[ ] Prev Gp

INDIO

02/04/20

80-545 HWY 111, STE B
INDIO, CA 92201

ARROWHEAD EVALUATION SERVICES, INC.
1680 Plum Lane
Redlands, California 92374
(909) 335-2323

Patient No: 273000 DATE 02/22/20 TIME 10:30:00

APPLICANT: RAFAEL DE SANTIAGO B/D 01/28/43 SS# *****7624 PHONE: 760-409-7877*

MAILING ADDRESS: 82193 KENNER AVE., INDIO, CA 92201 ALT PHONE: N/A

TYPE OF INJURY: NECK, LT ARM, LT SHOULDER & BACK EMAIL: N/A

DOCTOR: DONALD D. KIM, M.D. TYPE OF EXAM: PANEL QME Panel QME #2493409

SCHEDULING AGENCY: REZAI & ASSOCIATES PHONE: 949-752-7227

CALLER: M. ALLIE LOPEZ FAX: 949-752-7337

APP. ATTY. FIRM: REZAI & ASSOCIATES

APP ATTY: FARI A. REZAI, ESQ. APP. ATTY PHONE: 949-752-7227

A.A. ADDRESS: 2601 MAIN ST., SUITE 150 IRVINE CA 92614 A.A. FAX: 949-752-7337

A.A. EMAIL ADDRESS: MLOPEZ@REZAILAW.COM

DEF. ATTY. FIRM: FLOYD SKEREN MANUKIAN LANGEVIN, LLP

DEF. ATTY: STACY LEE, ESQ. DEF. ATTY. PHONE: 714-558-8892

DEF. ATTY. ADDRESS: 2045 W. ORANGEWOOD AVE., SUITE A ORANGE CA 92868 DEF. FAX: 714-558-8159

DEF. ATTY EMAIL ADDRESS: N/A

INTERPRETER [☑] INTERPRETER NAME

SCHED. AGENCY WILL SET INTERPRETER [ ] AGENCY GO 2 MED MANG PHONE: 888 405 2505

INS. CARRIER: MARRIOTT CLAIMS

INS. ADDRESS: P.O. BOX 29210 HOT SPRINGS AK 71903

CLAIM REP: BEBBIZ MARQUEZ PHONE: 714-545-5261 FAX:

CLAIM REP. EMAIL ADDRESS: N/A

DATE OF INJURY: CT 08/06/16 - 08/06/17 ADJ. NO. 11068591 CLAIM NO. 592043

EMPLOYER: RENAISSANCE INDIAN WELLS SPA

EMPLOYER ADDRESS: 44400 INDIAN WELLS LN., INDIAN WELLS, CA 92210

PATIENT CONFIRM DATE 01/16/20 HIST/PX/SENT 01/16/20 MD QME 110 MAILED 01/03/20

COVER LETTER 02/04/20 AA MED RECS REC'D: [1CD] [02/04/20] [ ] [ ]

X-RAYS: REFERRAL TAKEN BY: Mariao 12/31/19]

APPLICANT'S ADVOCACY ORTHOPAEDIC PQME MEDICAL EXAMINATION LETTER
QME Appointment on: 09/22/2020

273000
2/22/20
AAC
RECEIVED
FEB 04 2020
BY: AES

Donald D. Kim, M.D.
80-545 Hwy 111 Ste B
Indio, CA 92201

RE: Rafael De Santiago vs. Renaissance Indian Wells Resort and Spa
Our Client: Rafael De Santiago
Claim No.: 592043, 595758
Our File No: 31468

Dear Dr. Kim:

You are scheduled to examine the above-named applicant in your capacity as a Panel Qualified Medical Examiner on 09/22/2020. The parties are deeply appreciative of your efforts on our behalf.

Necessary diagnostic studies and medical reports are attached; please provide an MMI report, detailing whole person impairment, future medical care, and eligibility of a voucher

STATEMENT OF CHRONOLOGICAL FACTS

Date of Birth:
- The applicant, Rafael De Santiago, was born on 01/28/1943.

Date of Hire:
- On 08/21/1989 the Applicant started employment at Renaissance Indian Wells Resort and Spa.
- Applicant's position was as a cook.
- Applicant worked for employer for 28 years.

Alleged Injuries:
- On CT: 08/06/2016-08/06/2017 while employed at Renaissance Indian Wells Resort and Spa the applicant alleges injuries to his neck, left arm, back, and left shoulder.
- On 05/26/2017 while employed at Renaissance Indian Wells Resort and Spa the applicant alleges injuries to his lower and middle abdomen.
- Applicant alleges reporting injuries on 05/26/2017.
- Applicant's last day of work: 08/06/2017.

Medical Treatment PRIOR TO LAST DAY OF WORK
- Executive Urgent Care

Applicant's Attorney referred him/her over to following doctors:
- The applicant sought out medical treatment with Dr. Marco Antonio Cazares.

SCANNED

Other Workers Compensation Cases:

ADJ3442252	RIV-ADJ	ESMERALDA RESORT	DOI: 11/29/2006
ADJ1505426	RIV-ADJ	ESMERALDA RESORT	DOI: 01/24/2008

Upon review of records, any necessary testing, and your examination of the applicant, we will need your narrative report on the following issues.

Please issue report within 30 days of the evaluation under labor code 139.2 (J) (1) (A) title 8 California rule 38

ISSUES:

Please perform your usual and thorough examination and issue a report setting forth all of your findings.

