehicle.
  - ☐ no operation of machinery.
  - ☐ Other: ______
- ☒ Off work (TTD) until 9/4/07.
- ☐ Off work (TTD) because no temporary alternative work is available until ______.
- ☐ Return to work on ______ with NO LIMITATIONS.

Listed limitations apply to all non-work related activities (home, sports, hobbies, etc.)

INSTRUCTIONS TO EMPLOYEE:

- ☐ Keep wound bandage clean and dry.
- ☐ Wear ☐ SPLINT ☐ ARM SLING ☐ SUPPORT during working shift.
- ☐ Use ☐ CANE ☐ CRUTCHES during working hours.

Dispensed medications that can be taken during working shift:
1. ______
2. ______

Dispensed medications that MUST NOT be taken during work shift:
1. ______
2. ______

- ☐ Employee advised to see his/her private physician because his/her medical condition is NOT WORK RELATED (non-industrial).
- ☐ Employee referred for specialty evaluation. Type: Physical Therapy & MRI of (L) knee

Estimated Length of Treatment ______ days 6 weeks.
Estimated Length of Disability ______ days 1 weeks.

- ☐ There is no permanent disability expected.
- ☐ Employee's medical condition is permanent and stationary.
- ☐ Employee is released from further medical care.

RETURN APPOINTMENT: Date 9-4-07 Time: 10:30 (AM) PM

Provider signature: [signature] | Date: 8-27-07

DREAMWEAVER MEDICAL GROUP
420 W. Las Tunas Drive
San Gabriel, CA 91776
(626) 289-8493

Patient Name: Floreen Books
Date of Birth: 6-20-49
SSN #: 130-38-8610
MR #: ______

WORK STATUS REPORT

Claim# — 05124168

SCIF RECD DTE 09/21/2007 BKSCAN 5 09/21/2007 09:04 AM 023037 9 7

02 318168 000000001 042 195 05124168

WORK STATUS REPORT

Date of Injury: 8-9-07 | Today's Date: 8-14-07

Employer: D'Veal Family Youth Services

Diagnosis: (1) (L) ankle sprain (3) (L) hip p..
(2) (L) knee pain

WORK STATUS

- ☐ Return to usual and customary work with no limitations.
- ☐ Off work balance of current work shift and return to work on ____________.
  - ☐ with NO limitations
  - ☐ with the limitations listed below.
- ☒ Return to temporary alternate work with the following limitations:
  - ☒ no continuous walking or prolonged standing
  - ☒ no lifting, pushing, or pulling over ________ pounds.
  - ☐ no repetitive bending or stooping.
  - ☐ limited use of the ☐ RIGHT ☐ LEFT ☐ HAND ☐ ARM
  - ☐ no use of the ☐ RIGHT ☐ LEFT ☐ HAND ☐ ARM
  - ☐ no repetitive kneeling or squatting.
  - ☐ no work above shoulder level.
  - ☒ must be sitting the majority of work shift.
  - ☒ sitting work only.
  - ☒ must keep the ☐ RIGHT ☒ LEFT ☒ FOOT ☐ LEG elevated major of work shift.
  - ☐ no driving commercial vehicle.
  - ☐ no operation of machinery.
  - ☒ Other: Limited Driving (to & from work)
- ☐ Off work (TTD) until ____________.
- ☐ Off work (TTD) because no temporary alternative work is available until ____________.
- ☐ Return to work on ____________ with NO LIMITATIONS.

Listed limitations apply to all non-work related activities (home, sports, hobbies, etc.)

INSTRUCTIONS TO EMPLOYEE:

- ☐ Keep wound bandage clean and dry.
- ☒ Wear ☒ SPLINT ☐ ARM SLING ☐ SUPPORT during working shift.
- ☒ Use ☒ CANE ☐ CRUTCHES during working hours.
- ☒ Dispensed medications that can be taken during working shift: Otter
  1. ____________
  2. ____________
- Dispensed medications that MUST NOT be taken during work shift:
  1. ____________
  2. ____________
- ☐ Employee advised to see his/her private physician because his/her medical condition is NOT WORK RELATED (non-industrial).
- ☒ Employee referred for specialty evaluation. Type: P.T.

Estimated Length of Treatment ____________ days 2 weeks.
Estimated Length of Disability ____________ days ____________ weeks.

- ☐ There is no permanent disability expected.
- ☐ Employee's medical condition is permanent and stationary.
- ☐ Employee is released from further medical care.

RETURN APPOINTMENT: Date 8-27-07 Time: 11:00 (AM) PM

Provider signature: [signature] | Date: 8-14-07

DREAMWEAVER MEDICAL GROUP
420 W. Las Tunas Drive
San Gabriel, CA 91776
(626) 289-8493

Patient Name: Floreen Books
Date of Birth: 6-20-49
SSN #: 130-38-8612
MR #: ____________

Claim# - 05124168

02 318168 000000001 043 195 05124168

05124168

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/10/2007 Doctor: RALPH GAMBARDELLA MD

INSERT FORMS

COMPREHENSIVE ORTHOPAEDIC EVALUATION

HISTORY:

A 58-year-old female here today for comprehensive orthopaedic evaluation or treatment regarding an injury to her left knee that she sustained on August 9, 2007. History is obtained today from direct interview of the patient as well as review of records that are available. These are records from Dr. Jung. The patient was employed by D'Veal Family and Youth Services and states that she slipped on a piece of a cucumber, falling. The patient at the time felt that she fell on her entire left side, the ankle being the most painful. When asked today, there is no history of direct blow. The patient again is unsure, but she thinks she just landed on her left side. The patient, however, has persisted with some discomfort in the left knee, some overall irritability and had onset of swelling. She complains of the swelling with activities and the pain pattern which is diffuse as tenderness more on the medial side than on the lateral side.

There is no previous history of injury to the left knee as outlined in Dr. Jung's note. There is previous injury to the left ankle.

PHYSICAL EXAMINATION:

INSERT PHYSICAL EXAMINATION FORM

X-RAYS:

We have outside x-rays available for review, AP and lateral. It is unclear if this is a weightbearing view, which shows no specific joint space narrowing with very minimal osteophyte formation in the medial compartment.

An AP of right and left knees and a sunrise of right and left knee is ordered, seen and interpreted here today by me at the Kerlan-Jobe Clinic in Pasadena, show first of all in the sunrise view there is some increased patellar tilt bilaterally with narrowing of the lateral facet space consistent with early chondromalacia patellofemoral joint right and left knees. Then on the AP standing views, there is some early osteophyte formation of both left and right knees. The left knee shows 1-mm joint space narrowing with also some intercondylar notch spur formation and also mild lateral compartment spur

02 318168 00000001 044 195 05124168

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/10/2007 Doctor: RALPH GAMBARDELLA MD

---

formation consistent with early degenerative osteoarthritis of left and right knee, left worse than right.

IMPRESSION:

1. Synovitis of the left knee with underlying early degenerative osteoarthritis of left knee including patellofemoral early arthrosis with mild patellofemoral malalignment, left and right knees.
2. Pes bursitis, left knee.

RECOMMENDATIONS AND DISCUSSION:

This patient at this time has evidence of underlying pre-existing early degenerative osteoarthritis on the left knee and has then had a work-related injury that has resulted in a flareup of her arthritic condition. The patient has outlined to me that she had not had any symptoms prior to the work injury from a clinical standpoint. However, clearly with the x-ray evidence there was pre-existing disease present.

At this time there is not a good history of a twist injury and with the patient's mild hypersensitivity and diffuse tenderness I would not recommend any diagnostic testing which most likely would be positive. However, I would recommend a comprehensive physical therapy program on a twice-a-week basis for 6 weeks and to follow up in 6 weeks for repeat evaluation. In addition, the patient appears to be not seeing any symptomatic improvement with the Naprosyn. We therefore will switch her to Voltaren XR. Drug warning given relative to the medication. The patient did note that prior to the work injury she was using 2-3 Advil in the morning for her ankle.

I would defer relative to her ankle to Dr. Jung. We have recommended that she should however maintain some ankle exercise program and also some intermittent elevation to help decrease the chance of blood clot in the left lower extremity. On today's examination, there is no evidence to suggest a clot or DVT.

WORK RESTRICTIONS:

At this time I would also recommend that the patient should have work restrictions relative to the left knee. These work restrictions would consist of sedentary type of work activities, no climbing, a lifting restriction of 10 pounds, no squatting or kneeling activities, and standing and walking limited to no more than 15 minutes per hour. If these restrictions are not available, the patient will remain temporarily totally disabled pending followup evaluation in 6 weeks.

02 318168 00000001 045 195 0S124168

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/10/2007 Doctor: RALPH GAMBARDELLA MD

DISCLOSURE:

I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that the contents of this report and bill are true and correct to the best of my knowledge.

