1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Brotherhood Mutual Insurance
P.O. Box 2228
Fort Wayne, IN 46801
ATTN:Janice Gardner, Claims Repres

CARRIER

PICA

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE ☐ CHAMPUS (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER: 550613 (For Program in Item 1): Moazzaz

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Sarver, Victoria

3. PATIENT'S BIRTH DATE MM DD YY: 11 01 1966 SEX: M ☐ F ☑

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Lighthouse Community Church

5. PATIENT'S ADDRESS (No., Street): 666 W. 18th St., Apt. 4

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Costa Mesa STATE: CA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: 92627 TELEPHONE (Include Area Code): (949)933-8644

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE: P-QME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete Item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY: 09 01 2013 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: Board Certified Orthopaedic Surgeon

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. M60.9
2.
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 07 14 2018	07 14 2018	11		ML 104	95		2562.50	41		NPI	1538304704
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

*****NO PPO DISCOUNTS*****
MEDICAL - LEGAL REPORT
****REPORT ATTACHED****
*****SEE FEE DISCLOSURE*****

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
27-3146950	☑	176188-1	YES ☐ NO ☐	$ 2562.50	$ 0.00	$ 2562.50

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Payam Moazzaz, M.D.

SIGNED 07/23/2018 DATE

ALL CHECKS MUST BE SENT TO:
8221 N. FRESNO ST.
FRESNO, CA 93720

33. BILLING PROVIDER INFO & PH # ( )

Payam Moazzaz, M.D.
8221 N. Fresno St
Fresno, CA 93720

a. b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
PAYAM MOAZZAZ M.D. A PROFESSIONAL MEDICAL COPORATION

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:
☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☑ S Corporation ☐ Partnership ☐ Trust/estate
☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any)
Exemption from FATCA reporting code (if any)
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)
8221 N. FRESNO STREET

Requester's name and address (optional)

6 City, state, and ZIP code
FRESNO, CA 93720

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number
[ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

or

Employer identification number
2 7 - 3 1 4 6 9 5 0

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here | **Signature of U.S. person ▶** [signature] **Date ▶** 7-23-15

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Payam Moazzaz, M.D.

Board Certified Orthopaedic Surgeon
Fellow, American Academy of Orthopaedic Surgeons
Qualified Medical Evaluator

MAILING ADDRESS
8221 N. Fresno St
Fresno, CA 93720
(559) 222-2294

PANEL QUALIFIED MEDICAL EVALUATION

Brotherhood Mutual Insurance
P.O. Box 2228
Fort Wayne, IN 46801

RE:	SARVER, VICTORIA
DATE OF EVALUATION:	July 14, 2018
EMPLOYER	Lighthouse Community Church
DATE OF INJURY:	September 1, 2013
CLAIM NO:	550613
FILE NO:	176188-1

FEE DISCLOSURE

ML 104-95: This is a Qualified Medical Evaluation with Extraordinary Circumstances as a result of meeting the requirements of 4 complexity factors, which are listed below:

- 7 ½ hour(s) of record review time
- 30 minutes of face to face time
- 2 ¼ hour(s) of report preparation time
- 10 ¼ total hours of combined time
- Four hours or more of any combination of 2 complexity factors (2 factors)
- Addressing issues of causation (1 factor)
- Addressing issues of apportionment when the physician addresses: (1 factor)
    - 2+ injuries to 2 **DIFFERENT** body system or regions

****This is a medical legal report and does not qualify for a PPO/Network discount.**

Thank you for the opportunity to evaluate Victoria Sarver on Saturday, July 14, 2018 in my office at 1120 W. Warner Ave., Ste. A.

The history and physical examination is not intended to be construed as a general or complete medical evaluation. It is intended for medical legal purposes only and focuses on those areas in question. No treatment relationship is established or implied.

This medical-legal evaluation is based only on the current information and records submitted. It is solely the treating physician's responsibility to determine their patient's differential diagnoses and subsequent needs for medical treatment. This would be inclusive of all psychiatric conditions, vascular diseases, neuromuscular disorders, central nervous system disorders, auto-immune diseases, internal medicine disorders and all tumors, benign or malignant, even if they are undiagnosed or currently occult.

HISTORY OF INJURY

This is a very pleasant 51-year-old right-hand dominant woman who describes a history of multiple injuries she sustained while employed as a janitor at Lighthouse Community Church.

She describes a specific injury she sustained on December 20, 2013. She states that she was lifting up a vacuum and felt a sharp pain and popping sensation in her lower back as well as the right groin. She states that she felt a "bump" in the right groin that was subsequently diagnosed as a hernia. She reported the injury to her supervisor but states medical care was not offered to her. She continued working. She then saw her own personal physician who referred her to a hernia surgeon. She states she underwent surgery on December 25, 2013 for hernia repair. She states this required two surgeries due to complications but she is not sure of the details.

She also describes a history of cumulative trauma injury she sustained to multiple body parts from September 1, 2013 through September 1, 2017 also while employed as a janitor at Lighthouse Community Church. She states she developed pain involving her lower back, both knees, and both hands due to repetitive work including cleaning, mopping, moving furniture, lifting chairs, setting up for events, and cleaning up after

events. She states medical treatment was not offered by the employer for these injuries either. She continued working until June 2017 when she was terminated. She has had treatment since then with physical therapy, medications, and aquatic therapy. She describes persistent back pain and numbness and tingling in her hands and pain in both of her knees. She states she was terminated in June 2017 and has not worked since that time.

She also describes a third injury in which she was rear-ended in 2017 resulting in injury to her upper back and neck. She does not recall the details or date.

CURRENT MEDICAL TREATMENT

She is currently under the care of Dr. Savazen and sees her physician every three months. She is taking Norco as needed for pain. She is receiving physical therapy. She reports no change in her condition with the treatment provided to date. She has undergone multiple MRI studies but is not sure of the results.