Please include the following:

- A complete history.
- Reviewing and summarizing prior medical records.
- Composing and drafting your medical conclusions.
- Temporary disability attributed to the industrial injury. If any TD periods should be found please set forth the start and end date of temporary disability.
- Activities of Daily Living and if Applicant has any additional impairment to his rating due to "ADL".
- Almaraz/Guzman in order to provide the most accurate impairment analysis where necessary, if applicable.

CAUSATION OF INJURY:

Please discuss, within reasonable medical probability, whether the injured worker's employment caused the injury. Please also discuss whether the employment contributed to, aggravated, accelerated, triggered or lit up any condition that also caused injury.

MEDICAL TREATMENT:

Please provide your best estimate for all medical treatments, including medications you believe are reasonably necessary to care for the injured worker's future medical needs.

Please list all the medications that the applicant is currently taking and provide your opinion on the length of time that the applicant will need to continue taking those medications.

WORK RESTRICTIONS/PERMANENT DISABILITY:

Please provide the parties with a complete list of work limitations at the time you declare the applicant permanent and stationary or having reached maximum medical improvement.

THE AMA GUIDES:

Please prepare a report under the AMA Guides, 5th edition.
In preparing a report under the AMA Guides, you are obligated to provide a complete and comprehensive report. I therefore request that you address each and every activity of daily living mentioned in the AMA Guides, 5th edition and discuss every effect that this injury has had on these activities.

ALMARAZ/GUZMAN II:

The AMA Guides designation of a WPI is but a component or tool for assessing impairments. You should know that the AMA Guides allow you to exercise your judgment to modify an AMA impairment rating pursuant to Almaraz/Guzman II.

Describe "how" and "why" a modified application of the AMA Guides "most accurately reflects the injured employee's impairment" (Almaraz/Guzman II page 23.).

APPORTIONMENT:

Applicant respectfully requests that you include a discussion of apportionment under Labor Code section 4663 and Labor Code 4664.

When you determine that the applicant is P&S/M.M.I., applicant respectfully requests that you include a discussion of apportionment in order to be compliant with recent case law, addressing each of the questions that follow the discussion below.

Regarding INDUSTRIAL sources of the current disability:

1. Is all of the current permanent disability directly caused by ONE of the industrial injuries? If so, you must explain "how and why" you made this determination, and state your conclusion in terms of "reasonable medical probability".

OR:

2. Is the current permanent disability directly caused by more than one industrial injury? If this is your opinion, separately assign a percentage of the overall current permanent disability to each of the industrial injuries that are responsible. You must explain "how and why" you made this determination, and state your conclusion in terms of "reasonable medical probability."

Regarding NON-INDUSTRIAL sources of the current disability:

3. If you choose to "parcel out" non-industrial source(s) that directly caused the current permanent disability, you must explain how and why you arrived at your opinion based on the standard of reasonable medical probability.

Please advise if there are any records you need to review to complete your report. They will be forwarded to your attention as soon as possible.

Upon completion of your report, please forward a copy of the reports to the following:

Law Offices of Rezai & Associates
2601 Main Street, Suite 150
Irvine, CA 92614

and to:

Stacy S. Lee, Esq.
Floyd, Skeren & Kelly, LLP
2045 West Orangewood Ave # A
Orange, CA 92868

Also, please forward a copy of your report and an itemized statement for your services to the attention of:

Debbie Marquez
Marriott Claims Management
P.O. Box 29210
Hot Springs, AR 71903

Thank you for assisting the parties in the capacity of as a Panel Qualified Medical Examiner in this matter.

Very Truly Yours,

By: _____ DATED: 01/30/2020

Fari Rezai, Applicant's Counsel
Rezai and Associates
2601 Main Street, Suite 150
Irvine, CA 92614

Enclosure: SCHEDULE / INDEX OF RECORDS

SCHEDULE / INDEX OF RECORDS

To: Donald D. Kim Exam: 02/22/2020

RE: Rafael De Santiago vs. Renaissance Indian Wells Resort and Spa
WCAB Case No.: ADJ11068591, ADJ11068589
Claim No.: 592043, 595758

ITEM	DATE:
DWC FORM 1 EMPLOYEE'S CLAIM	08/16/2017, 08/16/2017
APPLICATION FOR ADJUDICATION	10/23/2017, 10/23/2017
APPLICANT'S DEPOSITION TRANSCRIPT	01/23/20128, 03/09/2018

MEDICAL RECORDS

Marco A. Cazares, D.C.	08/31/2017, 09/06/2017, 09/29/2017, 10/11/2017
Joseph L. Vanderlinden, M.D. (PQME)	03/21/2018, 09/06/2018
Abdominal Ultrasound	09/29/2017
Multidetector CT Abdomen/Pelvis	08/09/2017

SUBPOENA RECORDS

Werner Gonzalez Family Practice
Desert Oasis Healthcare
Executive Urgent Care

{***Recent medical reports are pending and will be forwarded to your attention as soon as possible***}

LAW OFFICES OF

R E Z A I & ASSOCIATES P.C.