Ralph A. Gambardella, M.D.
RAG/ Orig Job #: 0001AT-00000KU4
D: 9/10/2007 1:52:53PM
T: 9/10/2007 2:49:04PM
ROOKS, FLOREEN

02 518168 00000001 046 195 05124168

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/10/2007 Doctor: RALPH GAMBARDELLA MD

COMPREHENSIVE ORTHOPAEDIC EVALUATION

HISTORY:

A 58-year-old female here today for comprehensive orthopaedic evaluation or treatment regarding an injury to her left knee that she sustained on August 9, 2007. History is obtained today from direct interview of the patient as well as review of records that are available. These are records from Dr. Jung. The patient was employed by D'Veal Family and Youth Services and states that she slipped on a piece of a cucumber, falling. The patient at the time felt that she fell on her entire left side, the ankle being the most painful. When asked today, there is no history of direct blow. The patient again is unsure, but she thinks she just landed on her left side. The patient, however, has persisted with some discomfort in the left knee, some overall irritability and had onset of swelling. She complains of the swelling with activities and the pain pattern which is diffuse as tenderness more on the medial side than on the lateral side.

There is no previous history of injury to the left knee as outlined in Dr. Jung's note. There is previous injury to the left ankle.

PHYSICAL EXAMINATION:

KNEE PHYSICAL EXAMINATION:

GENERAL APPEARANCE OF THE PATIENT:
Normal appearance, well nourished.

MOOD AND AFFECT:
Normal mood and affect, cooperative, no apparent distress, in good spirits.

RANGE OF MOTION

	Right	Left	Normal
Flexion	130	125	135 degrees
Extension	180	180	180 degrees

INSPECTION/PALPATION:

	Right	Left
Distal quadriceps tenderness	no	YES
Distal quadriceps defect	no	no
Medial patellar facet tenderness	no	YES
Lateral patellar facet tenderness	no	YES

02 318168 000000001 047 195 05124168

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/10/2007 Doctor: RALPH GAMBARDELLA MD

Patellar tendon tenderness	no	YES
Patellar tendon defect	no	no
Medial epicondylar tenderness	no	YES
Medial joint line tenderness	no	YES
Medial tibia tenderness	no	YES
Lateral epicondylar tenderness	no	no
Lateral joint line tenderness	no	YES
Lateral fibula head tenderness	no	no
Effusion	YES	YES
Alignment abnormal	no	no
Ecchymosis	no	no
Scars	no	no
Spasm	no	no
Medial crepitus	no	no
Lateral crepitus	no	no
Patellar crepitus	YES	YES
Atrophy	no	no

STABILITY:	Right	Left
Patellar apprehension	no	no
Patellar Subluxation	no	no
Patellar tilt	no	no
Lateral McMurray's sign	no	no
Medial McMurray's sign	no	no
MCL (Valgus)	no	no
LCL (Varus)	no	no
PCL(Posterior drawer)	no	no
Posterolateral rotation	no	no
ACL (Anterior drawer)	no	no
Lachman's test present	no	no
Pivot shift	no	no
General ligamentous laxity	no	no

MUSCLE STRENGTH AND TONE:	Right	Left
Thigh Atrophy	no	no
Calf Atrophy	no	no
Quadriceps muscle strength	5	5
Hamstring muscle strength	5	5

02 318168 000000001 048 195 05124168

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/10/2007 Doctor: RALPH GAMBARDELLA MD

SENSATION/NEUROLOGIC FUNCTION:

	Right	Left
Distal sensation	normal	NO hypersensitive
pes		
REFLEXES		
Patellar reflex	2+	2+
Achilles reflex	2+	2+

VASCULAR:	Right	Left
Femoral pulse	1	1
Posterior tibialis pulse	1	1
Dorsalis pedis pulse	1	1
Cyanosis	no	no
Calf tenderness	no	no
Edema	no	YES trace pretibial
Homans' sign	no	no

X-RAYS:

We have outside x-rays available for review, AP and lateral. It is unclear if this is a weightbearing view, which shows no speeific joint space narrowing with very minimal osteophyte formation in the medial compartment.

An AP of right and left knees and a sunrise of right and left knee is ordered, seen and interpreted here today by me at the Kerlan-Jobe Clinic in Pasadena, show first of all in the sunrise view there is some increased patellar tilt bilaterally with narrowing of the lateral facet space consistent with early chondromalacia patellofemoral joint right and left knees. Then on the AP standing views, there is some early osteophyte formation of both left and right knees. The left knee shows 1-mm joint space narrowing with also some intercondylar notch spur formation and also mild lateral compartment spur formation consistent with early degenerative osteoarthritis of left and right knee, left worse than right.

IMPRESSION:

1. Synovitis of the left knee with underlying early degenerative osteoarthritis of left knee including patellofemoral early arthrosis with mild patellofemoral malalignment, left and right knees.
2. Pes bursitis, left knee.

02 318168 000000001 049 195 05124168

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/10/2007 Doctor: RALPH GAMBARDELLA MD

RECOMMENDATIONS AND DISCUSSION:

This patient at this time has evidence of underlying pre-existing early degenerative osteoarthritis on the left knee and has then had a work-related injury that has resulted in a flareup of her arthritic condition. The patient has outlined to me that she had not had any symptoms prior to the work injury from a elinical standpoint. However, clearly with the x-ray evidence there was pre-existing disease present.

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I would defer relative to her ankle to Dr. Jung. We have recommended that she should however maintain some ankle exercise program and also some intermittent elevation to help decrease the ehanee of blood clot in the left lower extremity. On today's examination, there is no evidence to suggest a clot or DVT.

WORK RESTRICTIONS:

At this time I would also recommend that the patient should have work restrictions relative to the left knee. These work restrictions would consist of sedentary type of work activities, no climbing, a lifting restriction of 10 pounds, no squatting or kneeling activities, and standing and walking limited to no more than 15 minutes per hour. If these restrictions are not available, the patient will remain temporarily totally disabled pending follow up evaluation in 6 weeks.

SCIF RECD DTE 09/15/2007 BKSCAN 8 09/17/2007 07:18 AM 023022 7 5

02 318168 000000001 050 195 05124168

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/10/2007 Doctor: RALPH GAMBARDELLA MD

DISCLOSURE:

I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that the contents of this report and bill are true and correct to the best of my knowledge.

Ralph A. Gambardella, M.D.
RAG/ Orig Job #: 0001AT-00000KU4
D: 9/10/2007 1:52:53PM
T: 9/10/2007 2:49:04PM
ROOKS, FLOREEN
/gtc

8083

SCI000173

SCIF RECD DTE 09/15/2007 BKSCAN 8 09/17/2007 07:18 AM 023022 7 6

02 318168 000000001 051 195 05124168

Kerlan · Jobe
Orthopaedic Clinic
At
Centinela Freeman
Regional Medical Center
Where the science of medicine enhances the art of life.

Robert K. Kerlan, MD
1922-1996

Sports Medicine Surgery
Frank W. Jobe, MD
Clarence L. Shields, Jr., MD
Stephen J. Lombardo, MD
Lewis A. Yocum, MD
James E. Tibone, MD
Ralph A. Gambardella, MD
Ronald E. Glousman, MD
Ronald S. Kvitne, MD
Neal S. ElAttrache, MD
Daniel Kharrazi, MD
Orr Limpisvasti, MD

Spine Surgery
William H. Dillin, MD
Jae H. Chon, MD

Trauma Surgery
Robert W. Chandler, MD

Arthritis / Joint Replacement
Andrew I. Spitzer, MD

Foot / Ankle Surgery
Phillip K. Kwong, MD
Kenneth S. Jung, MD

Hand Surgery
Norman P. Zemel, MD
Steven S. Shin, MD

Neurology/Pain Management
Vernon B. Williams, MD

Physical & Sports Medicine
Luga Podesta, MD

Los Angeles Main Office
6801 Park Terrace
Los Angeles, CA 90045
Tel: (310) 665-7200

Orange County
2400 East Katella Ave.
Suite 400
Anaheim, CA 92806
Tel: (714) 937-1336
Fax: (714) 937-1814

Beverly Hills
120 S. Spalding Drive
Suite 400
Beverly Hills, CA 90212
Tel: (310) 860-3426
Fax: (310) 273-4721

Pasadena
301 North Lake Ave.
Suite 201
Pasadena, CA 91101
Tel: (626) 568-9030
Fax: (626) 568-8507

Administration Office
6801 Park Terrace
Suite 500
Los Angeles, CA 90045
Tel: (310) 665-7200

KJ-1072 (1/06)

September 10, 2007

State Comp
P.O Box 92622
Los Angeles, CA 90009

RE: ROOKS, FLOREEN
EMP: D'veal Family & Youth Services
D/I: 08-09-07
CL#: 05124168

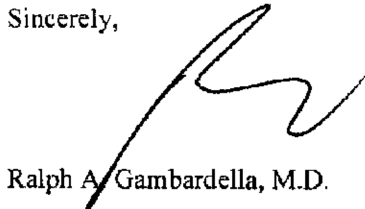
Dear Sir/Madam:

Please see the attached report on Floreen Rooks for the outpatient Worker's Compensation appointment on September 10, 2007.

DECLARATION:

"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 the information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information provided to me and, except as noted herein, that I believe it to be true.'

Sincerely,



Ralph A. Gambardella, M.D.