PRESENT COMPLAINTS

She describes persistent pain in the lower back and bilateral knees with associated swelling. She states her lower back pain radiates to her right knee and right foot. She also describes stiffness in the lower back and shoulders and hands with associated numbness and tingling in her hands and right foot. She describes the pain as sharp and shooting and aching and feels this discomfort "most of the time." She rates her pain as an 8 on a 10-point scale. She states she can sit for up to 20 minutes, stand for up to 10 minutes, and walk for up to 20 minutes. She states she can lift up to 5 pounds now as compared to over 50 pounds prior to the injury.

She also describes difficulty with her activities of daily living including "difficulty" taking a bath normally, brushing her teeth, dressing herself, combing her hair, eating and drinking, going to the toilet, urinating, writing comfortably, typing on a computer, speaking clearly, standing, sitting, walking normally, climbing stairs, feeling what she touches, holding something without pain, opening windows at home, lifting a child, riding in a car for 30 minutes, flying in a plane, having sexual intercourse, and sleeping restfully.

EMPLOYMENT STATUS AND JOB DESCRIPTION

She worked for approximately 10 years as a janitor and grounds woman at Lighthouse Community Church. She is not sure of the dates. She worked 8 hours per day and over 40 hours per week. Her job duties involved cleaning, setting up for events, moving chairs and furniture, and cleaning up after events. She states there have been no periods of light or modified work duties. She states she has been completely off work since June 2017 when she was terminated.

PAST MEDICAL HISTORY

SURGERIES: Two hernia surgeries. Hysterectomy.

ILLNESSES: None.

INJURIES: As described above. She describes a history of a rear-end motor vehicle accident in which she injured her neck and upper back but she does not recall the details.

MEDICATIONS: Norco as needed.

EXAMINEE PROFILE

The claimant is divorced. The claimant smokes six cigarettes per day and drinks alcohol on special occasions. She denies any recreational drug use.

REVIEW OF MEDICAL RECORDS

I received 955 pages of extensive medical records for this claimant that are summarized below:

07/23/10. (**Signature Illegible**). Hoag Memorial E.D. Note. DOI: N.A. S: Fever, chills, sore throat. O: Pharyngeal erythema, lymphadenopathy. A: Pharyngitis, exudative. P: Prescription given Azithromycin, Medrol. Discharged home. (p. 441 MR2)

10/25/11. (**Signature Illegible**). E.D. Note. DOI: N.A. S: Headaches, vomiting. Can't keep anything down. O: Distress, anxious, tacky mucus membrane, hyperventilation. A: Vomiting, diarrhea. Dehydration. Anxiety. Hyperventilation. P: Counseling, Zofran. Discharged. (p. 438 MR2)

06/05/12. (**Signature Illegible**). E.D. Note. DOI: N.A. S: Chronic L4-L5 low back pain, nausea and vomiting. O: Left-sided abdominal tenderness. Bradycardia on EKG. Left adrenal cyst on CT. A: Vomiting. P: Counseling. Zofran. Laboratory studies. Discharged. (p. 435 MR2)

06/05/12. Richard Taketa, M.D. (Radiology). Abdomen & Pelvis CT. DOI: N.A. Results: Comparison with chest x-ray of 02/03/07. Nondistended small bowel loops with isolated air-fluid levels. No obstruction, no acute abnormality. Incidental 1.2 cm left adnexal cysts and isolated splenic granuloma. (p. 451 MR2)

06/05/12. Subbarao Myla, M.D. (Cardio). ECG Tracing. DOI: N.A. Results: Sinus rhythm. No significant change from 02/03/07. Normal electrocardiogram. (p. 454 MR2)

06/05/12. Hoag Memorial Hospital Presbyterian. Laboratory Report. DOI: N.A. Results: Chemistry noted high protein. Hemogram noted low RBC, high MCV and MCH. (p. 471 MR2)

12/05/12. (**Signature Illegible**). E.D. Note. DOI: N.A. HXOI: 3 weeks ago, lifted a vacuum and heard a pop. S: Pelvic pain, right side, down to leg with "bump." O: Distress, reducible hernia. A: Right femoral hernia. P: Counseling. Discharged. (p. 432 MR2)

04/23/15. Brian Grade, M.D. (E.R.). H&P. DOI: N.A. S: Vaginal bleeding. O: Small dark blood in vaginal vault. A: Vaginal bleeding. Uterine fibroid. P: IV fluids. Consult. Ultrasound. Counseling. Discharged. (p. 423 MR2)

04/23/15. Michael Roossin, M.D. (Radiology). Pelvis Ultrasound. DOI: N.A. Impression: Comparison with 02/04/02 study. 1.7 cm uterine leiomyoma. Unilocular cyst within each ovary measuring 2.5 cm on the left and 1.7 cm on the right. (p. 449 MR2)

04/23/15. Hoag Memorial Hospital Presbyterian. Laboratory Report. DOI: N.A. Results: Chemistry panel noted low carbon monoxide and ALK Phos and high

glucose and SGOT/AST. Hemogram noted high WBC, MCH, and low RBC. Differential noted high %neutro and neutro, and low %lymph. (p. 465 MR2)

04/27/16. Mark Chen, M.D. (Radiology). Chest X-Ray. DOI: N.A. Impression: Comparison made with 02/03/07 study. No evidence of acute cardiopulmonary disease. (p. 447 MR2)

04/27/16. Brian Chesnie, M.D. (Cardio). ECG Tracing. DOI: N.A. Results: Sinus rhythm. No significant change compared to 06/05/12. Normal electrocardiogram. (p. 448 MR2)