Fari A. Rezai
Nahid Ghaderi
R. Allan Baker

ATTORNEYS AT LAW
2601 MAIN STREET, SUITE 150
IRVINE, CALIFORNIA 92614

Tel: 949-752-7227
Fax: 949-752-7733

REQUEST TO FILL OUT
"Physician Return-to-Work Form"- Senate Bill 863

January 30, 2020

Donald D. Kim, M.D.
80-545 Hwy 111 Ste B
Indio, CA 92201

RE: Rafael De Santiago vs. Renaissance Indian Wells Resort and Spa
WCAB Case No.: ADJ11068591, ADJ11068589
Claim No.: 592043, 595758
Our File No: 31468

Dear Dr. Kim:

Pursuant to labor code 4658.7, Senate Bill 863, and the DWC please fill out the enclosed DWC-A 10133.36 form "Physician Return-to-Work." Kindly forward a copy to all parties along with your report.

For any questions please contact the DWC or the Medical Unit.

Truly yours,

REZAI & ASSOCIATES

Fari Rezai,
Applicant Attorney

:vvf

State of California, Division of Workers' Compensation
Retraining and Return to Work Unit

Physician's Return-to-Work & Voucher Report Instructions
For injuries on or after January 1, 2013
DWC - AD 10133.36

Who is responsible for filling out this form? The first physician who finds that the disability from all conditions for which compensation is claimed has become permanent and stationary (or has reached maximum medical improvement) and finds that the injury has caused permanent partial disability. The physician can be the primary treating physician, a Qualified Medical Evaluator, or an Agreed Medical Evaluator.

What is the purpose of this form? The purpose of the form is to fully inform the employer of the work capacities and activity restrictions resulting from the injury that are relevant to potential regular work, modified work, or alternative work. The information contained on the form is for voucher purposes and is not considered in any permanent impairment rating or any permanent disability indemnity.

Is this a mandatory form? This is a mandatory attachment to the first medical report finding that the disability from all conditions for which compensation is claimed has become permanent and stationary and that the injury has caused permanent partial disability. This form should be attached to a comprehensive medical-legal evaluation and does not replace such comprehensive medical-legal evaluations.

When does the form need to be completed? This form does not need to be completed until all conditions for which compensation is claimed have become permanent and stationary.

If the employer or claims administrator has provided the physician with a job description providing physical requirements of the employee's regular work, proposed modified work, or proposed alternative work, the physician shall evaluate and describe in the form whether the work capacities and activity restrictions are compatible with the physical requirements set forth in that job description. The bottom portion of the form does not need to be completed if the physician has not been provided with a job description.

Completing the employee's work restrictions: The physician should indicate work restrictions in terms of how many hours a particular activity can be performed during an 8-hour work day. For hand restrictions, the physician should indicate whether the restrictions are for the right hand, left hand, or both.

Other Restrictions can include psychiatric restrictions, chemical exposure, use of equipment, or any other restrictions. The space can also be used to further clarify or explain any of the checked restrictions.

How does the employer receive the form? The claims administrator shall forward the form to the employer.

Physician's Return-to-Work & Voucher Report

For injuries occurring on or after January 1, 2013

☐ The Employee is P&S from all conditions and the injury has caused permanent partial disability

Employee Last Name _____ Employee First Name _____ MI ____ Date of Injury _____

Claims Administrator: _____ Claims Representative _____

Employer name: _____ Employer Street Address: _____

Employer City: _____ State _____ Zip Code _____ Claim No. _____

☐ The Employee can return to regular work

☐ The Employee can work with restrictions:

		1-2 hours	2-4 hours	4-6 hours	6-8 hours	None
	Stand	☐	☐	☐	☐	☐
	Walk	☐	☐	☐	☐	☐
	Sit	☐	☐	☐	☐	☐
	Bend	☐	☐	☐	☐	☐
	Squat	☐	☐	☐	☐	☐
	Climb	☐	☐	☐	☐	☐
	Twist	☐	☐	☐	☐	☐
	Reach	☐	☐	☐	☐	☐
	Crawl	☐	☐	☐	☐	☐
	Drive	☐	☐	☐	☐	☐
	Reach	☐	☐	☐	☐	☐
R/L/Bilat Hand(s) (circle):	Grasp	☐	☐	☐	☐	☐
R/L/Bilat Hand(s) (circle):	Push/Pull	☐	☐	☐	☐	☐

Lift/Carry Restrictions: May not lift/carry at a height of _____ more than _____ lbs. for more than _____ hours per day.

Other Restrictions: _____

If a Job Description has been provided, please complete: Job Description provided of: ☐ *Regular* ☐ *Modified* ☐ *Alternative Work*

Job Title: _____ *Work Location* _____

Are the Work Duties compatible with the activity restrictions set forth in the provided job description? ☐ *Yes* ☐ *No, explain below*

_____

Physician's Name _____ Role of Doctor (PTP, QME, AME) _____

Physician's Signature _____ Date _____

PROOF OF SERVICE
STATE OF CALIFORNIA, COUNTY OF ORANGE

I am employed in the county of Orange, State of California, I am over the age of 18 and not a party to the within action; my business address is LAW OFFICES OF REZAI & ASSOCIATES, 2601 Main St., Suite 150 Irvine, CA 92614; (949) 752-7227, Fax (949) 752-7733.