RAG/gtc
WC0224215A

Physicians to the Dodgers, Angels, Lakers, Kings, Ducks, Avengers, Sparks, Galaxy, PGA Tour, Senior PGA Tour, Loyola and USC Sports.
World renowned care since 1955 • Consultation • Surgery • Research • Education • Diagnostics
www.kerlanjobe.com

02 318168 0000000001 052 195 05124168

WC02242154

TREATMENT AND DISABILITY INFORMATION

Kerlan - Jobe
Orthopaedic Clinic,
Centinela Freeman
Health System

Robert K. Kerlan, MD
1922-1996

Sports Medicine Surgery
Frank W. Jobe, MD
Clarence L. Shields, Jr., MD
Stephen J. Lombardo, MD
Lewis A. Yocum, MD
James E. Tibone, MD
Ralph A. Gambardella, MD
Ronald E. Glousman, MD
Ronald S. Kvitne, MD
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Pasadena
301 North Lake Ave.
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Pasadena, CA 91101
Tel: (626) 585-9030
Fax: (626) 585-8587

Administration Office
6801 Park Terrace
Suite 500
Los Angeles, CA 90045
Tel: (310) 665-7200

DATE: 9-4-07

TIME IN: 750 OUT: _____

PATIENT: Rooks Floren

DATE INJURED: 8-9-07

DIAGNOSIS: (L) Ankle

TREATMENT ADMINISTERED: ___ (X-rays circled)

(Initial Exam circled) ___ Medication

___ Re-evaluation ___ Injection

___ AUTHORIZATION REQUESTED

___ RECOMMENDATIONS ONLY

✓ TRANSFER CARE TO KJOC (requested by patient)

___ MRI ___ GAD ___ BONE SCAN
___ EMG / NCV ___ NEURO CONSULT
___ MYELOGRAM ___ C.T. SCAN
___ ARTHROGRAM ___ DISCOGRAM
___ OTHER (specify below) FCE ___

BRACE

___ P.T./ ___ O.T./ ___ X WK/ ___ WKS

SURGERY, CONSISTING OF:

WORK STATUS: ACCOUNT # _____

___ CONTINUE WORKING / UNRESTRICTED

___ PERMANENT AND STATIONARY EFFECTIVE _____

___ RELEASED TO REGULAR WORK EFFECTIVE _____

✓ TEMPORARILY TOTALLY DISABLED UNTIL 9/10/07.

___ "CONSULT ONLY" (see disability recommendations)

___ QUALIFIED INJURED WORKER

✓ * RESTRICTED DUTY ONLY (SEE BELOW) EFFECTIVE 9/11/07.

WORK RESTRICTIONS:

* IF RESTRICTED DUTY IS NOT AVAILABLE, PATIENT IS TEMPORARILY TOTALLY DISABLED

✓ SEDENTARY WORK ONLY
___ NO USE OF INJURED EXTREMITY
___ NO OVERHEAD WITH INJURED EXTREMITY
___ NO CLIMBING / BENDING
___ LIFTING LIMITED TO ___ POUNDS
___ NO SQUATTING / KNEELING
___ STANDING / WALKING ___ MIN / HR
___ ADDITIONAL RESTRICTIONS AS FOLLOWS:

RETURN TO CLINIC: 6 wks.

****

RU-90 STATUS INFORMATION

___ I expect to release the patient to return to pre-injury occupation on or about: _____

___ Patient is a Qualified Injured Worker
___ Physically able to participate in Vocational Rehabilitation
___ Not physically able to participate in Vocational Rehabilitation
If not, I expect to be able to give this information: _____

___ At this time, I am unable to give an opinion concerning the patient's ability to return to work. I expect to be able to provide an opinion on or about: _____

Signature of Doctor: [signature] Name: [signature]

Acknowledgment of receipt by Patient: [signature]

KJ-1006 (5/06)

02 518168 00000001 053 195 0524168

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/04/2007 Doctor: KENNETH JUNG MD

INITIAL ORTHOPAEDIC CONSULTATION

DATE OF INJURY:

August 9, 2007.

CONDITION:

Left ankle.

HISTORY OF PRESENT ILLNESS:

A 58-year-old female marriage and family therapist presents for evaluation of left ankle injury sustained on August 9, 2007. The patient reports slipping on a piece of cucumber and falling. She injured her knee and ankle. She was initially seen and given a cane and a prescription for Naprosyn. She has been using an elastic ankle brace and taking antiinflammatories as needed. She reports sharp, achy, cramping, incapacitating pain. It bothers her all day. It hurts her most of the day. There is swelling, tenderness, and giving way. It hurts her when she does exercises such as driving and walking.

Her history is significant for a left ankle fracture sustained about 14 years ago. She underwent an open reduction and internal fixation. This injury did not occur at work. It occurred after she fell down some stairs.

Past surgical, medical, family, social histories and review of systems, please refer to the patient questionnaire.

PHYSICAL EXAMINATION:

A pleasant female. In no acute distress. Alert and oriented x3.

Examination of the left ankle and foot reveals well-healed incision. No erythema or signs of infection.

She has limited ankle dorsiflexion and plantar flexion. She is hesitant due to pain. She also is hesitant to inversion and eversion on examination.

Anterior drawer is negative.

02 318168 000000001 054 195 05124168

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/04/2007 Doctor: KENNETH JUNG MD

Motor is intact. Capillary refill is brisk. Sensation is grossly intact to light touch.

She also reports pain to palpation over the midfoot and forefoot. No subluxation or crepitus is noted. There is no tenting of the skin. No erythema.

RADIOGRAPHS:

The patient has brought in outside films obtained on August 10, 2007. Radiographs show hardware in the ankle. There appears to be extensive degenerative changes including anterior osteophytes of the tibia and talus.

At KJOC Pasadena I ordered and interpreted AP, lateral, and oblique views of the left foot as well as a mortise ankle view. Radiographs show extensive degenerative changes in the ankle joint. Intact hardware. There is extensive anterior spurring. No fractures are seen in the foot or midfoot.

IMPRESSION:

1. Left ankle posttraumatic arthritis, status post open reduction and internal fixation ankle fracture.
2. Industrial injury secondary to fall.
3. Ankle pain after industrial fall.

PLAN:

This patient does not appear to have any acute injuries after her most recent fall. She most likely exacerbated a pre-existing condition, posttraumatic arthritis. She is currently wearing an elastic ankle sleeve. I would recommend the use of a lace-up ankle brace that provides further support. She has been provided with one today. She can be weightbearing as tolerated.

She reports she is scheduled to see Dr. Ralph Gambardella with regards to her left knee on September 10, 2007.

WORK STATUS:

I would keep this patient temporarily totally disabled until her office visit with Dr. Ralph Gambardella on September 10, 2007. After that point the patient is cleared for sedentary work.

Patient: FLOREEN ROOKS
DOB: 06/20/1949 Chart: WC0224215A
Age: 58 y
Date of Service: 09/04/2007 Doctor: KENNETH JUNG MD

I would like to see this patient in about 4 weeks' time. If she is doing better, I would plan to clear her for a full duty with regards to her left ankle.

DISCLOSURE:

I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that the contents of this report and bill are true and correct to the best of my knowledge.

Kenneth Jung, M.D.
/ Orig Job #: 0002H9-000003YN
D: 9/04/2007 1:01:00PM
T: 9/04/2007 5:44:01PM
ROOKS, SLOREEN.

SCIF RECD DTE 09/13/2007 BKSCAN 12 09/13/2007 06:05 PM 021333 18 1

KERLAN-JOBE ORTHOPAEDIC CLINIC

6801 Park Terrace #500
Los Angeles, CA 90045
Email:shirley.smith @kerlanjobe.com

REQUEST FOR AUTHORIZATION

PLEASE FAX AUTHORIZATIONS TO THE BELOW FAX NUMBER AND MAIL HARD COPY TO THE ABOVE ADDRESS

DATE: 09-10-07

FROM: SHIRLEY SMITH , WORKER COMPENSATION SPECIALIST
WORK COMP DEPARTMENT
PHONE#: 310-665-7200 ext 7628 **PAGES:** 5 **including cover**
FAX#: 310-337-9303 or 310-649-0177

TO: ~~SHERRIE CHOW~~ Yolanda Nelson
FAX #: ~~818-662-6341~~

05124168 -LG

INJURED WORKER: FLOREEN ROOKS
DATE OF INJURY: 08-09-07
CLAIM# 05124168

REQUESTING M.D: KENNETH H JUNG
SPECIALTY: ORTHOPAEDIC SURGEON

SHERIE CHOU
SEP 12 2007
LA GLENDALE LOC.
Rvd for Yolanda

- Requesting authorization for the following:
- TRANSFER OF CARE TO DR KENNETH JUNG

****** *Above authorized: _______Yes No: _____************************

Authorized By: ____________________ Date: ____________________

Per Labor Code 4610 (g) (1) "*Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five (5) working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.*"

*****IF THIS REQUEST WILL BE FORWARDED FOR PEER REVIEW, PLEASE FORWARD THIS COVER LETTER AND ALL DOCUMENTATION ATTACHED IN ORDER TO EXPEDITE REVIEW. PEER REVIEW PHYSICIAN MUST BE THE SAME SPECIALTY AS REQUESTING PHYSICIAN*****

CONFIDENTIALITY NOTE: The information contained in this facsimile message may be legally privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient you are hereby notified that any use, dissemination, distribution or copying of this information is strictly prohibited and may result in violations of federal or state law. If you have received this telecopy in error, please immediately notify us by calling the telephone number above, also collect and destroy the original message. Thank you

8083

ATTACHMENT TO: STATE COMP INS. FUND FORM 3069

WORK STATUS REPORT

Date of Injury: 8-9-07 | Today's Date: 8-27-07

Employer: Dveal Family Youth Services

Diagnosis:
(L) ankle sprain
(L) knee sprain

WORK STATUS

- ☐ Return to usual and customary work with no limitations.
- ☐ Off work balance of current work shift and return to work on ____________.
  - ☐ with NO limitations
  - ☐ with the limitations listed below.
- ☐ Return to temporary alternate work with the following limitations:
  - ☐ no continuous walking or prolonged standing
  - ☐ no lifting, pushing, or pulling over ________ pounds.
  - ☐ no repetitive bending or stooping.
  - ☐ limited use of the ☐ RIGHT ☐ LEFT ☐ HAND ☐ ARM
  - ☐ no use of the ☐ RIGHT ☐ LEFT ☐ HAND ☐ ARM
  - ☐ no repetitive kneeling or squatting.
  - ☐ no work above shoulder level.
  - ☐ must be sitting the majority of work shift.
  - ☐ sitting work only.
  - ☐ must keep the ☐ RIGHT ☐ LEFT ☐ FOOT ☐ LEG elevated major of work shift.
  - ☐ no driving commercial vehicle.
  - ☐ no operation of machinery.
  - ☐ Other: ____________
- ☒ Off work (TTD) until 9/4/07.
- ☐ Off work (TTD) because no temporary alternative work is available until ____________.
- ☐ Return to work on ____________ with NO LIMITATIONS.