04/27/16. Hoag Memorial Hospital Presbyterian. Laboratory Report. DOI: N.A. Results: Hemogram noted low RBC, HCT, and high MCH and RDW-SD. Differential noted high %neutro. (p. 458 MR2)

04/28/16. Roya Rakhshani, M.D. (Ob-Gyn). H&P. DOI: N.A. S: Heavy bleeding. History of hernia repair and chronic back pain. O: Uterus diffusely enlarged, tender to motion. A: Menorrhagia, pelvic pain. P: Laparoscopic robotic assisted hysterectomy, bilateral salpingo-oophorectomy, possible exploratory laparotomy. (p. 416 MR2)

04/29/16. Roya Rakhshani, M.D. (Ob-Gyn). Operative Report. DOI: N.A. Pre-op DX: Chronic pelvic pain and menorrhagia, unresponsive to medical treatment. Post-op DX: Adhesions and probable adenomyosis. Procedures Performed: Laparoscopic robotic-assisted hysterectomy, bilateral salpingo-oophorectomy and lysis of adhesions. (p. 410 MR2)

05/02/16. John Cupp, M.D. (Pathology). Pathology Report. DOI: N.A. Impression: Cervix with no significant pathologic abnormality. Secretory endometrium; no malignancy. Adenomyosis and leiomyomata. Bilateral fallopian tubes and ovaries with no significant pathologic abnormality. (p. 463 MR2)

06/15/17. Munazza Khan, M.D. (I.M.). Office Visit. DOI: N.A. HXOI: Car accident. S: Dizziness, neck and bilateral knee pain. O: Normal physical exam. A: Anxiety. Back pain. Weight loss. Knee and right elbow pain. P: Chest x-ray, head CT. Cyclobenzaprine, diclofenac sodium, Valium, discontinue Xanax. Follow-up in 4 to 6 weeks. (p. 767 MR2)

09/06/17. M. Mohsin Shah, M.D. (Neurology). Initial Report. DOI: 06/07/17. S: Pain. O: Tremors, limited motor examination due to pain, spasm. A: Postconcussion syndrome. Posttraumatic stress disorder. Depression. Cervical myospasm. Sprain, lumbar spine. Low back pain. Based on the information available, it does appear that the patient's complaints are related to the June 7, 2017 accident. P: Transcranial magnetic stimulation. Psych evaluation. Ortho referral. Follow-up in 1 month. (p. 823 MR2)

10/04/17. M. Mohsin Shah, M.D. (Neurology). Interim Report. DOI: 06/07/17. S: Paralyzed to do anything due to grief. Has not been able to work hence she was fired. Tearful, anxious, nervous, difficulty in focus, concentration, short-term memory and judgment. O: Sad mood, spasm. A: Head concussion. Postconcussional syndrome. Severe depression. Posttraumatic disorder. P: Transcranial magnetic stimulation. Paxil. 20-lbs. weight restriction until feeling better. Follow-up in 2 to 3 months. (p. 817 MR2)

01/11/18. Harold Iseke, D.C. (Chiro). Initial Report. DOI: 08/30/17, CT 09/01/13 – 09/01/17. S: Headaches, pain in the upper, mid & low back, R elbow, forearm & hand, B knees, abdominal pain, loss of sleep, stress. Gradual onset of pain due to her job duties. O: Tenderness, positive ortho tests. A: Headaches. Thoracolumbar spine sprain. Pain in the R elbow, R hand, B knees, lower back, R ankle & abdomen. P: MRIs. Acupuncture, chiro treatment. Ortho and Hernia specialist referrals. TTD. (p. 4 MR1)

01/11/18, 01/25/18. Harold Iseke, D.C. (Chiro). Treatment Notes. (p. 904 MR2)

DEPO DATE: 01/19/18. EXAMINEE NAME: Victoria Sarver. DOB: 11/01/66. DOI: 08/30/17; CT 09/01/13 to 09/01/17. (p. 1 MR2)

The applicant stated her full name as Victoria Marleen Sarver. She noted seeing Dr. Iseke last week. She took Valium last night. It was prescribed by Dr. Khon, her primary doctor for seven years.

She had filed two claims – one for a specific injury that occurred on 08/30/17. This involved an incident wherein she was forced on her knees in the middle of the parish crowd to wash the floors. This caused her stress, sleep problems, depression, and mental anguish resulting in flashbacks. Her other claim happened over a period of time – from 09/01/13 to 09/01/17 wherein she is alleging stress and strain from

repetitive work, causing headache, as well as pain in the neck, shoulders, arms, wrists, lower back and lower extremities.

She is scheduled for an appointment today with Dr. Michael Shabazian, a pain specialist, whom she has been seeing for three years now. However, she canceled this for next week. She is seeing Dr. Shabazian for the pain in her back, knees and foot.

She is residing at West 18th Street with her daughter, Olivia Rogers. Her oldest daughter, Lindsey Richardson, would come and stay once in a while. She was married to Henry Rogers once. They got divorced in 2015. She was able to present her driver's license to the counsel.

About 17 years ago, she spent time in jail for a DUI. She was a victim of burglary in 2015 when a man broke into the church and stole her money. She was saving up for the divorce and had kept the money in the church office. This caused her financial stress. About 20 years ago, Lindsey's father, used to beat her up. She tried to have him arrested but the cops would not do it. His uncle was the chief of the Sheriff's Department.

She was involved in an automobile accident on 06/07/17, and sustained injuries to her knees and lower back. She saw Dr. Khon, and then Dr. Greenoak. She saw Dr. Greenoak four or five times, and then stopped because she did not like him. Her lawyer also sent her to Dr. Shaw for depression.

She is using CB, which she rubs on her body to help with the pain.

Around 25 years ago, she underwent drug counseling. She was partying too much and did not like it. She wanted then to make sure that she got help before it got out of hand.