RE: Rafael De Santiago vs. Renaissance Indian Wells Resort and Spa
WCAB Case No.: ADJ11068591, ADJ11068589
Our File No: 31468

On January 30, 2020, I served the foregoing document(s):

- **APPLICANT'S ADVOCACY ORTHOPAEDIC PQME MEDICAL EXAMINATION LETTER**
- DWC-A 10133.36 form "Physician Return-to-Work"
- DWC FORM 1 EMPLOYEE'S CLAIM — 08/16/2017, 08/16/2017
- APPLICATION FOR ADJUDICATION — 10/23/2017, 10/23/2017
- APPLICANT'S DEPOSITION TRANSCRIPT — 01/23/20128, 03/09/2018
- MEDICAL RECORDS
- Marco A. Cazares, D.C. — 08/31/2017, 09/06/2017, 09/29/2017,
- 10/11/2017
- Joseph L. Vanderlinden, M.D. (PQME) — 03/21/2018, 09/06/2018
- Abdominal Ultrasound — 09/29/2017
- Multidetector CT Abdomen/Pelvis — 08/09/2017
- SUBPOENA RECORDS
- Werner Gonzalez Family Practice
- Desert Oasis Healthcare
- Executive Urgent Care

By placing a true copy thereof enclosed in a sealed envelope addressed as follows:

Donald D. Kim, M.D.
1680 Plum Lane
Redlands, CA 92374

Floyd, Skeren & Kelly, LLP
2045 West Orangewood Ave # A
Orange, CA 92868

Attn: Willard Steven Heise, Esq.
Law Offices of Callas & Heise, LLP
942 W. Foothill Boulevard, Suite A
Upland, CA 91786

[XX] BY MAIL

I deposited such envelope in the mail as Orange County, California. The envelope was mailed with postage thereon fully prepaid.

I am readily familiar with the firm's practice of collection and processing correspondence for mailing. Under that practice, it would be deposited with U.S. postal service on that day with postage thereon fully prepaid at Orange County 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 the affidavit.

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

Vanessa Fuentes

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)

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 in the Notice of Potential Eligibility, which is 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. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

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 felony.

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

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 benficios de compensación al trabjador.

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

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 "felonía".

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

1. Name. *Nombre.* Rafael De Santiago Today's Date. *Fecha de Hoy.* 08/16/2017
2. Home Address. *Dirección Residencial.* 82-193 Kenner Ave.
3. City. *Ciudad.* Indio State. *Estado.* CA Zip. *Código Postal.* 92201
4. Date of Injury. *Fecha de la lesión (accidente)* 05/26/2017 Time of injury. *Hora en que ocurrió* _____ a.m _____ *p.m.*
5. Address and description of where injury happened. *Dirección/lugar dónde occurió e/ accidente.* Jobsite- Indian Wells CA 92210
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* Tripped and fell Lower Adbomen & Middle
7. Social Security Number. *Número de Seguro Social del Empleado* 549-21-7624
8. ☐ Check if you agree to receive notices about your claim by email only. ☐ Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico. Employee's e-mail _____ Correo electrónico del empleado. _____
9. Signature of employee. *Firma del empleado.* ON FILE

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

10. Name of employer. *Nombre del empleador.* _____
11. Address. *Dirección.* _____
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se /e entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* _____
16. Insurance Policy Number. *El número de la póliza del Seguro* _____
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* _____ 19. 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 employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

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.

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

Rev. 1/1/2016

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

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

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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.

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

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

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3. City. *Ciudad.* Indio State. *Estado.* CA Zip. *Código Postal.* 92201
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5. Address and description of where injury happened. *Dirección/lugar dónde occurió e/ accidente.* Jobsite- Indian Wells CA 92210
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* Due to repetitive job duties Lower Back, Neck, L. Shoulder, L- Arm
7. Social Security Number. *Número de Seguro Social del Empleado* 549-21-7624
8. ☒ Check if you agree to receive notices about your claim by email only. ☐ Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico. Employee's e-mail _____ Correo electrónico del empleado. _____
9. Signature of employee. *Firma del empleado.* ON FILE

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

10. Name of employer. *Nombre del empleador.* _____
11. Address. *Dirección.* _____
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se /e entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* _____
16. Insurance Policy Number. *El número de la póliza del Seguro* _____
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* _____ 19. 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 employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

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.

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 OF CALIFORNIA
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET

Is this a new case? Yes ☑ No ☐ Companion Cases Exist ☐ Walkthrough Yes ☐ No ☐

More than 15 Companion Cases ☐

10/23/2017
Date:(MM/DD/YYYY)

SSN: 549217624

☐ Specific Injury

Case Number 1

☑ Cumulative Injury 08/06/2016 (Start Date: MM/DD/YYYY) 08/06/2017 (End Date: MM/DD/YYYY)

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

Body Part 1: 200

Body Part 3: 319

Body Part 2: 420

Body Part 4: 450

Other Body Parts:

Please check unit to be filed on (check only one box)

☑ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ INT ☐ RSU

Companion Cases

☐ 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 3:

Body Part 2:

Body Part 4:

Other Body Parts:

DOCUMENT SEPARATOR SHEET

Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: APPLICATION FOR ADJUDICATION

Document Date: 10/23/2017
MM/DD/YYYY

Author: FARI REZAI IRVINE

Office Use Only

Received Date: _____
MM/DD/YYYY

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
APPLICATION FOR ADJUDICATION OF CLAIM

☐ Amended Application

Case No.