Listed limitations apply to all non-work related activities (home, sports, hobbies, etc.)

INSTRUCTIONS TO EMPLOYEE:

- ☐ Keep wound bandage clean and dry.
- ☐ Wear ☐ SPLINT ☐ ARM SLING ☐ SUPPORT during working shift.
- ☐ Use ☐ CANE ☐ CRUTCHES during working hours.

Dispensed medications that can be taken during working shift:
1. ____________
2. ____________

Dispensed medications that MUST NOT be taken during work shift:
1. ____________
2. ____________

- ☐ Employee advised to see his/her private physician because his/her medical condition is NOT WORK RELATED (non-industrial).
- ☐ Employee referred for specialty evaluation. Type: Physical Therapy & MRI of (L) knee

Estimated Length of Treatment ____________ days 6 weeks.
Estimated Length of Disability ____________ days 1 weeks.

- ☐ There is no permanent disability expected.
- ☐ Employee's medical condition is permanent and stationary.
- ☐ Employee is released from further medical care.

cx appt. per Sherry @ State Fund.

RETURN APPOINTMENT: Date 9-4-07 Time: 10:30 (AM) PM

Provider signature: [signature] | Date: 8-27-07

DREAMWEAVER MEDICAL GROUP
420 W. Las Tunas Drive
San Gabriel, CA 91776
(626) 289-8493

Patient Name: Floreen Books
Date of Birth: 6-30-49
SSN #: 130-38-8610
MR #: 2140

WORK STATUS REPORT

05124168

WC022424157

TREATMENT AND DISABILITY INFORMATION

Kerlan - Jobe
Orthopaedic Clinic,
Centinela Freeman
Health System

Robert K. Kerlan, MD
1922-1996

Sports Medicine Surgery
Frank W. Jobe, MD
Clarence L. Shields, Jr., MD
Stephen J. Lombardo, MD
Lewis A. Yocum, MD
James E. Tibone, MD
Ralph A. Gambardella, MD
Ronald E. Glousman, MD
Ronald S. Kvitne, MD
Neal S. ElAttrache, MD
Daniel Kharrazi, MD
Orr Limpisvasti, MD

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Hand Surgery
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Neurology/Pain Management
Vernon B. Williams, MD

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Los Angeles, CA 90045
Tel: (310) 665-7200

KJ-1006 (5/06)

DATE: 8-4-07

TIME IN: 750 OUT: ____

PATIENT: Rooks Floren

DATE INJURED: 2/9-07

DIAGNOSIS: (L) Ankle

TREATMENT ADMINISTERED: ____ (X-rays)

(Initial Exam) ____ Medication

____ Re-evaluation ____ Injection

____ AUTHORIZATION REQUESTED

____ RECOMMENDATIONS ONLY

✓ TRANSFER CARE TO KJOC (requested by patient)

____ MRI ____ GAD ____ BONE SCAN
____ EMG / NCV ____ NEURO CONSULT
____ MYELOGRAM ____ C.T. SCAN
____ ARTHROGRAM ____ DISCOGRAM
____ OTHER (specify below) FCE ____

Brace

____ P.T./ ____ O.T./ ____ X WK/ ____ WKS

ACCOUNT # ____

WORK STATUS:

____ CONTINUE WORKING / UNRESTRICTED

____ PERMANENT AND STATIONARY EFFECTIVE ____

____ RELEASED TO REGULAR WORK EFFECTIVE ____

✓ TEMPORARILY TOTALLY DISABLED UNTIL 9/10/07

____ "CONSULT ONLY" (see disability recommendations)

____ QUALIFIED INJURED WORKER

✓ * RESTRICTED DUTY ONLY (SEE BELOW) EFFECTIVE 9/11/07

WORK RESTRICTIONS:

* IF RESTRICTED DUTY IS NOT AVAILABLE, PATIENT IS TEMPORARILY TOTALLY DISABLED

✓ SEDENTARY WORK ONLY
____ NO USE OF INJURED EXTREMITY
____ NO OVERHEAD WITH INJURED EXTREMITY
____ NO CLIMBING / BENDING
____ LIFTING LIMITED TO ____ POUNDS
____ NO SQUATTING / KNEELING
____ STANDING / WALKING ____ MIN / HR
____ ADDITIONAL RESTRICTIONS AS FOLLOWS:

RETURN TO CLINIC: 6 wks.

SURGERY, CONSISTING OF:

RU-90 STATUS INFORMATION

____ I expect to release the patient to return to pre-injury occupation on or about: ____

____ Patient is a Qualified Injured Worker
____ Physically able to participate in Vocational Rehabilitation
____ Not physically able to participate in Vocational Rehabilitation
If not, I expect to be able to give this information: ____

____ At this time, I am unable to give an opinion concerning the patient's ability to return to work. I expect to be able to provide an opinion on or about: ____

Signature of Doctor: [signature] Name: [signature]

Acknowledgment of receipt by Patient: [signature]

8083

SCIF RECD DTE 12/06/2007 BKSCAN 12 12/06/2007 08:18 AM 023410 25 1

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Orthopaedic Clinic
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Robert K. Kerlan, MD
1922-1996

Sports Medicine Surgery
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KJ-1072 (1/06)

November 26, 2007

State Comp
PO Box 92622
Los Angeles, CA 90009

RE: ROOKS, FLOREEN
EMP: D'veal Family & Youth Services
D/I: 08-09-07
CL#: 05124168

PERMANENT AND STATIONARY REPORT

Dear Sir/Madam:

CASE SUMMARY:

The patient was initially seen by me on September 10, 2007, relative to a work injury. At the time, the patient was 58 years of age and had sustained an injury to her left knee on August 9, 2007. This had occurred when she had slipped on a piece of cucumber and falling. The patient had injured her left knee as well as her ankle for which she had been under the care of Dr. Jung. Dr. Jung had referred the patient here for an evaluation regarding her left knee. At the time of her evaluation, she was found to have a synovitis of the left knee with a mild pes bursitis with underlying early degenerative osteoarthritis and patellofemoral arthrosis with mild patellofemoral malalignment. We recommended a comprehensive physical therapy program.

The patient is here today. She has returned and states that she did undergo her physical therapy program and with physical therapy did see improvement of her knee condition. The patient states that she is no longer having any type of significant discomfort with the knee. She still gets some aches and minimal irritability. There has not been any recurrent swelling but has been still occasional swelling. The patient feels that her knee condition is improved to the point that she is capable of returning back to her regular employment.

The patient, however, in the interim has also had a new work injury which occurred to her right lower extremity resulting in a fracture in her right foot and today is ambulatory with the assistance of a cane and in a Moon boot. The patient is aware of the fact that she is being seen separately for her right lower extremity injury. We have asked the patient again and she has agreed and is comfortable with the fact that in the absence of her present right foot condition, that she would be able to return back to regular work relative to her left knee and her left knee has overall been significantly improved with only the occasional remaining symptomatology as outlined above.

PHYSICAL EXAMINATION:

Physical examination today of the left knee, there is mild crepitance with ranging patellofemoral joint. There is no effusion. There is no longer any joint line tenderness, retinacular tenderness, no tenderness over the pes bursal area. Range of motion is 0-130 degrees.

FINAL IMPRESSION:

Underlying degenerative osteoarthritis including patellofemoral arthrosis and mild patellofemoral mal-alignment, left knee status post posttraumatic synovitis and pes bursitis, left knee.

RECOMMENDATIONS:

This patient is in a permanent and stationary position for rating.

SUBJECTIVE FACTORS:

The permanent subjective factors to be considered are the occasional minimal pain with activities of daily living increasing to occasional to intermittent, minimal-to-slight pain with heavier squatting, kneeling, or lifting activities.

SCIF RECD DTE 12/06/2007 BKSCAN 12 12/06/2007 08:19 AM 023410 25 3

OBJECTIVE FACTORS:

The objective factors to be considered are the radiographic evidence of the patellofemoral joint space narrowing and degenerative osteoarthritis joint space narrowing noted radiographically. There are no other objective factors to be considered.