Two years ago, the applicant sought counseling in relation to several incidents with Pastor Leigh. The first incident took place in 2014. While in the sanctuary, she had just moved all the chairs when Pastor Leigh came in. She thought that Pastor Leigh was going to give her a hug and say "thank you" for moving the chairs. Instead, the pastor "French-kissed me, and open mouth." She felt shock and grossed out. She turned around, walked out, and left for the whole day. The next day, Pastor Leigh called her to the office. The pastor wanted to discuss what happened, but she refused. She noted that she was scared. She did not want anyone to get hurt. The pastor's wife was a very good friend of hers.

A couple of months later, when she and Henry were going through the divorce, "It started to get weird." When asking for advice from the older women, she would be told to go and talk to Pastor Leigh. However, she could not go to him, as the pastor would say little comments that were inappropriate. She never reported the incidents because she was scared to lose her job.

By 2015, when Lindsey told her that Pastor Leigh was "patting her on the ass in an inappropriate way," the applicant went straight to Eric. She told Eric that she needed to speak to him away from the church campus. Eric came to her house with another elder of the church, Rich Rapolli. She told them everything that had happened. They told her that they would talk to Pastor Leigh.

A couple of days later, she received a phone call from Eric. She was told that Pastor Leigh "did not deny what was said." The applicant asked if she could work during nighttime. She added that Eric did not care when she got her work done, as long as she got it done. Eric told all the elders what happened during a meeting. As a result, the applicant felt belittled. "They made me do things I never had to do before." She was not allowed to volunteer anymore. They kept cutting her hours. She now had to lift heavy things on her own, causing burning pain in her back.

Eric offered his mother to be her mentor so she could cope up with this. The applicant received a lot of phone counseling from Eric's mother, Cindy Wayman. She only met Cindy twice.

The applicant got divorced in 2015. As of 01/2016, Pastor Leigh told her, "Now that you're divorced, does that mean we can date?"

The applicant admitted to being disciplined during her last year at least four times. She stated that after 10 years, she was now getting written up for leaving a light on, not calling when she had called certain times, and doing certain things. She felt that it was unfair.

The deposition proceedings commenced at 2:20 p.m. and concluded at 4:50 p.m.

02/26/18. Harold Iseke, D.C. (Chiro). PR-2. DOI: 08/30/17, CT 09/01/13 – 09/01/17. S: Headaches, pain in the upper, mid and low back, R elbow, forearm & hand, B knees, abdominal pain. O: Decreased ROM, tenderness diffusely, diffuse spasm including "spasm of superior border of patella". "Valgus is positive. Varus is

positive." A: Headaches. Thoracolumbar spine sprain. Pain in the R elbow, R hand, B knees, lower back, R ankle & abdomen. P: MRIs. Acupuncture, chiro treatment. Ortho & hernia consult. TTD. (p. 13 MR1)

DEPO VOLUME II DATE: 05/11/18. EXAMINEE NAME: Victoria Sarver. DOB: N.A. DOI: 08/30/17. (p. 133 MR2)

The applicant's last deposition took place on 01/19/18. She noted working for the managers of her apartment about four months ago, cleaning up the kitchen for about two hours.

She presented her driver's license to the attorney. She took Norco in the past eight hours as prescribed by Dr. Shahbazian for the pain in her lower back. She is also receiving injections from this doctor.

She is claiming that she injured her low back while working at the church. Prior to her auto accident, she was experiencing low back pain from moving chairs and stuff. "It just went out one day."

She mentioned to Dr. Shahbazian about her auto accident in 2017, as well as to Dr. Khan. She noted seeing Dr. Shah, but this doctor does not know about her worker's comp case since has never brought it up. She is seeing Dr. Shah for her head and depression. The applicant indicated that she started to have depression about four years ago – "the way that things were going in my life." She was then going through a divorce, her daughter was leaving home, the church, and a lot of things at once.

Dr. Khan had prescribed Paxil. However, she stopped taking this medication about two months ago. It was Dr. Khan who referred her to Dr. Shahbazian.

She saw Dr. Shah on 09/06/17 in regard to her auto accident wherein she injured her knees and lower back. She also injured her right elbow. She recalled that the toenail of her left big toe just came off. She mention to the doctor that her "head is getting weird."

The applicant believed that she was fired from the church because they just did not want her around.

On 08/30/17, the applicant is alleging that she was forced to go down on her knees before a crowd by Nissim. Nissim was working in the offices that were getting

redone. Since his wife works in the church, he also does maintenance stuff. The applicant told Nissim that she would wipe off the floor after she got her work done. However, Nissim told her, "Clean it up now." There was a lot of drywall pieces and dust outside the office. Nissim wanted the mess outside the door to be cleaned first, before she could clean the inside of the office. The applicant indicated that Nissim was being "a jerk." She swept up the dust and drywall pieces, and started doing inside the office. She got embarrassed after that, as she saw Robin and Jeannie (office manager) laughing and giggling about it.

When she went to Robin's office, she asked what was that all about. Robin only shrugged it off. The applicant noted that Robin is one of those to whom she was close to in the office.

The applicant could not recall what happened next. All she knew was that she was getting pulled in a lot of different directions on that day. She added that her knees were "really swollen from the accident still." It was really bad. Jeannie took her home that day, as she did not have her car yet from the accident. Her knees swelled up from using "wipies" when washing the floors.

The applicant believed that the harassment she was experiencing was a continuation of her disclosure related to sexual harassment by Pastor Leigh. She could not recall if she was sexually harassed on August 30th.

As of August 30, she did have depression from three things – the events of August 30th, the auto accident, and the treatment she was receiving from certain people before August 30.

Before the 08/30/17 incident, the applicant was counseled by Eric Wayman for poor work performance. She was written up on four occasions, which she felt was unfair.

