Management Services, Inc.
Ontario, CA 91761
Phone: (855) 238-4936 ◆ Fax: (909) 942-8918
www.sedgwick.com

sedgwick.

May 3, 2019

MARVETTA JOHNSON
1022 WEST 138TH STREET
Compton, CA 90222

Chiro Panel

RE:

Employee:	MARVETTA JOHNSON
Employee No.:	254656
Dept. No./Name:	County of Los Angeles/Probation
Claim No:	419-02165-D
DOI:	03/14/2019

NOTICE OF DELAY OF CLAIM FOR WORKERS' COMPENSATION BENEFITS

I am handling your workers' compensation claim on behalf of the County of Los Angeles. This notice is to advise you of the status of workers' compensation benefits for your claimed injury referenced above.

Workers' compensation benefits are being delayed because we need medical evidence to substantiate industrial causation, witness statements and our complete employer level investigation. We will notify you of our decision on or before **7/18/19**.

This delay of claim is related to a medical issue. To resolve this issue and allow me to make a determination on your entitlement to benefits, a comprehensive medical evaluation maybe needed. Enclosed is a form that you must submit to the state Department of Workers' Compensation (DWC) within **10 days** to request a panel of three Qualified Medical Evaluators (QMEs). If you do not submit the form within **10 days** we will have the right to submit the form. In addition, within **10 days** after the DWC sends you a panel, you must choose a QME from the panel, make an appointment to be examined by the QME, and inform me of your choice and appointment time. If you inform us of your choice but you do not arrange the appointment, we will arrange the appointment. If you do not inform us of your choice, we may choose the QME who will examine you and arrange the appointment.

Although workers' compensation benefits have been delayed, you may still be eligible to continue receiving short term or long term disability benefits through the County. For more information on these disability benefits, please call the Sedgwick Disability Claims Office at 1-800-786-8600.

For claims reported on or after April 19, 2004, regardless of the date of injury, if you submitted a claim form to your employer or claim administrator, Labor Code section 5402 (c) provides that within one working day after you file the claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide such medical treatment until the claims administrative accepts or denies liability for the claim. Until the date the claim is accepted or rejected, liability for medical treatment under this Labor Code section shall be limited to a maximum of ten thousand dollars ($10,000). Unless you have done so already, you should immediately send for consideration of payment, all bills for medical services provided from the date the completed claim form was given to the employer.

Sedgwick cannot agree at this time to provide notices electronically via email.

[redacted]formation may be found in the publication: **Workers' Compensation in California: A Guidebook for [redacted]red Workers**. A complete copy of the Guidebook may be obtained on the Division of Workers' Compensation website (see URL below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation. Chapters 2, 4, and 9 of the Guidebook contain information addressing the determination of liability for a workers' compensation claim and the QME process.

Guidebook for Injured Workers: http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html

Chapter 2: After You Get Hurt on the Job:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter2.pdf

Chapter 4: Resolving Problems with Medical Care and Medical Reports:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter4.pdf

Chapter 9: For More Information and Help:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter9.pdf

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

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call me, CHRISTINE ROWNEY, at (909)942-8936. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not me.

For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an information and assistance (I&A) officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call (800) 736-7401.

Keep this notice. It contains important information about your workers' compensation benefits.

Sincerely,
Sedgwick Claims Management Services, Inc.

CHRISTINE ROWNEY
(909)942-8936

Enc: QME Panel Form (QME Form 105 and attachment)

Cc: File
County of Los Angeles/Probation

PROOF OF SERVICE BY MAIL

1013a(3) CCP Revised 5/01/88

(RE: MARVETTA JOHNSON, County of Los Angeles)

STATE OF CALIFORNIA, COUNTY OF SAN BERNARDINO

I, the undersigned, hereby declare that I am over the age of eighteen years and not a party to the within action. I am employed in the County of San Bernardino and my business address is P.O. Box 51350, Ontario, CA 91761.