PERMANENT WORK RESTRICTIONS:

None indicated. This patient can be released to her regular work activities effective November 26, 2007.

LOSS OF PRE-INJURY CAPACITY:

None.

FUTURE MEDICAL CARE REQUIREMENTS:

In the future, this patient may have a flare-up of her condition that may require the use of oral anti-inflammatory medications, physical therapy, and/or cortisone injection and/or arthroscopic surgical intervention.

CAUSATION:

Based upon the history, this patient's condition is directly attributed to the work injury.

APPORTIONMENT:

There is no apportionment indicated as there is no residual disability. There was definite evidence of a preexisting osteoarthritis as was outlined from my original report . However, at this time, there is no residual disability and therefore there does not appear to be a need for apportionment.

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IMPAIRMENT RATING:

Using the AMA Guidelines to the Evaluation of Permanent Impairment, chapter 17, this patient using the radiographic table 17-31 had 1-mm joint space narrowing of the knee which is a 7% lower extremity impairment rating to that which would be added a 10% lower extremity impairment rating for the patellofemoral joint. This would combine to a 17% lower extremity impairment rating which then using table 17-3 translates into a 7% whole person impairment rating.

DECLARATION:

"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 the information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information provided to me and, except as noted herein, that I believe it to be true.'

Sincerely,

Ralph A. Gambardella, M.D.

RAG/gtc
WC0224215A

Specialists
3144 Santa Anita Avenue, Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	12/20/2007		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170380/Yolanda Nielsen

12/20/2007

State Comp 92622
P.O. Box 92622
Los Angeles, CA 90009-2622

ATTN: Worker's Compensation Claims

RE:	ROOKS, FLOREEN
Age & Sex:	58 & F
Occupation:	MARRIAGE FAMILY THERAPIST
Employer:	D'VEAL FAMILY & YOUTH SERVICES
Date of Injury:	11/10/2007
Date of Exam:	12/20/2007

ORTHOPEDIC SUPPLEMENTAL REPORT (PR-2)

Gentlemen:

As you are well aware, this patient has been under our care with a diagnosis of a fracture of her right fourth and fifth metatarsal. She has been using a Cam walker and indicates that her pain has steadily improved.

Patient has also complained of pain and discomfort of her left knee and her left ankle, which she indicates has been improving subjectively since her last visit.

PHYSICAL EXAMINATION:

RIGHT FOOT: There is evidence of mild tenderness. There is mild swelling. Motor and sensory function is intact distally.

LEFT KNEE: Reveals evidence of mild tenderness. There is no swelling. There is no spasm. No gross effusion is noted. No laxity is noted.

LEFT ANKLE: Reveals evidence of mild tenderness in the anterolateral aspect of the ankle. No swelling or spasm is noted. Motor and sensory function is intact distally.

RADIOGRAPHIC FINDINGS:

X-rays of the right foot reveal evidence of a healing fourth and fifth metatarsal fracture, overall good position.

IMPRESSION:

1. HEALING RIGHT FOURTH AND FIFTH METATARSAL FRACTURE.
2. LEFT KNEE SPRAIN.
3. LEFT ANKLE SPRAIN.

DISCUSSION:

I will recommend that Ms. Rooks at this time continue off of work. I will encourage her to continue the use of a Cam walker to allow the fractures to heal. A knee immobilizer will be provided for her left knee and I will recommend that she weightbear as tolerated with the assistive devices. I will maintain her off of work and I would like to see her back

Specialists
3144 Santa Anita Avenue. Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	12/20/2007		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

02 318168 000000001 069 195 05124168

for follow-up in four weeks' time, at which time x-rays will be taken to assess the healing fractures.

Should there be any questions or concerns, please do not hesitate to contact me.

"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge."

"I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true."

Sincerely Yours,

Thomas Saucedo, M.D. ____________________
DATE

Executed in the County of Los Angeles on 12/20/2007.

TS:pf/tj

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Orthopaedic Clinic
At
Centinela Freeman
Regional Medical Center
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Robert K. Kerlan, MD
1922-1996

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KJ-1072 (1/06)

November 5, 2007

State Comp
PO Box 92622
Los Angeles, CA 90009

RE: ROOKS, FLOREEN
EMP: D'veal Family & Youth Services
D/I: 08-09-07
CL#: 05124168

NO SHOW

Dear Sir/Madam:

This patient had a scheduled appointment today and did not show up.

DECLARATION:

"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 the information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information provided to me and, except as noted herein, that I believe it to be true.'

Sincerely,

Ralph A. Gambardella, M.D.

RAG/axy
WC0224215A

Radiology/Diagnostics

SCIF RECD DTE 02/09/2009 BKSCAN 9 02/10/2009 08:30 AM 040882 6 2

3144 Santa Anita Avenue, El Monte, CA 91733
(626) 444-0333 FAX (626) 582-7990

*Radiology Services Provided by Anthony Bledin, M.D., Inc.
Granada Hills (818) 832-3300 Oxnard (805) 988-1111

PATIENT:	ROOKS, FLOREEN
DOB:	06-20-49
CHART NUMBER:	32-295496
REFERRED BY:	DR. MICHAEL HADLEY
DATE:	03-19-08

MAGNETIC RESONANCE IMAGING OF THE LEFT KNEE

HISTORY

Rule out internal derangement. No known surgery.

TECHNIQUE

The following imaging sequences were acquired on a General Electric Signa Horizon MRI scanner: Sagittal T1 localizer images. Axial T2 FSE images. Coronal proton density fat saturated and T1 images. Sagittal proton density fat saturated and proton density images. Oblique Coronal T2 FSE images parallel to the anterior cruciate ligament.

FINDINGS

Minimal osteoarthritic changes are present in the knee joint, predominantly involving the medial compartment. The osteoarthritic changes are manifest by joint space narrowing, denudation of the articular cartilage and small 1 to 2 mm anterior femoral condylar articular surface osteophytes.

There is fraying and irregularity of the apex of the posterior horn of the medial meniscus. This abnormality is associated with an oblique signal abnormality in the peripheral capsular half of the posterior horn of the medial meniscus. This oblique signal abnormality freely communicates with the inferior meniscal surface and is compatible with a tear of the posterior horn of the medial meniscus. The body and anterior horn of the medial meniscus appear normal and the lateral meniscus demonstrates no significant abnormality.

A knee joint effusion is present with fluid in the suprapatellar bursa. The volume of this effusion is less than 5 cc. There is no significant popliteal cyst.

The cruciate ligaments, the collateral ligaments, the patellar tendon, quadriceps tendon appear normal.

(Continued On Page Two)

PATIENT: *ROOKS, FLOREEN*
EXAM: *MRI – LEFT KNEE*
DATE: *03-19-08*
PAGE: *2*

IMPRESSION

1. **Tear, posterior horn, medial meniscus (Grade III).**

2. **Early osteoarthritic changes of the medial compartment of the knee joint.**

3. **Knee joint effusion.**

Anthony Bledin, M. D.
Diplomate American Board of Radiology

AGB/tj
D: 03/19/08
T: 03/20/08

Arrow = tear posterior horn medial meniscus (sagittal)

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Granada Hills (818) 832-3300 Oxnard (805) 988-1111

PATIENT:	ROOKS, FLOREEN
DOB:	06-20-49
CHART NUMBER:	32-295496
REFERRED BY:	DR. MICHAEL HADLEY
DATE:	03-19-08

MAGNETIC RESONANCE IMAGING OF THE LEFT KNEE

HISTORY

Rule out internal derangement. No known surgery.

TECHNIQUE

The following imaging sequences were acquired on a General Electric Signa Horizon MRI scanner: Sagittal T1 localizer images. Axial T2 FSE images. Coronal proton density fat saturated and T1 images. Sagittal proton density fat saturated and proton density images. Oblique Coronal T2 FSE images parallel to the anterior cruciate ligament.

FINDINGS

Minimal osteoarthritic changes are present in the knee joint, predominantly involving the medial compartment. The osteoarthritic changes are manifest by joint space narrowing, denudation of the articular cartilage and small 1 to 2 mm anterior femoral condylar articular surface osteophytes.

There is fraying and irregularity of the apex of the posterior horn of the medial meniscus. This abnormality is associated with an oblique signal abnormality in the peripheral capsular half of the posterior horn of the medial meniscus. This oblique signal abnormality freely communicates with the inferior meniscal surface and is compatible with a tear of the posterior horn of the medial meniscus. The body and anterior horn of the medial meniscus appear normal and the lateral meniscus demonstrates no significant abnormality.

A knee joint effusion is present with fluid in the suprapatellar bursa. The volume of this effusion is less than 5 cc. There is no significant popliteal cyst.

The cruciate ligaments, the collateral ligaments, the patellar tendon, quadriceps tendon appear normal.