549217624
SSN (Numbers Only)

Venue choice is based upon (Completion of this section is required)

☐ 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).)

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

Injured Worker (Completion of this section is required)

RAFAEL
First Name

MI

DE SANTIAGO
Last Name

82193 KENNER AVE
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

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

INDIO
City

CA
State

92201
Zip Code

Applicant (If other than Injured Worker)

☐ Insurance Carrier ☐ Employer ☐ Lien Claimant

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

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

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Employer Information (Completion of this section is required)

☑ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

RENAISSANCE INDIAN WELLS RESORT AND SPA

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

44400 INDIAN WELLS

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

INDIAN WELLS	CA	92210
City	State	Zip Code

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

MARRIOTT HOT SPRINGS

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

PO BOX 29210

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

HOT SPRINGS	AR	71903
City	State	Zip Code

Claims Administrator Information (If known and if applicable)

MARRIOTT HOT SPRINGS

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

PO BOX 29210

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

HOT SPRINGS	AR	71903
City	State	Zip Code

IT IS CLAIMED THAT (Complete all relevant information):

1. The injured worker, born 01/28/1943 (DATE OF BIRTH: MM/DD/YYYY), while employed as a(n) COOK (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

suffered a :

☐ specific injury _____ (Date of injury: MM/DD/YYYY)

☑ cumulative injury which began on 08/06/2016 (Start Date: MM/DD/YYYY) and ended on 08/06/2017 (End Date: MM/DD/YYYY)

The injury occurred at JOBSITE

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

INDIAN WELLS	CA	92212
City	State	Zip Code

(State which parts of the body were injured)

Body Part 1: 200 NECK

Body Part 2: 319 ARM - NOT SPECIFIED

Body Part 3: 420 BACK - INCLUDING BACK MUSCLES, SPINE AND SPINAL CORD

Body Part 4: 450 SHOULDERS - SCAPULA AND CLAVICLE

Other Body Parts:

2. The injury occurred as follows:

(EXPLAIN WHAT THE WORKER WAS DOING AT THE TIME OF INJURY AND HOW THE INJURY OCCURED)

DUE TO REPETITIV

3. Actual earnings at the time of injury:

Rate of Pay $ _____ ☐ Monthly ☐ Weekly ☐ Hourly

State value of tips, meals, lodging, or other advantages, regularly received $ _____ ☐ Monthly ☐ Weekly ☐ Hourly

Number of hours worked per week _____

4. The injury caused disability as follows:

Last day off work due to injury: _____ MM/DD/YYYY

First Period of Disability: Start Date _____ MM/DD/YYYY End Date _____ MM/DD/YYYY

Second Period of Disability: Start Date _____ MM/DD/YYYY End Date _____ MM/DD/YYYY

5. Compensation:

Compensation was paid: ☐ Yes ☑ No

Total paid: _____

Weekly rate(s): _____

Date of last payment: _____ MM/DD/YYYY

6. Has the worker received any unemployment insurance benefits and/or any unemployment compensation disability benefits (state disability) since the date of injury? ☐ Yes ☑ No

7. Medical treatment:

Medical treatment was received: ☐ Yes ☑ No

All treatment was furnished by the Employer or Insurance Carrier: ☐ Yes ☑ No

Date of last treatment: _____ MM/DD/YYYY

Other treatment was provided/paid by: _____ (NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

Did Medi-Cal pay for any health care related to this claim? ☐ Yes ☑ No

Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or examined for this injury, but that were not provided or paid for by the employer or insurance carrier:

_____

Name of Doctor/Hospital/Clinic 1 (Please leave blank spaces between numbers, names or words)

_____

Name of Doctor/Hospital/Clinic 2 (Please leave blank spaces between numbers, names or words)

8. Other cases have been filed for industrial injuries by this worker as follows:

Case Number 1 _____ Case Number 3 _____

Case Number 2 _____ Case Number 4 _____

9. This application is filed because of a disagreement regarding liability for:

- ☑ Temporary disability indemnity
- ☑ Reimbursement for medical expense
- ☑ Medical treatment
- ☑ Compensation at proper rate
- ☑ Permanent disability indemnity
- ☑ Rehabilitation
- ☑ Supplemental Job Displacement/Return to Work
- ☑ Other (Specify) ALL BENEFITS

APPLICANT'S ADVOCACY ORTHOPAEDIC PQME MEDICAL EXAMINATION LETTER
QME Appointment on: 09/22/2020

273000
2/22/20
AAC
RECEIVED
FEB 04 2020
BY: AES

Donald D. Kim, M.D.
80-545 Hwy 111 Ste B
Indio, CA 92201

RE: Rafael De Santiago vs. Renaissance Indian Wells Resort and Spa
Our Client: Rafael De Santiago
Claim No.: 592043, 595758
Our File No: 31468

Dear Dr. Kim:

You are scheduled to examine the above-named applicant in your capacity as a Panel Qualified Medical Examiner on 09/22/2020. The parties are deeply appreciative of your efforts on our behalf.

Necessary diagnostic studies and medical reports are attached; please provide an MMI report, detailing whole person impairment, future medical care, and eligibility of a voucher

STATEMENT OF CHRONOLOGICAL FACTS

Date of Birth:
- The applicant, Rafael De Santiago, was born on 01/28/1943.