On 5/3/19, I served the foregoing document(s)described as:

DWC-Delay Benefit Notice, QME Panel Form (QME Form 105 and attachment)

on all interested parties in this action by placing a true copy thereof in a sealed envelope with postage thereon fully prepaid, in the United States Mail at Ontario, California, addressed as follows:

MARVETTA JOHNSON
1022 WEST 138TH STREET
Compton, CA 90222

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

CHRISTINE ROWNEY
DECLARANT NAME

DECLARANT SIGNATURE

State of California, Division of Workers' Compensation

REQUEST FOR QUALIFIED MEDICAL EVALUATOR PANEL
(Unrepresented Employee)

TO REQUEST A QUALIFIED MEDICAL EVALUTOR (QME) PANEL FOR AN UNREPRESENTED EMPLOYEE:

1. **Complete this form (print or type the information). Sign and date at bottom.**
2. **If the request is made to determine if the injury is work-related, include a copy of the claims administrator's notice that the claim was denied, or a copy of the claims administrator's request for an evaluation.**
3. **Complete the attached Proof of Service.**
4. **For Employee: Mail the completed signed form and Proof of Service to:**
   Division of Workers' Compensation – Medical Unit
   P.O. Box 71010, Oakland, CA 94612
   (510) 286-3700 or (800) 794-6900
5. **For Employee: Mail or deliver a signed copy of the form and Proof of Service to your Claims Administrator.**
6. **For Claims Administrator/Defense Attorney: Mail the completed signed form, attach a copy of the written objection to an opinion of a treating physician, and Proof of Service, to the Medical Unit with a copy served to the Employee.**

Panel Request Information:

Date of Injury: 03/14/2019 Claim No: 419-02165-D Specialty Request: _____ (Select only ONE specialty)

Requesting Party: ☐ Employee ☐ Claims Administrator ☐ Defense Attorney

Reason for QME Panel Request (check one):

☐ To determine if the injury is work-related (attach claims administrator's notice that claim was denied or a copy of the claims administrator's request for an evaluation).

☐ Objection to Primary Treating Physician's determination regarding temporary disability, permanent disability, or the need for future medical care.

☐ Work injury claim is accepted for one of more body parts, there is a dispute over additional body parts.

☐ Other (specify non-medical treatment dispute): _____

Employee Information

First Name: _____ Middle Initial: _____ Last Name: _____

Street Address of P.O. Box: _____

City: _____ State: _____ Zip Code: _____

If currently not living in state, enter the California zip code on date of injury: _____

If never resided in state, enter the California zip code agreed on for the evaluation: _____

Employer/Claims Administrator Information

Employer: COUNTY OF LOS ANGELES Zip Code of Employer: _____

Claims Administrator Company Name: SEDGWICK Adjuster/Contact Name (if known): _____

Street Address or P.O. Box: P.O. BOX 51350

City: Ontario State: CA Zip Code: 91761 Phone No.: _____

Requestor Signature: _____ Date: _____

PROOF OF SERVICE

Instructions:

1. **Complete the Proof of Service.**
2. **For Employee: Mail the completed signed form and Proof of Service to:**
   Division of Workers' Compensation – Medical Unit
   P.O. Box 71010, Oakland, CA 94612
   (510) 286-3700 or (800) 794-6900
3. **For Employee: Mail or deliver a signed copy of the form and Proof of Service to your Claims Administrator.**
4. **For Claims Administrator/Defense Attorney: Mail the completed signed form attach a copy of the written objection to an opinion of a treating physician, and Proof of Service, to the Medical Unit with a copy served to the Employee.**

I declare that I am a resident of or employed in the county of _____, California; I am over the age of eighteen years.

On _____, I served the attached completed Form 105 on the following parties:

☑ By mail to:

SEDGWICK
Name of Employee or Claims Administrator

PO BOX 51350
Street Address

ONTARIO, CA 91761
City, State, Zip Code

☐ By hand-delivery to:

_____
Name

_____
Street Address

_____
City, State, Zip Code

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

Executed on _____, at _____, California

Type or Print Name: _____

Signature: _____

For Use with the QME Panel Request Form 105

MD/DO SPECIALTY CODES

MAA	Anesthesiology
MAI	Allergy and Immunology
MPA	Pain Medicine
MDE	Dermatology
MAI	Dermatology – Allergy & Immunology
MEM	Emergency Medicine
MTT	Emergency Medicine - Toxicology
MFP	Family Practice
MPM	General Preventative Medicine
MTT	General Preventative Medicine - Toxicology
MMM	Internal Medicine
MAI	Internal Medicine - Allergy and Immunology
MMV	Internal Medicine – Cardiovascular Disease
MME	Internal Medicine – Endocrinology Diabetes and Metabolism
MMG	Internal Medicine - Gastroenterology
MMH	Internal Medicine - Hematology
MMI	Internal Medicine – Infectious Disease
MMO	Oncology – Internal Medicine
MMN	Internal Medicine - Nephrology
MMP	Internal Medicine – Pulmonary Disease
MMR	Internal Medicine - Rheumatology
MPN	Neurology
MPA	Neurology - Pain Medicine
MNS	Neurological Surgery *(other than Spine)*
MNB	Neurological Surgery - Spine
MOG	Obstetrics and Gynecology
MOQ	Medicine Otherwise Qualified
MPO	Occupational Medicine
MTT	Occupational Medicine - Toxicology
MOP	Opthalmology
MOS	Orthopaedic Surgery *(other than Spine or Hand)*
MNB	Orthopaedic Surgery - Spine
MHH	Orthopaedic Surgery - Hand
MTO	Otolaryngology
MHA	Pathology
MPR	Physical Medicine & Rehabilitation
MPA	Physical Medicine & Rehabilitation - Pain Medicine
MPS	Plastic Surgery *(other than Hand)*
MHH	Plastic Surgery - Hand
MPD	Psychiatry *(other than Pain Medicine)*
MPA	Psychiatry – Pain Medicine
MSY	Surgery *(other than Spine or Hand)*
MHH	Surgery - Hand
MSG	Surgery – General Vascular
MTS	Thoracic Surgery
MUU	Urology

NON-MD/DO SPECIALTY CODES

ACA	Acupuncture
DCH	Chiropractic
DEN	Dentistry
OPT	Optometry
POD	Podiatry
PSY	Psychology

Do not file this page with your form!

State of California, Division of Workers' Compensation

REQUEST FOR QUALIFIED MEDICAL EVALUATOR PANEL
(Unrepresented Employee)

TO REQUEST A QUALIFIED MEDICAL EVALUATOR (QME) PANEL FOR AN UNREPRESENTED EMPLOYEE:

1. **Complete this form (print or type the information). Sign and date at bottom.**
2. **If the request is made to determine if the injury is work-related, include a copy of the claims administrator's notice that the claim was denied, or a copy of the claims administrator's request for an evaluation.**
3. **Complete the attached Proof of Service.**
4. **For Employee: Mail the completed signed form and Proof of Service to:**
   Division of Workers' Compensation – Medical Unit
   P.O. Box 71010, Oakland, CA 94612
   (510) 286-3700 or (800) 794-6900
5. **For Employee: Mail or deliver a signed copy of the form and Proof of Service to your Claims Administrator.**
6. **For Claims Administrator/Defense Attorney: Mail the completed signed form, attach a copy of the written objection to an opinion of a treating physician, and Proof of Service, to the Medical Unit with a copy served to the Employee.**

Panel Request Information :

Date of Injury: _____ **Claim Number:** _____ **Specialty Requested:** _____ (Select only ONE specialty)

Requesting Party: ☐ **Employee** ☐ **Claims Administrator** ☐ **Defense Attorney**

Reason for QME Panel Request (check one):

☐ To determine if the injury is work-related (attach claims administrator's notice that claim was denied or a copy of the claims administrator's request for an evaluation).
☐ Objection to Primary Treating Physician's determination regarding temporary disability, permanent disability, or the need for future medical care.
☐ Work injury claim is accepted for one or more body parts, there is a dispute over additional body parts.
☐ Other (specify non-medical treatment dispute): _____

Employee Information

First Name: _____ Middle Initial: _____ Last Name: _____

Street Address or P.O. Box: _____

City: _____ State _____ Zip Code: _____

If currently not living in state, enter the California zip code on date of injury: _____

If never resided in state, enter the California zip code agreed on for the evaluation: _____

Employer/Claims Administrator Information

Employer: _____ Zip Code of Employer: _____

Claims Administrator Company Name: _____ Adjuster/Contact Name (if known): _____

Street Address or P.O. Box: _____

City: _____ State: _____ Zip Code: _____ Phone No.: _____

Requestor Signature: _____ **Date:** _____

PROOF OF SERVICE

Instructions:

1.Complete the Proof of Service.

2. For Employee: Mail the completed signed form and Proof of Service to:
Division of Workers' Compensation – Medical Unit
P.O. Box 71010, Oakland, CA 94612
(510) 286-3700 or (800) 794-6900

3. For Employee: Mail or deliver a signed copy of the form and Proof of Service to your Claims Administrator.

4. For Claims Administrator/Defense Attorney: Mail the completed signed form attach a copy of the written objection to an opinion of a treating physician, and Proof of Service, to the Medical Unit with a copy served to the Employee.