When she saw Dr. Shah in the beginning of September last year, her main concern was the foggy state of her mild. She described being slow. Words would not come to her right away. She started to notice this after the auto accident.

In regard to the 08/30/17 incident wherein she had to go on her knees to clean up the mess, she affirmed that she felt embarrassed during that situation. She felt belittled. At that time, she had pain in the lower back and knees. When Nissim wanted her to clean up the floor, "It hurt really bad."

She is treating with Dr. Iseke. She does not believe that she has a future appointment with this doctor. The doctor has not released her, but she does not know if she can get there or not. She noted that she could not drive far. She would get panic attacks even when driving.

The applicant affirmed that she does not know her rights about Workman's Compensation. The church administration did not give her any form or paperwork to complete regarding her pain.

The proceedings commenced at 10:38 a.m. and concluded at 2:50 p.m.

DIAGNOSTIC TESTING

No new imaging studies were obtained today.

PHYSICAL EXAMINATION

GENERAL

General Appearance:

Height is 5 feet 2 inches and weight is 103 pounds.

The examinee has a well-nourished appearance and well-groomed hygiene.

She appeared to be in no distress. She displays appropriate emotional affect.

The examinee sits comfortably. The claimant requires no assistance getting up and down from the exam table.

Posture:

The examinee stands with a level pelvis, level shoulders, and straight spine. The claimant's head is centered over the shoulders.

Gait:

The examinee ambulates with a normal gait with good heel strike and toe off and presents without any assistive devices. The claimant is unable to heel walk, toe walk, or squat.

CERVICAL SPINE

Inspection:

There is no evidence of scars, swelling, abrasions, puncture wounds, or discoloration.

Palpation:

There is no tenderness to palpation over the cervical paraspinal musculature bilaterally. There is no muscle spasm or tightness noted.

Range of Motion:	Normal Average	Measured
Flexion	50°	50°
Extension	60°	60°
Right Lateral Bending	45°	45°
Left Lateral Bending	45°	45°
Right Rotation	80°	80°
Left Rotation	80°	80°

Deep Tendon Reflexes:	Right	Left
Biceps	2+	2+
Triceps	2+	2+
Brachioradialis	2+	2+
Hoffman's	Negative	Negative

Sensory:

Sensation is intact to light touch and pinprick in all dermatomes in the bilateral upper extremities.

Motor:	Right	Left

Deltoid	5/5	5/5
Biceps	5/5	5/5
Triceps	5/5	5/5
Brachialis	5/5	5/5
Wrist Extensors	5/5	5/5
Wrist Flexors	5/5	5/5
Hand Abductors	5/5	5/5

Vascular:	Right	Left
Radial Pulse	2+	2+
Ulnar Pulse	2+	2+

SHOULDERS

Inspection:

The examinee has normal symmetry and movement of the shoulders with walking. The contour and posture are symmetrical on the right and the left. There are no areas of discoloration, abrasions or scars present.

Palpation:

The anterior aspect of the acromion is not tender. The bicipital groove is not tender. The subdeltoid bursa is not tender, and there is no sign of inflammation.

There is no palpable defect, crepitus or tenderness at the acromioclavicular joint.

The superior, vertebral and lateral borders of the scapula are not tender. There is no tenderness of the axilla. Latissimus dorsi and pectoralis major are not tender from its origin to its insertion.

Range of Motion:	Normal	Right	Left
Abduction	0 – 180	0 – 180	0 – 180
Adduction	0 – 30	0 – 30	0 – 30
Flexion	0 – 180	0 – 180	0 – 180
Extension	0 – 40	0 – 40	0 – 40
Internal Rotation	0 – 80	0 – 80	0 – 80

External Rotation	0 – 90	0 – 90	0 – 90

There is normal scapulothoracic movement and normal glenohumeral joint motion.

Neurological

There is no evidence of injury to the suprascapular, axillary, or long thoracic nerves.

Motor	Right	Left
Abduction	5/5	5/5
Flexion	5/5	5/5
Adduction	5/5	5/5
External Rotation	5/5	5/5
Internal Rotation	5/5	5/5
Scapular Elevation	5/5	5/5
Entire Shoulder Girdle	5/5	5/5

Special Testing:

There is no anterior, posterior, inferior, or multidirectional instability noted.

Examination of the shoulders for impingement reveals negative Neer and Hawkin's impingement testing of the shoulder bilaterally. There is no weakness with rotator cuff strength testing.

There is no combination of instability and impingement noted.

ELBOWS

Inspection:

There is no obvious deformity of the carrying angle. There is no evidence of scar or abrasion noted. There is no diffuse or localized swelling noted.

Palpation:

There is no tenderness around the ulnar notch where the ulnar nerve passes. Tinel's test is negative. There is no tenderness of the medial epicondyle. There is no tenderness of the wrist flexors.

There is no evidence of tennis elbow noted. There is no tenderness of the radial head. There is no tenderness of the lateral epicondyle. There is no tenderness of the wrist extensors.

There is no tenderness of the radial and ulnar collateral ligaments. There is no tenderness or defect noted to the areas of the olecranon bursa or along the course of the triceps muscle. There is no tenderness or defect noted at the biceps muscle insertion or the cubital fossa.

Range of Motion:	Normal	Right	Left
Flexion	0 – 150	0 – 150	0 – 150
Pronation	0 – 90	0 – 90	0 – 90
Supination	0 – 90	0 – 90	0 – 90

Motor:	Right	Left
Flexion	5/5	5/5
Extension	5/5	5/5
Supination	5/5	5/5
Pronation	5/5	5/5

Vascular:

Circulations to the upper extremities are without compromise.

Special Testing:

There is no ligamentous instability noted.