(Continued On Page Two)

02 318168 000000001 073 195 05124168

PATIENT: *ROOKS, FLOREEN*
EXAM: *MRI - LEFT KNEE*
DATE: *03-19-08*
PAGE: *2*

IMPRESSION

1. **Tear, posterior horn, medial meniscus (Grade III).**
2. **Early osteoarthritic changes of the medial compartment of the knee joint.**
3. **Knee joint effusion.**

Anthony Bledin, M. D.
Diplomate American Board of Radiology
AGB/aj
D: 03/19/08
T: 03/20/08

Arrow = tear posterior horn medial meniscus (sagittal)

02 318168 00000001 074 195 05124168

PACIFIC MEDICAL
Imaging & Oncology Center

707 S Garfield Ave
Suite 001
Alhambra, CA 91801
Tel: 626-227-2727
Fax: 626-227-2799

Sharon Norris, MD
420 W Las Tunas Dr
San Gabriel, CA 91776

RE: Floreen Rooks
PT No. 9067

Date of birth: 06/20/1949
Accession #: 17470

LEFT KNEE SERIES, 3 VIEWS

Exam Date: 08/10/07

IMPRESSION:

1. **Generalized demineralization.**
2. **Suspect small loose body within the central joint.**
3. **No acute fracture nor subluxation is demonstrated.**

FINDINGS:

There is generalized demineralization. No acute fracture nor subluxation is demonstrated. There is mild joint space narrowing with hypertrophic bony changes noted at the medial compartment. Finding is compatible with mild osteoarthritis. The AP view shows apparent small ossified body at the mid joint, which may represent a synovial osteochondroma or loose body. No joint effusion is identified.

Thank you for referring Floreen Rooks to Pacific Medical Imaging and Oncology Center.

RICHARD P. CHAO, M.D.
D: 08/10/07
T: 08/14/07
RPC/jgy

Document approved by: Richard P. Chao, MD Date: 08/15/2007 09:43

☐ Pull chart ☐ Pull chart for PCP PCP's box
☐ File ☐ Pull chart Send letter Schedule Appt.
PCP: 8/24/07

PACIFIC MEDICAL
Imaging & Oncology Center

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Fax: 626-227-2799

02 318168 00000001 0/5 195 05124168

Sharon Norris, MD
420 W Las Tunas Dr
San Gabriel, CA 91776

RE: Floreen Rooks
PT No. 9067

Date of birth: 06/20/1949
Accession #: 17468

LEFT ANKLE SERIES

Exam Date: 08/10/07

IMPRESSION:

1. **Old post-traumatic changes of the malleoli, status post prior ORIF.**
2. **There is secondary deformity and secondary osteoarthritic changes at the distal tibia and talus.**

FINDINGS:

The patient is status post open reduction and internal fixation of bi-malleolar fractures. Orthopedic plate and multiple screws are in place at the distal fibula with two screws transfixing the medial malleolus. There is mild deformity of the talus. Significant hypertrophic bony changes are seen at the distal tibia as well as the talus, compatible with old post-traumatic changes with secondary osteoarthritis. No acute fracture nor subluxation is demonstrated. There is mild diffuse soft tissue swelling.

Thank you for referring Floreen Rooks to Pacific Medical Imaging and Oncology Center.

RICHARD P. CHAO, M.D.
D: 08/10/07
T: 08/14/07
RPC/jgy

Document approved by: Richard P. Chao, MD Date: 08/15/2007 09:43

02 318168 00000001 076 195 05124168

PACIFIC MEDICAL
Imaging & Oncology Center

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Tel: 626-227-2727
Fax: 626-227-2799

Sharon Norris, MD
420 W Las Tunas Dr
San Gabriel, CA 91776

RE: Floreen Rooks
PT No. 9067

Date of birth: 06/20/1949
Accession #: 17469

AP PELVIS, AP AND LATERAL LEFT HIP

Exam Date: 08/10/07

IMPRESSION:

Negative study.

FINDINGS:

No acute fracture nor hip dislocation is demonstrated. The joint spaces appear preserved. No pelvic fracture is identified.

Thank you for referring Floreen Rooks to Pacific Medical Imaging and Oncology Center.

RICHARD P. CHAO, M.D.
D: 08/10/07
T: 08/14/07
RPC/jgy

Document approved by: Richard P. Chao, MD Date: 08/15/2007 09:43

PACIFIC MEDICAL
Imaging & Oncology Center

707 S Garfield Ave
Suite 001
Alhambra, CA 91801
Tel: 626-227-2727
Fax: 626-227-2799

Sharon Norris, MD
420 W Las Tunas Dr
San Gabriel, CA 91776

RE: Floreen Rooks **Date of birth:** 06/20/1949
PT No. 9067 **Accession #:** 17470

LEFT KNEE SERIES, 3 VIEWS **Exam Date:** 08/10/07

IMPRESSION:

1. **Generalized demineralization.**
2. **Suspect small loose body within the central joint.**
3. **No acute fracture nor subluxation is demonstrated.**

FINDINGS:

There is generalized demineralization. No acute fracture nor subluxation is demonstrated. There is mild joint space narrowing with hypertrophic bony changes noted at the medial compartment. Finding is compatible with mild osteoarthritis. The AP view shows apparent small ossified body at the mid joint, which may represent a synovial osteochondroma or loose body. No joint effusion is identified.

Thank you for referring Floreen Rooks to Pacific Medical Imaging and Oncology Center.

RICHARD P. CHAO, M.D.
D: 08/10/07
T: 08/14/07
RPC/jgy

Document approved by: Richard P. Chao, MD Date: 08/15/2007 09:43

☐ Pull chart ... ☐ Pull chart for PCP ... PCP's box
Reviewed: ...
☐ File ☐ Pull chart Send letter ☒ Schedule Appt.
PCP: 8/24/07

8083

PACIFIC MEDICAL
Imaging & Oncology Center

707 S Garfield Ave
Suite 001
Alhambra, CA 91801
Tel: 626-227-2727
Fax: 626-227-2799

Sharon Norris, MD
420 W Las Tunas Dr
San Gabriel, CA 91776

RE: Floreen Rooks **Date of birth:** 06/20/1949
PT No. 9067 **Accession #:** 17468

LEFT ANKLE SERIES **Exam Date:** 08/10/07

IMPRESSION:

1. **Old post-traumatic changes of the malleoli, status post prior ORIF.**
2. **There is secondary deformity and secondary osteoarthritic changes at the distal tibia and talus.**

FINDINGS:

The patient is status post open reduction and internal fixation of bi-malleolar fractures. Orthopedic plate and multiple screws are in place at the distal fibula with two screws transfixing the medial malleolus. There is mild deformity of the talus. Significant hypertrophic bony changes are seen at the distal tibia as well as the talus, compatible with old post-traumatic changes with secondary osteoarthritis. No acute fracture nor subluxation is demonstrated. There is mild diffuse soft tissue swelling.

Thank you for referring Floreen Rooks to Pacific Medical Imaging and Oncology Center.

RICHARD P. CHAO, M.D.
D: 08/10/07
T: 08/14/07
RPC/jgy

Document approved by: Richard P. Chao, MD Date: 08/15/2007 09:43

02 318168 000000001 080 195 05124168

PACIFIC MEDICAL
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707 S Garfield Ave
Suite 001
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Tel: 626-227-2727
Fax: 626-227-2799

Sharon Norris, MD
420 W Las Tunas Dr
San Gabriel, CA 91776

RE: Floreen Rooks
PT No. 9067

Date of birth: 06/20/1949
Accession #: 17469

AP PELVIS, AP AND LATERAL LEFT HIP

Exam Date: 08/10/07

IMPRESSION:

Negative study.

FINDINGS:

No acute fracture nor hip dislocation is demonstrated. The joint spaces appear preserved. No pelvic fracture is identified.

Thank you for referring Floreen Rooks to Pacific Medical Imaging and Oncology Center.

RICHARD P. CHAO, M.D.
D: 08/10/07
T: 08/14/07
RPC/jgy

Document approved by: Richard P. Chao, MD Date: 08/15/2007 09:43

SCIF RECD DTE 06/23/2008 BKSCAN 7 06/23/2008 05:59 PM 029884 2 11

Associated Sports Therapy (AST)
880 South Atlantic Blvd, Suite 203, Monterey Park, CA 91754
Phone: (626) 282-3577 Fax: (626) 284-4276

DIAGNOSIS: (L) knee [illegible] I & D

DATE	MAY 2 2 2008	MAY 2 8 2008	MAY 3 0 2008	JUN 0 3 2008	JUN 0 4 2008
Initial Evaluation	✓				
Re-Eval/Progress Report					
Treatment Modalities:					
Hot Packs					
Cold Packs	✓	20'	20'	20'	20
Ultrasound					
Whirlpool					
Paraffin					
Massage / STM / DTM / MFR	STM	STM	STM	STM	MFR/STM
E-Stim / TENS / IF / NMES	HW	HW	HW	HW	HW
Neuromuscular Re-ed	✓	✓	✓	✓	
Therapeutic Activities					
Gait Training					
Joint Mobilization Techniques					
Posture Education					
Body Mechanics					
Work Simulation					
Home Exercise Program (HEP)	✓			done	
Other:					
Therapeutic Procedures:					
Stationary Bike		15'	15	15	15
Squats (by the wall)	10x1	10x2	10x2	10x2	10x2
Heel Raises	10x1	10x2	10x2	10x2	10x2
Progressive Resistive Ex's (PRE's)					
-Theraband/Theratube					
-Ankle Weight					
-Swiss Ball	10x1		10x2	10x2	10x2
-Step ups	10x1		10x2	10x2	10x2
-SAQ's/LAQ's/SLR's	10x1	✓	10x2	10x2	10x2
Stretching Exercises					
-QS/HS/GS	10x1		10x2		
-Heelcord Stretch					
-Manual Stretch					
Other:					
Therapist Initials	AE	JD	JD	JD	JD