I declare that I am a resident of or employed in the county of _____, California; I am over the age of eighteen years.

On _____, I served the attached completed Form 105 on the following parties:

☐ by mail to:

_____
Name of Employee or Claims Administrator

_____
Street Address

_____
City, State, Zip code

☐ by hand-delivery to:

_____
Name

_____
Street Address

_____
City, State, Zip code

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

Executed on _____, **at** _____, **California**

Type or Print Name: _____

Signature: _____

For Use with the QME Panel Request Form 105

MD/DO SPECIALTY CODES

MAA Anesthesiology
MAI Allergy & Immunology
MPA Pain Medicine
MDE Dermatology
MAI Dermatology – Allergy & Immunology
MEM Emergency Medicine
MTT Emergency Medicine – Toxicology
MFP Family Practice
MPM General Preventive Medicine
MTT General Preventive Medicine – Toxicology
MMM Internal Medicine
MAI Internal Medicine- Allergy & Immunology
MMV Internal Medicine – Cardiolvascular Disease
MME Internal Medicine - Endocrinology Diabetes & Metabolism
MMG Internal Medicine – Gastroenterology
MMH Internal Medicine – Hematology
MMI Internal Medicine – Infectious Disease
MMO Internal Medicine – Medical Oncology
MMN Internal Medicine – Nephrology
MMP Internal Medicine – Pulmonary Disease
MMR Internal Medicine – Rheumatology
MPN Neurology
MPA Neurology – Pain Medicine
MNS Neurological Surgery (other than Spine)
MNB Neurological Surgery – Spine
MOG Obstetrics & Gynecology
MOQ Medicine Otherwise Qualified
MPO Occupational Medicine
MTT Occupational Medicine – Toxicology
MOP Ophthalmology
MOS Orthopedic Surgery (other than Spine or Hand)
MNB Orthopedic Surgery - Spine
MHH Orthopedic Surgery - Hand
MTO Otolaryngology
MHA Pathology
MPR Physical Medicine & Rehabilitation
MPA Physical Medicine & Rehabilitation – Pain Medicine
MPS Plastic Surgery (other than Hand)
MHH Plastic Surgery – Hand
MPD Psychiatry (other than Pain Medicine)
MPA Psychiatry – Pain Medicine
MSY Surgery (other than Spine or Hand)
MHH Surgery - Hand
MSG Surgery- General Vascular
MTS Thoracic Surgery
MUU Urology

NON-MD/DO SPECIALTIES CODES

ACA Acupuncture
DCH Chiropractic
DEN Dentistry
OPT Optometry
POD Podiatry
PSY Psychology

Do not file this page with your form!

...VISION OF WORKERS' COMPENSATION

Minimizing the impact of work-related injuries and illnesses. Helping resolve disputes over workers' compensation benefits. Monitoring the administration of claims.

ANSWERS TO YOUR QUESTIONS ABOUT QUALIFIED MEDICAL EVALUATORS AND AGREED MEDICAL EVALUATORS

FACT SHEET E

Qualified medical evaluators (QMEs) or agreed medical evaluators (AMEs) examine injured workers to determine the benefits they will receive if there is a disagreement over the treating physician's opinions.

QMEs are physicians licensed to practice in California as medical doctors, osteopaths, chiropractors, psychologists, dentists, optometrists, podiatrists or acupuncturists and are certified by the Division of Workers' Compensation Medical Unit to perform medical/legal evaluations.

AMEs are physicians selected by agreement between the defense and applicant's attorneys to perform medical/legal evaluations in a workers' compensation case. AMEs are only used if the injured worker is represented by an attorney.

What's the difference between a QME and an AME?
If you have an attorney, your attorney and the claims administrator may agree on a doctor without using the state system for getting a QME. The doctor they agree on is called an AME. If they cannot agree, they must ask for a QME.

I've been to the doctor. Why do I need to see a QME?
You and/or the claims administrator might disagree with what the treating doctor says. There could also be other disagreements over medical issues in your claim. A different doctor -- an AME or QME -- has to address these disagreements, which might include:

- Whether or not your injury was caused by your work
- Whether or not you need treatment for your injury (only if date of injury is before Jan. 1, 2013)
- Whether or not you need to stay home from work to recover
- Whether your condition is permanent and stationary
- Whether you have new and further disability
- A permanent disability rating.