WRIST AND HANDS:

Inspection:

The skin is intact. No laceration, abrasions, contusions or puncture wounds are visualized. The examinee splints the right hand.

Palpation:

There is no tenderness over the anatomical snuffbox or radial styloid on palpation. There is tenderness over the carpal tunnel bilaterally. Tinel sign is negative. Phalen's test with the wrist flexed to 90 degrees to reproduce symptoms of carpal tunnel syndrome is negative. Finkelstein test for De Quervain's tenosynovitis is negative.

Range of Motion:

Wrist:	Normal	Right	Left
Palmar Flexion	0 – 60	0 – 60	0 – 60
Dorsal Flexion / Extension	0 – 60	0 – 60	0 – 60
Radial Deviation	0 – 20	0 – 20	0 – 20
Ulnar Deviation	0 – 30	0 – 30	0 – 30

Neurological:

Sensory examinations of the hands are within normal limits.
Motor examinations of the hands are within normal limits.

Vascular:

Allen test is negative. Radial pulse is 2+. Capillary refill to all digits is normal. The nail beds blanch normally.

Special Testing:

The flexor digitorum profundus and flexor digitorum superficialis tendons are intact in the index, long, ring and small fingers. The flexor pollicis longus tendons are intact to the thumb. Ligamentous examination of each joint is within normal limits. There is no laxity noted. For composite motion of flexion, the fingertips touch the distal palmar crease. The wrist flexors and extensors are strong.

Measurements:	Right	Left
Biceps	22 cm	22 cm

Forearms	17 cm	17 cm

Jamar Dynamometer Grip Strength Testing: (in kilograms)

Right Hand:	First Trial	2
	Second Trial	2
	Third Trial	2
Left Hand:	First Trial	8
	Second Trial	6
	Third Trial	8

LUMBAR SPINE:

Inspection:

Inspection reveals no evidence of scars, abrasions, punctures, or discolorations.

Palpation:

There is no tenderness to palpation of the midline lumbar spinous processes. There is tenderness to palpation along the paraspinous muscles on the right over the lumbar spine and no tenderness over the sacrococcygeal area. There is no appreciable muscle spasm. There is no muscle spasm. There is pain with range of motion testing.

Range of Motion:	Normal Average	Measured
Flexion	60°	40°
Extension	25°	10°
Right Side Bending	25°	25°
Left Side Bending	25°	25°

Deep Tendon Reflexes:	Right	Left
Knee	2+	2+
Ankle	2+	2+
Clonus	Negative	Negative
Babinski's	Negative	Negative

Sensory:
Sensation is intact to light touch and pinprick in all dermatomes in the bilateral lower extremities.

Motor:	Right	Left
Quadriceps	5/5	5/5
Hamstrings	5/5	5/5
Tibialis Anterior	5/5	5/5
Extensor Hallucis Longus	5/5	5/5
Gastroc Soleus Complex	5/5	5/5
Peroneals	5/5	5/5

Vascular:	Right	Left
Posterior Tibialis	2+	2+
Dorsalis Pedis	2+	2+

Special Testing:	Right	Left
Sitting straight leg raise	Negative	Negative
Lasègue sign	Negative	Negative

Waddell Signs:

Pain with subcutaneous pinching	Negative
Pain with axial compression	Negative
Pain with trunk rotation	Negative
Symptom magnification	Negative

HIPS:

Inspection:

There is no evidence of abrasions, scars, skin discoloration, or puncture wounds.

Palpation:

There is no tenderness to palpation over the greater trochanter, anterior aspect of the groin, sciatic notch, or adductor muscles.

Range of Motion:	Right	Left
Flexion	100	100
Extension	30	30
Internal Rotation	40	40
External Rotation	50	50
Abduction	40	40
Adduction	20	20

Neurological:

Sensation and motor examination of the hips are within normal limits.

Special Testing:

FABER/Patrick's test is negative.

KNEES:

Inspection:

There is no obvious bony or arthritis deformity. There are normal shapes and contours present. Skin is intact, with no visible lacerations, abrasions, contusions or previous scars. There is no evidence of incision. There is no joint effusion present in the knees bilaterally. There is no increase in local temperature to touch over the knee. There is no evidence of Baker cyst present in the knee. There is no evidence of prepatellar bursa.

Palpation:

There is no tenderness with palpation over the medial joint line bilaterally. There is no tenderness with palpation over the lateral joint line. The fat pad is not tender. There is no tenderness over the lateral femoral condyle. There is tenderness with patellofemoral compression bilaterally. There is clicking beneath the patella bilaterally.

Range of Motion:	Normal	Right	Left
Extension	0	0	0
Flexion	150	120	120

Neurological:

Sensory and motor evaluation is normal in both knees. Vascular status is intact.

Special Testing:	Right	Left
McMurray Sign	Negative	Negative
Drawer Sign	Negative	Negative
Lachman Sign	Negative	Negative

There is no medial collateral ligamentous laxity. There is no lateral collateral ligamentous laxity. There is no anterior cruciate ligamentous laxity present.

ANKLES AND FEET:

Inspection:

Visual inspection reveals no evidence of deformity, abrasion, scars, or puncture wounds. There is no swelling noted.

Palpation:

Palpation of the feet and ankles reveal no areas of tenderness. The malleoli, lesser toes, big toes, heels, and metatarsals are non-tender.

Ankle Range of Motion:	Normal	Right	Left
Extension	20	20	20
Flexion	40	40	40
Eversion	20	20	20
Inversion	30	30	30

Neurological:

Sensation, motor, and vascular status are intact in the feet and ankles.

Special Testing:

The Ankle Drawer test is negative.