Date: MAY 2 2 2008 Initial eval. completed. PT Tx initiated & tol. fairly. [illegible] See PT eval for details — AE

Date: MAY 2 8 2008 Pt c/o (L) knee pain [illegible] Tx per flow chart; Pt tol. Tx [illegible] continue PT plan — JD

Date: MAY 3 0 2008 S: Pt c/o (L) knee pain [illegible] O: Tx per flow chart A: Pt tol Tx [illegible] P: continue PT plan — JD

Date: JUN 0 3 2008 S: [illegible] O: Tx per flow chart A: Pt tol Tx [illegible] P: continue plan — JD

Date: JUN 0 4 2008 S: [illegible] O: Tx per flow chart A: [illegible] P: continue PT plan — JD

Therapist Name/ Title	Initials
A. Escobar (signature) Albert Q. Escobar, RPT PT19096	AE

Patient Name: ROOKS, FLORENCE

Patient Account #: 7679

Physician's Name: DR. SAUCEDO

Treatment Flow Chart

(Hip and/or Knee)

8083

SCIF RECD DTE 06/23/2008 BKSCAN 7 06/23/2008 05:59 PM 029884 2 12

Associated Sports Therapy (AST)
880 South Atlantic Blvd, Suite 203, Monterey Park, CA 91754
Phone: (626) 282-3577 Fax: (626) 284-4276

DIAGNOSIS: (L) Knee P T & D

DATE	JUN 06 2008	JUN 09 2008	JUN 11 2008	JUN 13 2008	JUN 16 2008
Initial Evaluation					
Re-Eval/Progress Report					
Treatment Modalities:					
Hot Packs	20	20	20	✓	✓
Cold Packs	✓	✓			
Ultrasound					
Whirlpool					
Paraffin					
Massage / STM / DTM / MFR	STM	STM	STM	STM	STM
E-Stim / TENS / IF / NMES	HW	HW	HW	HW	HW
Neuromuscular Re-ed	✓	✓	✓	✓	✓
Therapeutic Activities					
Gait Training					
Joint Mobilization Techniques					
Posture Education					
Body Mechanics					
Work Simulation					
Home Exercise Program (HEP)	✓	✓			
Other:					
Therapeutic Procedures:					
Stationary Bike		30'	30	30'	30'
Squats (by the wall)		1X15	[illegible]	10X2	10X2
Heel Raises				10X2	10X2
Progressive Resistive Ex's (PRE's)					
-Theraband/Theratube					
-Ankle Weight					
-Swiss Ball	10X1	10X1		5X2	10X2
-Step ups	10X1	10X1		10X2	10X2
-SAQ's/LAQ's/SLR's	10X1	10X1		10X2	10X2
Stretching Exercises					
-QS/HS/GS	10X1	10X2	✓	10X2	X2
-Heelcord Stretch					
-Manual Stretch					
Other:					
Therapist Initials	JD	JD	[illegible]	AE	JD

Date: JUN 06 2008 [illegible] — JD

Date: JUN 09 2008 [illegible] — JD

Date: JUN 11 2008 S: pt c/o (L) knee pain [illegible] PT plan [illegible]

Date: JUN 13 2008 Cont to rec'd PT per flow chart. [illegible] — AE

Date: JUN 16 2008 [illegible] — JD

Therapist Name/ Title	Initials
[signature] Albert Q. Escobar, RPT PT19096	AE

Patient Name: BOOKS, FLORENCE

Patient Account #: 7679

Physician's Name: Dr. Saucedo

Treatment Flow Chart

(Hip and/or Knee)

8083

Associated Sports Therapy (AST)
880 South Atlantic Blvd, Suite 203, Monterey Park, CA 91754
Phone: (626) 282-3577 Fax: (626) 284-4276

DIAGNOSIS: (L) Knee ā I & P

DATE	JUN 18 2008					
Initial Evaluation						Date: JUN 18 2008
Re-Eval/Progress Report	✓					Pt states, she can't do
Treatment Modalities:						well. except pain seemed
Hot Packs	✓					to ↑'d @ night. Rec'd
Cold Packs						PT per plan chart
Ultrasound						+ f/u. will benefit
Whirlpool						from skilled PT — AE
Paraffin						Date:
Massage / STM / DTM / MFR	STM					
E-Stim / TENS / IF / NMES	HW					
Neuromuscular Re-ed	✓					
Therapeutic Activities						
Gait Training						
Joint Mobilization Techniques	✓					
Posture Education						
Body Mechanics						Date:
Work Simulation						
Home Exercise Program (HEP)	✓					
Other:						
Therapeutic Procedures:						
Stationary Bike	15'					
Squats (by the wall)	10x2					Date:
Heel Raises	10x2					
Progressive Resistive Ex's (PRE's)						
-Theraband/Theratube						
-Ankle Weight	10x2					
-Swiss Ball	10x2					
-Step ups	10x2					
-SAQ's/LAQ's/SLR's	10x2					
Stretching Exercises						Date:
-QS/HS/GS	10x2					
-Heelcord Stretch						
-Manual Stretch						
Other:						
Therapist Initials	AE					

Therapist Name/ Title	Initials
AEscobar PT *Albert Q. Escobar, RPT* PT19096	AE

Patient Name: ROOKS, FLORENCE
Patient Account #: 7679
Physician's Name: DR. SAUCEDO

Treatment Flow Chart
(Hip and/or Knee)

8083

ASSOCIATED SPORT[illegible]RAPY

DR: Saucedo — ICD9. 719 ☒ WC ☐ PVT ☐ CASH

Account Number: 7679

Patient Name: Rooks, Flosene

CLAIM: 88283

DOB: 6.20.49

DOI: 11.10.07

Date	TOTAL VISITS	EVALUATION & RE-EVALUATION	913 Intermediate (New Pt)	905 Extended (New Pt)	907 Comprehensive (New Pt)	916 Intermediate (Est Pt)	910 Extended (Est Pt)	912 Comprehensive (Est Pt)	940 Reassessment/Report	934 Manual Muscle Test / Report	THERAPEUTIC PROCEDURE	928 Exercise (Range & Flexibility) 97110	946 Neuromuscular Re-Education 97112	947 Manual traction	949 Gait training	951 Therapeutic Massage 97124	950 Myofascial Release 97250	988 Joint Mobilization	933 [illegible]	989 Soft Tissue Mobilization	963 Iontophoresis	914 Functional Activities	927 Each Additional [illegible]	MODALITIES	911 Mech. traction	916 Electrical Stimulation	919 Whirlpool	921 Paraffin Bath	963 Contrast Bath	SUPPLIES	4481 Electrodes	6914 Ultrasound	587 Thermotherapy
MAY 22 2008	12		✓									✓	✓		✓											✓							
MAY 28 2008	11											✓					✓									✓							
MAY 30 2008	10											✓														✓							
JUN 03 2008	9											✓					✓									✓							
JUN 04 2008	8											✓					✓									✓							
JUN 06 2008	7											✓					✓									✓							
JUN 09 2008	6											✓					✓									✓							
JUN 11 2008	5											✓					✓									✓							
JUN 13 2008	4											✓	✓				✓									✓							
JUN 16 2008	3											✓					✓									✓							
JUN 18 2008	2											✓	✓				✓									✓							

RX Date: 5.09.08 (3 x / wk X 4 wks) Total Visits Auth 12 To:

Auth Date: 5.19.08 Pre-Cert #:

Authorized by (Adj / RN): Start Date: 5/19/08 End Date: ~~6.09.08~~ 7/18/08

Ph #:

Fax #:

Next MD Appt: (time / date) Progress Report:

Also Authorized: Progress Report Supplies: Tx Body Area(s):

SCIF RECD DTE 06/23/2008 [illegible] 5:59 PM 029884 2 15

880 S. [illegible]LANTIC BLVD, SUITE 203
MON[illegible]EREY PARK, CA. 91754
PHONE (626) 282-3577 FAX (626) 284-4276

Physical Therapy Progress Report

Patient Name: Rooks, Florence
Referring Physician: Dr. Saucedo
Diagnosis: (L) knee S/P [illegible]
Claim Number: 80283

Date: JUN 18 2008
Visits: 11
Account #: 7619
D.O.I.: 11-10-07

Chief Complain(s): 0-10 pain scale

C/S PAIN
T/S PAIN
L/S PAIN
Radicular Symptoms Ø
Extremity Pain (L) knee joint 4-5/10
Other

Improvement(s) Noted: ^ = change ↑ = increased ↓ = decreased

(no ^-↑-↓) ROM ↑'d (L) knee flexion to 0°-115°
(no ^-↑-↓)Strength ↑'d strength of (L) LE about 1/2 gr. level
(no ^-↑-↓)Function ↑'d overall function + able to walk longer distance
(no ^-↑-↓)Radiculopathy Ø
(no ^-↑-↓)Pain (L) knee 4-5/10
(no ^-↑-↓)Other Has ↓'d tenderness on (L) knee significantly.

General Assessment: Pt has showed significant improvement + has improved dynamic balance + endurance. Cont to have residual pain + weakness + would benefit from cont PT treatment.