Date of Hire:
- On 08/21/1989 the Applicant started employment at Renaissance Indian Wells Resort and Spa.
- Applicant's position was as a cook.
- Applicant worked for employer for 28 years.

Alleged Injuries:
- On CT: 08/06/2016-08/06/2017 while employed at Renaissance Indian Wells Resort and Spa the applicant alleges injuries to his neck, left arm, back, and left shoulder.
- On 05/26/2017 while employed at Renaissance Indian Wells Resort and Spa the applicant alleges injuries to his lower and middle abdomen.
- Applicant alleges reporting injuries on 05/26/2017.
- Applicant's last day of work: 08/06/2017.

Medical Treatment PRIOR TO LAST DAY OF WORK
- Executive Urgent Care

Applicant's Attorney referred him/her over to following doctors:
- The applicant sought out medical treatment with Dr. Marco Antonio Cazares.

SCANNED

Regarding NON-INDUSTRIAL sources of the current disability:

3. If you choose to "parcel out" non-industrial source(s) that directly caused the current permanent disability, you must explain how and why you arrived at your opinion based on the standard of reasonable medical probability.

Please advise if there are any records you need to review to complete your report. They will be forwarded to your attention as soon as possible.

Upon completion of your report, please forward a copy of the reports to the following:

Law Offices of Rezai & Associates
2601 Main Street, Suite 150
Irvine, CA 92614

and to:

Stacy S. Lee, Esq.
Floyd, Skeren & Kelly, LLP
2045 West Orangewood Ave # A
Orange, CA 92868

Also, please forward a copy of your report and an itemized statement for your services to the attention of:

Debbie Marquez
Marriott Claims Management
P.O. Box 29210
Hot Springs, AR 71903

Thank you for assisting the parties in the capacity of as a Panel Qualified Medical Examiner in this matter.

Very Truly Yours,

By: _____ DATED: 01/30/2020

Fari Rezai, Applicant's Counsel
Rezai and Associates
2601 Main Street, Suite 150
Irvine, CA 92614

Enclosure: SCHEDULE / INDEX OF RECORDS

State of California, Division of Workers' Compensation
Retraining and Return to Work Unit

Physician's Return-to-Work & Voucher Report Instructions
For injuries on or after January 1, 2013
DWC - AD 10133.36

Who is responsible for filling out this form? The first physician who finds that the disability from all conditions for which compensation is claimed has become permanent and stationary (or has reached maximum medical improvement) and finds that the injury has caused permanent partial disability. The physician can be the primary treating physician, a Qualified Medical Evaluator, or an Agreed Medical Evaluator.

What is the purpose of this form? The purpose of the form is to fully inform the employer of the work capacities and activity restrictions resulting from the injury that are relevant to potential regular work, modified work, or alternative work. The information contained on the form is for voucher purposes and is not considered in any permanent impairment rating or any permanent disability indemnity.

Is this a mandatory form? This is a mandatory attachment to the first medical report finding that the disability from all conditions for which compensation is claimed has become permanent and stationary and that the injury has caused permanent partial disability. This form should be attached to a comprehensive medical-legal evaluation and does not replace such comprehensive medical-legal evaluations.

When does the form need to be completed? This form does not need to be completed until all conditions for which compensation is claimed have become permanent and stationary.

If the employer or claims administrator has provided the physician with a job description providing physical requirements of the employee's regular work, proposed modified work, or proposed alternative work, the physician shall evaluate and describe in the form whether the work capacities and activity restrictions are compatible with the physical requirements set forth in that job description. The bottom portion of the form does not need to be completed if the physician has not been provided with a job description.

Completing the employee's work restrictions: The physician should indicate work restrictions in terms of how many hours a particular activity can be performed during an 8-hour work day. For hand restrictions, the physician should indicate whether the restrictions are for the right hand, left hand, or both.

Other Restrictions can include psychiatric restrictions, chemical exposure, use of equipment, or any other restrictions. The space can also be used to further clarify or explain any of the checked restrictions.

How does the employer receive the form? The claims administrator shall forward the form to the employer.

2.) The protected health information (PHI) disclosed consists of findings concerning a work related illness or injury or a workplace related medical surveillance;

3.) Your employer needs such findings in order to comply with its obligations under federal or state law to record such illness or injury or to carry out responsibilities for workplace medical surveillance; or

4.) Casa Colina provides written notice to you that health information relating to the medical surveillance of your workplace and work-related illnesses and injuries is disclosed to the employer:

- By giving a copy of the notice to you at the time health care is provided HIPAA also permits disclosure of your health information to the extent necessary to comply with worker's compensation or similar programs that provide benefits for work-related injuries or illnesses without regard to fault.

[45 C.F.R. Section 164.512(1)]

x Edward E Molitor

Client

x _____

If Client/Resident unable to sign, Responsible Party

x 9/8/14

Date

x _____

Relationship to Client/Resident

Crystal Mejia

Witness

_____

Date

NAME. Molitor, Edward MR#: 609-99-28
DOB: 3/26/1956 AGE. 61 SEX: M

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

IDENTIFICATION AND EMERGENCY INFORMATION

This information is required under the H & S Code and the regulations of the Department to be maintained on every person admitted to a community care facility, to be readily available to the person in charge, but not accessible to unauthorized persons. All information must be kept current. See other side for additional information required for residential facilities for children.