Measurements:	Right	Left
Quadriceps muscle mass 10 cm above superior margin of patella	37 cm	37 cm
Calf muscle mass at Point of maximum growth	33 cm	33 cm

DIAGNOSTIC IMPRESSION

1. Lumbar sprain/strain with radiculitis.
2. History of chronic low back pain.
3. Possible recurrent hernia.
4. Bilateral hand paresthesias, rule out bilateral hand carpal tunnel syndrome.
5. Bilateral knee arthralgia, rule out bilateral knee internal derangement.

DISCUSSION

This is a somewhat complex case due to the multiple injuries involved and conflicting history regarding the actual dates of injury. The claimant described to me a specific injury on December 20, 2013 in which she sustained an injury to the lower back and hernia while lifting a vacuum. (However the medical records provided reflect this may have actually occurred in November 2012, three weeks prior to the December 5, 2012 evaluation provided- p. 432 MR2) The claimant states this required two surgeries due to complications following the first surgery. She is reporting persistent pain in the surgical area and I would recommend to a general surgery hernia specialist regarding her hernia as this is outside my area of expertise as an orthopaedic surgeon.

She describes a second distinct injury due to a non-industrial motor vehicle accident sometime in June 2017. (The deposition transcript documents the date of the accident was June 7, 2017). The claimant told me that she injured her neck and upper back in this accident. However, the medical records provided document complaints of injuries to the knees in the accident as well. The claimant's deposition transcript also documents complaints of swelling in the knees that she attributes to the motor vehicle accident. The medical records from Dr. Khan and Dr. Shah also document back pain after the motor vehicle accident. (p. 767 MR2) and (p. 823 MR2)

She also describes a third injury in the form of cumulative trauma injuries to the bilateral hands, lower back, and bilateral knees. Based on the physical nature of her work as a janitor and grounds woman and the timeframe of this industrial exposure, it is more likely than not in my opinion that the claimant did sustain these cumulative trauma injuries as she described to me. However, with regards to the bilateral knees apportionment to the non-industrial motor vehicle accident would also be appropriate.

With regards to the lumbar spine, the medical records provided include the June 5, 2012 emergency room evaluation that documents "chronic L4-L5 low back pain." (p. 435 MR2) This history of chronic lower back pain noted in 2012 is prior to the cumulative trauma industrial injury timeframe in question. Apportionment to this pre-existing chronic lower back pain would be indicated as well as apportionment to the specific injury while lifting a vacuum in approximately November 2012.

With regards to the cervical spine and bilateral shoulders, the physical examination findings today were within normal limits.

It should be noted that after review of the extensive medical records provided, there were no diagnostic study reports provided. The claimant states she has had multiple MRI studies and received treatment with a pain management specialist including injections treatments for her lumbar spine condition. However, these reports also were not provided. Further diagnostic testing with EMG nerve conduction study testing of the upper extremities as well as MRI studies of the lumbar spine and bilateral knees without contrast would be appropriate at this time to better evaluate the etiology of her subjective complaints. I would be able to provide a supplemental report after review of the complete medical records for this claimant including the results of her prior diagnostic studies for comparison as well as the requested diagnostic studies.

SUBJECTIVE COMPLAINTS SUPPORT OBJECTIVE FINDINGS

The subjective complaints appear to support the objective findings based on the history and physical examination.

PERMANENT AND STATIONARY

The claimant has had treatment with activity modification, medications, and physical therapy and reports no improvement in her condition with the treatment provided to date. Further diagnostic testing is indicated at this time and the claimant has not yet reached a permanent and stationary status.

SUBJECTIVE FINDINGS

Subjective findings of disability include frequent sharp, aching, and shooting pain in the lower back and knees with associated swelling and numbness and tingling in her hands and right foot. Subjective findings of disability also include diminished sitting capacity of up to 20 minutes, standing capacity of up to 10 minutes, and walking capacity of up to 20 minutes. Subjective findings of disability also include diminished lifting capacity of up to 5 pounds now as compared to over 50 pounds prior to the injury.

Subjective findings of disability also include difficulty with activities of daily living including "difficulty" taking a bath normally, brushing her teeth, dressing herself, combing her hair, eating and drinking, going to the toilet, urinating, writing comfortably, typing on a computer, speaking clearly, standing, sitting, walking normally, climbing stairs, feeling what she touches, holding something without pain, opening windows at home, lifting a child, riding in a car for 30 minutes, flying in a plane, having sexual intercourse, and sleeping restfully.

OBJECTIVE FINDINGS

Objective findings of disability include physical examination findings of reported inability to heel walk, toe walk, or squat during the gait exam, splinting and guarding of the right hand, tenderness over the carpal tunnel bilaterally, tenderness to palpation along the paraspinous muscles on the right over the lumbar spine, pain with lumbar

spine range of motion testing, diminished range of motion of the lumbar spine, tenderness with patellofemoral compression bilaterally, and clicking beneath the patella bilaterally.

There were no diagnostic study reports provided to include as objective findings of disability.

WORK RESTRICTIONS

It is my opinion that the claimant can return to work as of today with restrictions. She may lift and carry up to 20 pounds occasionally and 10 pounds frequently. She may stand or walk for 6 hours in an eight-hour work day and may sit for 8 hours in an eight-hour workday with normal breaks. Climbing, kneeling, stooping, crawling, and crouching should not be required. Overhead activities may be done on an occasional basis. Use of the hands for fine or gross manipulative movements may be done on a frequent basis. The claimant does not require the use of an assistive ambulatory device.

I would reserve the right to modify my opinions on work restrictions after review of the requested additional diagnostic testing.

CAUSATION

In my opinion based on reasonable medical probability and the history and physical examination I performed and documentation reviewed, the claimant's symptoms are a result of a combination of the cumulative trauma industrial injury sustained from September 1, 2013 through September 1, 2017, the specific industrial injury sustained in November 2012, and the motor vehicle accident of June 7, 2017.