Treatment Plan/Recommendations: Cont. skilled PT intervention
☑ Contine with same treatment plan ☐Add

GOAL(S): 1) further ↓ pain in (L) knee to 1-2/10 2) ↑ strength in (L) LE 1/2 gr. higher 3) Improve/promote normal gait pattern. 4) To ambulate in community [illegible] AD + independently.

PHYSICAL THERAPIST [illegible] PT JUN 18 2008

SCIF RECD DTE 06/23/2008 BKSCAN 7 06/23/2008 05:59 PM 029884 2 16

ASSOCIATED SPORTS THERAPY
860 S. ATLANTIC BOULEVARD, #203
MONTEREY PARK, CALIFORNIA 91754
(626) 282-3577

Name: Roots, Florenn Date: 05-09-08
Diagnosis: [illegible]
Precautions:
Frecuency: 3 x weekly for 4

☐ EVALUATE & TREAT

☐ SPECIFIC TREATMENT ORDER: Please ✓

HEAT / COLD
☑ Hot Packs
☐ Ultrasound
☑ Cold Packs

ELECTROTHERAPY
☑ Electrical Stimulation
☐ Iontophoresis
☐ TENS

HYDROTHERAPY
☐ Whirlpool
☐ Contrast Bath

TRACTION
☐ Cervical
☐ Pelvic
☐ Inversion

PATIENT TEACHING
☐ Home Program

MASSAGE
☐ Therapeutic Massage
☐ Myofascial Release

EXERCISES
☑ Passive/Active ROM
☑ Stretches
☑ PRE's
☑ Therapeutic Ex
☑ Mobilization
☑ Isometrics

REHAB PROGRAM
☐ General Orthopedic
☐ Whiplash Syndrome
☐ Back Program
☐ Shoulder Problems

Other (T)

SIGNATURE ______________, M.D.

PROGRESS NOTE: ADULT (07/07)

Date: 8-27-07 | B/P: 140/80 | P: 74 | R: 20 | T: 97.5 | Wt: 214 | Ht: 5'6" | LMP: | Age: 58

Allergies: PCN

Last TB Test:

Medications:

Chief Complaint: F/UP

Problem – from last visit:

Nurse: E Lopez LVN

Previous visit follow-up by provider? ☐ Yes ☐ No

S: 58 yo ♀ c̄ (L) knee/ankle/hip injury on 8/4/07. Pt has only taken 2 Naproxen since injury. Pt has relief c̄ Naproxen. With no use of Naproxen pt was bedridden 2° to pain. Xrays show small "loose body" w/n the central joint (L) knee. Still has pain + swelling in (L) knee. (L) knee also has "wierd" feeling x (1) ½ wks.

O: GEN: overweight ♀ NAD, AxOx3, conformed about workers comp + disability

EXT: No pain c̄ palpation of (L) knee, medial & lateral joint line negative McMurray's sign (L) negative. mildly edematous (L) ankle + (L) knee. (L) ankle - no pain to palpation

Provider Signature:

Name:

Face to Face time 1 hour.

CC & significant history:

Assessment: (L) knee sprain c̄ swelling.

Plan: (1) MRI of (L) knee to r/o meniscal tear

(2) Physical Therapy for (L) knee/ankle

(3) RTC 1 wk [illegible]

Signature: [signature]

Lab Results Discussed with patient?
☐ Yes ☐ No
☐ N/A

Patient Education Discussed
Yes ○ ○ No

Topics Discussed
- ○ Advanced directive
- ○ Asthma
- ○ Breast self exam
- ○ Cholesterol
- ○ Dental
- ○ Diabetes
- ○ Diet/Nutrition
- ○ Exercise
- ○ Family planning
- ○ Hypertension
- ○ Injury prevention
- ○ Medications
- ○ Obesity
- ○ Prenatal care
- ○ STD's
- ○ Substance abuse
- ○ Testicular self exam
- ○ Tobacco cessation
- ○ Tuberculosis
- ○ Other

Patient verbalizes understanding?
☐ Yes ☐ No

Educational materials Given?
☐ Yes ☐ No

Describe

Instructed to call if problem persists ☐

Follow-up Visit
Days
Weeks: 1
Months:

Dreamweaver Medical Group
420 West Las Tunas Drive
San Gabriel, CA 91776
(626) 296-9500

Patient Name: Florern Rooks

Date of Birth: 6-20-49

PROGRESS NOTE: ADULT

02 318168 000000001 060 195 05124168

05124168 195 061 000000001 318168 02

PROGRESS NOTE: ADULT (07/07)

Date: 8-14-07 | B/P: 130/80 | P: 76 | R: 14 | T: 98.4 | Wt: 216 | Ht: 5'6" | LMP: | Age: 58

Allergies: PCN

Last TB Test:

Medications: Naproxen 500 mg

Chief Complaint: Follow Up

Problem from last visit:

Nurse:

Previous visit follow-up by provider? ☐ Yes ☐ No

S. States feeling moderately better. Still swollen (L) ankle. Pt. states just lying in bed x 4 days. Naproxen showed ↓ relief. Shoulder is better.

O. VSS

Exam: Pt [illegible] (L) ankle, (L) knee, (L) hip. (Pt gait (c cane) ↓ [illegible] noted on while walking competent c usage of cane [illegible]

Imaging: OA @ knee & ankle (L) ⊕STS of (L) ankle s/p old fx & fixation of (L) ankle.

A/P. 1.) (L) ankle sprain → D/c Ultram 25 mg q4 prn
↑ PT b/c of old fx.
2.) (L) knee pain - Ultram
3.) (L) hip pain - Ultram.

RTC 2wk
- Limited work. (sitting mostly)

Provider Signature:

Name:

CC & significant history:

Assessment:

Plan:

Signature:

Lab Results Discussed with patient?
☐ Yes ☐ No
☐ N/A

Patient Education Discussed
Yes ○ ○ No

Topics Discussed
- ○ Advanced directive
- ○ Asthma
- ○ Breast self exam
- ○ Cholesterol
- ○ Dental
- ○ Diabetes
- ○ Diet/Nutrition
- ○ Exercise
- ○ Family planning
- ○ Hypertension
- ○ Injury prevention
- ○ Medications
- ○ Obesity
- ○ Prenatal care
- ○ STD's
- ○ Substance abuse
- ○ Testicular self exam
- ○ Tobacco cessation
- ○ Tuberculosis
- ○ Other

Patient verbalizes understanding?
☐ Yes ☐ No

Educational materials Given?
☐ Yes ☐ No

Describe

Instructed to call if problem persists ☐

Follow-up Visit
Days
Weeks:
Months:

Dreamweaver Medical Group
420 West Las Tunas Drive
San Gabriel, CA 91776
(626) 296-9500

Patient Name: Floreen Books

Date of Birth: 6-20-49

PROGRESS NOTE: ADULT

8083

02 318168 000000001 062 195 05124168

PROGRESS NOTE: ADULT (07/07)

Date: 8-9-07 | B/P: 116/78 | P: 88 | R: 16 | T: 98.0 | Wt: 210 | Ht: 5'6" | LMP: | Age: 58

Allergies: PCN | Last TB Test:

Medications:

Chief Complaint: Work Injury (Hip, Knee, Ankle) | Problem — from last visit:

Nurse: [illegible signature]

Previous visit follow-up by provider? ☐ Yes ☐ No

S: Pt. states that this afternoon slipped & fell onto (L) hip from ground level. ø "pop" or "crack". Now c̄ pain in (L) hip, (L) knee, & (L) ankle. Ankle being the most painful. Also c̄ pain in (R) shoulder as well. Can not describe how pain in (R) shoulder originated. ø weight bearing on (L) LE @ all.

PMH: (L) ankle fx (? yr)

O: VSS

Ext: ⊕ tender @ (L) hip, (L) knee, (L) ankle (medial/lat. malleolus)

↓ AROM & PROM (of all limbs) due to pain.

ø erythema ø ecchymosis ø gross deformity.

Provider Signature: [signature]

Name: [signature]

CC & significant history:

Assessment: 1.) (L) hip, knee ankle pain

Plan: Signature:

1.) Naprosyn 500mg BID prn pain & ice-packs

- X-rays to r/o fx

- out of work x 3 days RTC 3 days for eval of pain

Naproxen 500mg [stamp, illegible]

Lab Results Discussed with patient? ☐ Yes ☐ No ☐ N/A

Patient Education Discussed: Yes ○ ○ No

Topics Discussed:
- ○ Advanced directive
- ○ Asthma
- ○ Breast self exam
- ○ Cholesterol
- ○ Dental
- ○ Diabetes
- ○ Diet/Nutrition
- ○ Exercise
- ○ Family planning
- ○ Hypertension
- ○ Injury prevention
- ○ Medications
- ○ Obesity
- ○ Prenatal care
- ○ STD's
- ○ Substance abuse
- ○ Testicular self exam
- ○ Tobacco cessation
- ○ Tuberculosis
- ○ Other

Patient verbalizes understanding? ☐ Yes ☐ No

Educational materials Given? ☐ Yes ☐ No

Describe

Instructed to call if problem persists ☐

Follow-up Visit
Days
Weeks:
Months:

Dreamweaver Medical Group
420 West Las Tunas Drive
San Gabriel, CA 91776
(626) 296-9500

Patient Name: Floreen Brooks

Date of Birth: 6-20-49

PROGRESS NOTE: ADULT