A. ALL FACILITIES [EXCEPT CHILD CARE CENTER/FAMILY CHILD CARE HOME COMPLETES LIC 700]

1 NAME: Molitor, Edward MR#: 609-99-28 DOB: 3/26/1956 AGE: 61 SEX: M		SOCIAL SECURITY NUMBER (OPTIONAL)	DATE OF BIRTH	AGE / SEX
2. RESPONSIBLE PERSON OR PLACEMENT AGENCY		ADDRESS		TELEPHONE ( )
3. NAME OF NEAREST RELATIVE (OPTIONAL) Carol Molitor	RELATIONSHIP Wife	ADDRESS		TELEPHONE (909) 560-5906
4. DATE ADMITTED TO FACILITY	ADDRESS PRIOR TO ADMISSION			
5. DATE LEFT	FORWARDING ADDRESS			
6 REASONS FOR LEAVING FACILITY				

7. PERSON(S) RESPONSIBLE FOR FINANCIAL AFFAIRS, PAYMENT FOR CARE, LEGAL GUARDIAN, IF ANY

NAME	ADDRESS	TELEPHONE
	N/A	( )
		( )
		( )

8. OTHER PERSONS TO BE NOTIFIED IN EMERGENCY

	NAME	ADDRESS	TELEPHONE
a PHYSICIAN	N/A		( )
b. MENTAL HEALTH PROVIDER, IF ANY	N/A	N/A	( ) N/A
c DENTIST	N/A		( )
d RELATIVE(S)	N/A		( )
e FRIEND(S)	N/A		( )

9. EMERGENCY HOSPITALIZATION PLAN

NAME OF HOSPITAL TO BE TAKEN IN AN EMERGENCY POMONA VALLEY MEDICAL CENTER	ADDRESS OF HOSPITAL TO BE TAKEN IN AN EMERGENCY 1798 N. GAREY AVE. POMONA CA 91767
MEDICAL PLAN SEE FACE SHEET	MEDICAL PLAN IDENTIFICATION NUMBER
NAME OF DENTAL PLAN (IF ANY)	DENTAL PLAN NUMBER (IF ANY)

10 OTHER REQUIRED INFORMATION

a. AMBULATORY STATUS non-ambulatory

b RELIGIOUS PREFERENCE Christian	NAME AND ADDRESS OF CLERGYMAN OR RELIGIOUS ADVISOR, IF ANY N/A	TELEPHONE ( ) N/A

11. COMMENTS

SIGNATURE OF RESIDENT X [signature]	SIGNATURE OF PERSON COMPLETING FORM X	TITLE X	DATE X 9/8/17

LIC 601 (8/08) Personal

PERSONAL RIGHTS
ADULT COMMUNITY CARE FACILITIES

EXPLANATION: The California Code of Regulations, Title 22 requires that any person admitted to a facility must be advised of his/her personal rights. Facilities are also required to post these rights in areas accessible to the public. Consequently, this form is designed to meet both the needs of persons admitted to facilities and the facility owners who are required to post these rights.

This form describes the personal rights to be afforded each person admitted to an adult community care facility. The form also provides the complaint procedures for the client and representative/conservator. The facility staff or client representative must communicate these rights in a manner appropriate for client's ability.

This form is to be reviewed, completed and signed by each client and/or each representative/conservator upon admission to the facility. The client and/or representative/conservator also has the right to receive a completed copy of the originally signed form. The original signed copy shall be retained in the client's file which is maintained by the facility.

TO: CLIENT OR AUTHORIZED REPRESENTATIVE:

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: At the time of admission I have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22.

(PRINT THE NAME OF THE FACILITY) (PRINT THE ADDRESS OF THE FACILITY)

CASA COLINA TRANSITIONAL LIVING CENTER 255 E. BONITA AVE. POMONA CA 91767

(PRINT THE NAME OF THE CLIENT)
NAME: Molitor, Edward MR#: 609-99-28
DOB: 3/26/1956 AGE. 61 SEX: M

(SIGNATURE OF THE CLIENT) (DATE)
X Edward E Molitor X 9/8/17

(SIGNATURE OF THE REPRESENTATIVE/CONSERVATOR)
X

(TITLE OF THE REPRESENTATIVE/CONSERVATOR) (DATE)
X X

THE CLIENT AND/OR THE REPRESENTATIVE/CONSERVATOR HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS. THIS AGENCY IS:

NAME
State State Dept of Social Services Community Care Licensing Div Los Angeles East Dist Office

ADDRESS
1000 Corporate Center Dr. #500

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Monterrey Park, CA	91754	(323) 981-3300

AMBULATORY STAT his person is ☑ a 'ory ☐ nonambula

Ambulatory means able to demonstrate the mental and physical ability to leave a building without the assistance of a person or the use of a mechanical device. An ambulatory person must be able to do the following:

YES	NO	
☐	☑	Able to walk without any physical assistance (e.g., walker, crutches, other person), or able to walk with a cane.
☑	☐	Mentally and physically able to follow signals and instructions for evacuation.
☐	☑	Able to use evacuation routes including stairs if necessary.
☐	☑	Able to evacuate reasonably quickly (e.g., walk directly the route without hesitation).