APPORTIONMENT

The claimant has not yet reached a permanent and stationary status for final apportionment determination. However, based on the information currently available and the history and physical examination I performed and reasonable medical probability, with regards to the bilateral knees, apportionment would be indicated

between the cumulative trauma industrial injury of September 1, 2013 through September 1, 2017 and the non-industrial motor vehicle accident of June 7, 2017. With regards to the lumbar spine, apportionment would be indicated between the specific injury of November 2012, the cumulative trauma industrial injury of September 1, 2013 through September 1, 2017, the motor vehicle accident of June 7, 2017, and the patient's history of chronic lower back pain prior to the industrial injury timeframe. With regards to the bilateral hands, this is attributable to the cumulative trauma injury of September 1, 2013 through September 1, 2017 and apportionment would not be indicated.

My opinion regarding apportionment is made in consideration of Labor Code Sections 4663 and 4664.

FUTURE MEDICAL CARE

Further diagnostic testing is indicated at this time with EMG nerve conduction study testing of the bilateral upper extremities as well as MRI studies of the lumbar spine and bilateral knees without contrast.

IMPAIRMENT

The claimant has not yet reached a permanent and stationary status for whole person impairment determination. I would be able to provide a supplemental report including any indicated whole person impairment percentages should the claimant be found to have reached a permanent and stationary status after review of the requested additional diagnostic studies and complete medical records including her earlier diagnostic studies.

Thank you for the opportunity to evaluate this examinee. If I may be of additional assistance please correspond with me, in writing, at 8221 N. Fresno St, Fresno, Ca. 93720.

ATTESTATION

I, Payam Moazzaz, M.D., personally took the examinee's history, reviewed the medical records, performed the physical examination, and dictated this report. All of the opinions expressed in the report are mine. In the preparation of the report Rogeline Diaz, MT, arranged all of the records in chronological order and prepared a list and excerpt of records for my review. I personally then reviewed all of the available medical records and the excerpt prior to the preparation of my report. Staff time has not been included in the calculation of time spent on this report. The entire report was personally reviewed by me and signed on the date and county as indicated.

I hereby declare under penalty of perjury that I have not violated Labor Code Section 139.3 to the best of my knowledge and have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage, dividend, discount or other consideration for any referral for examination or evaluation by a physician.

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,

Payam Moazzaz, M.D.
Board Certified Orthopaedic Surgeon

Signed this 18th day of July 2018 in San Diego County in the State of California.

REQUEST FOR SPECIAL STUDIES

EXAMINEE'S NAME: Victoria Sarver

TYPE OF STUDY:

- [x] MRI lumbar spine and bilateral knees L - R
  - [ ] With Contrast
  - [x] Without Contrast
- [x] EMG / NCV bilateral upper extremities
- [ ] X-RAY

VIEW:

DIAGNOSIS:

1. sprain/strain
2.
3.

RULE OUT: internal derangement

DOCTOR: MOAZZAZ

LICENSE #: A100652

SEND FILMS / REPORT TO:
8221 N. FRESNO ST.
FRESNO, CA 93720
(800) 242-0880

OUR OFFICE DOES NOT SCHEDULE APPOINTMENTS FOR SPECIAL STUDIES. THE INSURANCE COMPANY MUST SCHEDULE.

Payam Moazzaz, M.D.

Board Certified Orthopaedic Surgeon
Qualified Medical Evaluator

8221 N. Fresno St
Fresno, CA 93720
(559) 222-2294

RE:	SARVER, VICTORIA
DATE OF EVALUATION:	July 14, 2018
EMPLOYER	Lighthouse Community Church
DATE OF INJURY:	September 01, 2013
CLAIM NO:	550613

Dear Raymond Meister, M.D., M.P.H.:

The above mentioned injured worker was seen in my office for a Panel Qualified Medical Evaluation. While speaking with the injured worker and reviewing the medical records I have identified the following injuries that are outside my area of expertise:

1: Hernia

2:

3:

4:

5:

6:

Per regulations I am notifying all parties that these items are outside my scope of expertise.

Sincerely yours,

Payam Moazzaz, M.D.
Board Certified Orthopaedic Surgeon

Signed this 18th day of July 2018 in San Diego County in the State of California.

State of California

DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT

AME or QME Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))

Case Name: Victoria Sarver *(employee name)* v Brotherhood Mutual Insurance *(claims administrator name, or if none employer)*

Claim No.: 550613 **EAMS or WCAB Case No. (if any):**

I, **Maria Vega**, declare:

1. I am over the age of 18 and I am not a party to this case.
2. My business address is: **8221 N. Fresno St, Fresno, CA 93720**
3. On the date shown below, I served this QME Findings Summary Form with the original, or a true and correct copy of the original, comprehensive medical-legal report, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

A depositing the sealed envelope with the U.S. Postal Service with the postage fully prepaid.

X placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.

C placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.

D placing the sealed envelope for pick up by a professional messenger service for service.
(Messenger must return to you a completed declaration of personal service.)

E personally delivering the sealed envelope to the person or firm named below at the address shown below.

Means of service: *(For each addressee, Enter A-E as appropriate)*	Date Served:	Addressee and Address:
B	7/23/2018	Victoria Sarver, 666 W. 18th St., Apt. 4 Costa Mesa CA 92627
B	7/23/2018	Brotherhood Mutual Insurance, P.O. Box 2228 Fort Wayne IN 46801
B	7/23/2018	L/O Natalie Foley, 8306 Wilshire Blvd., Suite 115 Beverly Hills CA 90211-
B	7/23/2018	L/O Famiglietti & Volpe, 1748 W. Katella Ave., Suite 209 Orange CA 92867-

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

Date: 7/23/2018

Maria Vega
(Signature of Declarant)

Maria Vega
(Print Name)