Who makes the decision about going to a QME?
You, your attorney or the claims administrator can request a QME exam.

The DWC Medical Unit will provide whomever makes the request with a list (called a panel) of three QMEs. Each QME panel is randomly generated and the physicians listed are specialists of the type requested. One physician from the list is chosen to examine you and make a report on your condition. Once a QME is chosen for your claim, most disputes must go to that QME.

How do I request a QME exam?
Complete the "Request for QME panel" form and submit it to the DWC Medical Unit. See Information & Assistance (I&A) guide 2 for help with this form.

NOTE: If your employer or claims administrator says there's a problem with your claim and sends you a "Request for QME panel" form, you have 10 days to complete the form, select the QME medical specialty and send the form to the DWC Medical Unit. If you do not submit the form within 10 days, the claims administrator will do it and will get to choose the kind of doctor you'll see.

What difference does it make who submits the form to request the QME?

[redacted]ubmits the request form picks the specialty of the doctor for the exam. See I&A guide 2 for [redacted] information. When you receive the panel, you will also receive a letter that explains how to set up the QME appointment and how to provide the QME with important information about yourself. Within 10 days of the date on the list, you must pick a QME from the list, make an appointment and tell the claims administrator. If you do not do this, the claims administrator may select the doctor and make the appointment for you.

Is there anything I can do if I disagree with what the QME says?
Yes, you have 30 days from the receipt of the report to decide if you agree with the QME's report or if you need more information. When you receive the report, read it right away and decide if you think it is accurate. If not, and you have an attorney, you should talk to him or her about your options.

If you don't have an attorney, first call the claims administrator. If that doesn't help, contact an I&A officer at your local Workers' Compensation Appeals Board (WCAB) district office. The I&A officer can help you figure out what's best in your case.

If you are in a union, you may be able to see an ombudsperson or mediator under the terms of your collective bargaining agreement or labor-management agreement.

I'm in a medical provider network (MPN). Does the QME process apply to me?
Yes, the QME process may still be utilized if you are part of a MPN.

I still have questions. Who do I contact?
If you have questions about requesting a QME panel, contact the DWC Medical Unit by phone at 1-800-794-6900 or by writing to: DWC Medical Unit, P O Box 71010, Oakland, CA 94612.

For more information, call 1-800-736-7401 or visit the DWC Web site at www.dwc.ca.gov to find a local I&A office. You may also download I&A guides and get information on workshops for injured workers.

Sedgwick Claims Management Services, Inc.
P.O. Box 51350
Ontario, CA 91761

sedgwick.

Phone: (855) 238-4936
Fax: (909) 942-8918

PROOF OF SERVICE BY MAIL

I, the undersigned, hereby declare that I am over the age of eighteen years and not a party to the within action. I am employed in the County of San Bernardino and my business address is: Sedgwick Claims Management Services, Inc., P.O. Box 51350, Ontario, CA 91761.

On ***5/20/19*** *I served the following:*

Q.M.E. Panel Request Form 105
Delay letter for claim #: 419-02165-D
Blank Q.M.E. Panel Request Form 105
DWC Fact Sheet E
Proof of Service

On the parties in said action by placing a true copy thereof in a sealed envelope with postage thereon fully prepaid, in the United States Mail at Ontario, California, addressed as follows:

MARVETTA JOHNSON
1022 WEST 138TH STREET
Compton, CA 90222

I declare under penalty of perjury that the foregoing is true and correct. Executed at Ontario, California on 5/20/19.

LINDA HAUGEN

Name of Declarant
Sedgwick Claims Management Services, Inc.

Linda Haugen

Signature of Declarant
Sedgwick Claims Management Services, Inc.

Sedgwick Claims Management Services, Inc.
P.O. Box 51350
Ontario, CA 91761

sedgwick.

Phone: (855) 238-4936
Fax: (909) 942-8918

5/20/19

Division of Worker's Compensation – Medical Unit
P.O. Box 71010
Oakland, California 94612

Re:	**Employee:**	**MARVETTA JOHNSON**
	Employer:	**County of Los Angeles/PROBATION**
	Claim No:	**419-02165-D**
	D/Injury:	**03/14/2019**

Dear Medical Unit:

Sedgwick Claims Management Services, Inc. is requesting a panel Q.M.E. for an unrepresented injured worker pursuant to section 4060, 4061 or 4062.

Please find the attached correspondence to the injured worker, which has gone unanswered since 5/3/19.

Sincerely,
Sedgwick Claims Management Services, Inc.

CHRISTINE ROWNEY
CLAIMS EXAMINER
(909)942-8936

cc: File 419-02165-D
MARVETTA JOHNSON

Enclosure: Q.M.E. Panel Request Form 105
Delay letter for claim #: 419-02165-D
Blank Q.M.E. Panel Request Form 105
DWC Fact Sheet E
Proof of Service

State of California, Division of Workers' Compensation

REQUEST FOR QUALIFIED MEDICAL EVALUATOR PANEL
(Unrepresented Employee)

TO REQUEST A QUALIFIED MEDICAL EVALUTOR (QME) PANEL FOR AN UNREPRESENTED EMPLOYEE:

1. **Complete this form (print or type the information). Sign and date at bottom.**
2. **If the request is made to determine if the injury is work-related, include a copy of the claims administrator's notice that the claim was denied, or a copy of the claims administrator's request for an evaluation.**
3. **Complete the attached Proof of Service.**
4. **For Employee: Mail the completed signed form and Proof of Service to:**
   Division of Workers' Compensation – Medical Unit
   P.O. Box 71010, Oakland, CA 94612
   (510) 286-3700 or (800) 794-6900
5. **For Employee: Mail or deliver a signed copy of the form and Proof of Service to your Claims Administrator.**
6. **For Claims Administrator/Defense Attorney: Mail the completed signed form, attach a copy of the written objection to an opinion of a treating physician, and Proof of Service, to the Medical Unit with a copy served to the Employee.**

Panel Request Information:

Date of Injury: 03/14/2019 Claim Number: 419-02165-D Specialty Requested: MOS (Select only ONE specialty)

Requesting Party: ☐ Employee ☑ Claims Administrator ☐ Defense Attorney

Reason for QME Panel Request (check one):

☑ To determine if the injury is work-related (attach claims administrator's notice that claim was denied or a copy of the claims administrator's request for an evaluation).

☐ Objection to Primary Treating Physician's determination regarding temporary disability, permanent disability, or the need for future medical care.

☐ Work injury claim is accepted for one of more body parts, there is a dispute over additional body parts.

☐ Other (specify non-medical treatment dispute): _____

Employee Information

First Name: MARVETTA Middle Initial: _____ Last Name: JOHNSON

Street Address of P.O. Box: 1022 WEST 138TH STREET

City: Compton State: CALIFORNIA Zip Code: 90222

If currently not living in state, enter the California zip code on date of injury: _____

If never resided in state, enter the California zip code agreed on for the evaluation: _____

Employer/Claims Administrator Information

Employer: COUNTY OF LOS ANGELES Zip Code of Employer: 90242

Claims Administrator Company Name: SEDGWICK Adjuster/Contact Name (if known): CHRISTINE ROWNEY

Street Address or P.O. Box: P.O. BOX 51350

City: Ontario State: CA Zip Code: 91761 Phone No.: (909)942-8936

5/20/19

Requestor Signature: _____ Date: _____

PROOF OF SERVICE

Instructions:

1. **Complete the Proof of Service.**
2. **For Employee: Mail the completed signed form and Proof of Service to:**
   Division of Workers' Compensation – Medical Unit
   P.O. Box 71010, Oakland, CA 94612
   (510) 286-3700 or (800) 794-6900
3. **For Employee: Mail or deliver a signed copy of the form and Proof of Service to your Claims Administrator.**
4. **For Claims Administrator/Defense Attorney: Mail the completed signed form attach a copy of the written objection to an opinion of a treating physician, and Proof of Service, to the Medical Unit with a copy served to the Employee.**

I declare that I am a resident of or employed in the county of San Bernardino, California; I am over the age of eighteen years.

On 5/20/19, I served the attached completed Form 105 on the following parties:

☑ By mail to:

MARVETTA JOHNSON
Name of Employee or Claims Administrator

1022 WEST 138TH STREET
Street Address

Compton, CA 90222
City, State, Zip Code

☐ By hand-delivery to:

Name

Street Address

City, State, Zip Code

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

Executed on 5/20/19, at Ontario, California

Type or Print Name: LINDA HAUGEN

Signature: Linda Haugen