FUNCTIONAL CAPABILITIES (Check all items below)

YES	NO			
☐	☑	Active, requires no personal help of any kind - able to go up and down stairs easily		
☑	☐	Active, but has difficulty climbing or descending stairs		
☑	☐	Uses brace or crutch		
☐	☑	Feeble or slow		
☐	☑	Uses walker. If Yes, can get in and out unassisted?	☐ Yes	☑ No
☑	☐	Uses wheelchair. If Yes, can get in and out unassisted?	☐ Yes	☑ No
☑	☐	Requires grab bars in bathroom		
☐	☑	Other: (Describe)		

MOLITOR, EDWARD
Acct: 00680956 Tm: 517
MRUN: 609-99-28
09/05/17 M 03/26/56
ADMINSURE

SERVICES NEEDED (Check items and explain)

YES	NO	
☑	☐	Help in transferring in and out of bed and dressing
☑	☐	Help with bathing, hair care, personal hygiene
☐	☑	Does client desire and is client capable of doing own personal laundry and other household tasks (specify)
☑	☐	Help with moving about the facility
☐	☑	Help with eating (need for adaptive devices or assistance from another person)
☐	☑	Special diet/observation of food intake
☑	☐	Toileting, including assistance equipment, or assistance of another person
☐	☑	Continence, bowel or bladder control. Are assistive devices such as a catheter required?
☑	☐	Help with medication
☐	☑	Needs special observation/night supervision (due to confusion, forgetfulness, wandering)
☐	☑	Help in managing own cash resources
☑	☐	Help in participating in activity programs
☐	☑	Special medical attention
☐	☑	Assistance in incidental health and medical care
☐	☑	Other "Services Needed" not identified above

Is there any additional information which would assist the facility in determining applicant's suitability for admission? ☐ Yes ☑ No

If Yes, please attach comments on separate sheet.

To the best of my knowledge; I (the above person) do not need skilled nursing care.

SIGNATURE Carol Molitor APPLICANT (CLIENT) OR AUTHORIZED REPRESENTATIVE	DATE COMPLETED 9/5/17
Edward Molitor SIGNATURE Carol Molitor LICENSEE OR DESIGNATED REPRESENTATIVE	DATE COMPLETED 9-5-17
WN	DATE COMPLETED 9/5/17

C. COLINA
Hospitals and Centers for Healthcare

TRANSITIONAL LIVING CENTER
HOUSE RULES

1. Phone hours are 8-9 am, 12-1 pm, and 3-10 pm daily. These hours include personal cell phones. Clients utilizing the TLC telephone are asked to limit their calls to 15 minutes per hour to allow other clients access to the phones. Cell phones should be turned off during therapy sessions.

2. Visiting hours are from 12-1 pm and 3-9 pm daily Monday through Friday, 12-9 pm Saturday, and 10 am - 9 pm Sunday. Exceptions include family training when pre-arranged with your case manager.

3. Client and family visitation is to take place in common areas (e.g., the kitchen, the T.V. rooms, the area by the fire place). Visiting in client bedrooms is not permitted without prior approval from the program administrator.

4. Hours of operation for audio-visual (game consoles, iPads, tablets, TV's, etc) and computer equipment include 8-9 am, 12-1 pm, and 3-9 pm daily with consideration of your roommate and other residents. Use of such equipment after 9 pm will require headphones.

5. Snacks (e.g., pretzels, chips, candy, granola bars, etc.) may be kept in client rooms if sealed in an airtight dated container and stored properly. Clients may have refrigerated food stored in an airtight container in the ADL refrigerator. This food must be labeled, dated, and follow appropriate food storage guidelines. Food that is homemade or does not have an expiration date must be consumed within three days of being placed in the refrigerator. For the safety of the client, staff retains the right to dispose of food not in compliance with the food storage guidelines. All food items will need to be cleared by the nurse to ensure compliance with prescribed diet.

6. Clients may not borrow, share, or give away money, cigarettes, or personal belongings to other clients or staff.

7. Meals are to be eaten in designated areas only, to include both of the dining rooms, the tables in the recreation room, and the outside tables.

8. Day passes and overnight passes must have prior approval of your treatment team, physician, and insurance company. Please check with your case manager regarding approval.

9. When clients leave the facility, they must sign out and back in with the shift supervisor at the main nurse's station. If the client is unable to sign a family member or other authorizec individual by the client or family may do so.

10. Alcohol and illegal drugs are not permitted. All medications are to be kept in the nursing station.

11. All medications are to be kept in the nursing station, including over the counter medications. Please speak with Nursing if there are any questions.

MOLITOR,EDWARD
Acct: 00680956 Tm: 517
MRUN: 609-99-28
09/05/17 M 03/26/56
ADMINSURE

CASA CALINA
Hospital and Centers for Healthcare

TLC Apartment Agreement for Clients

Apartment requirements are as follow:

Clients are responsible to consistently moat the team goals in the apartment setting.

All house rules for TLC residence apply to the TLC apartments. (Refer to the house rules posted within the apartment. These apply to all clients.)

No pets are allowed.

Children are to be supervised by parents at all times and must not interfere with other clients.

The kitchen is for use of the client only - not families and friends.

Visiting hours are the same as for TLC residence.

Use of the shared space for the living room and kitchen will be limited to the hours of 7:00am to 10:00pm.

Clients are responsible for monitoring the noise level at all times to be considerate of other clients.

Home skills are expected to be carried out as per the plan with OT. Housekeeping will NOT provide these services in the apartments.

Furniture or furnishings are not to be moved from the house.

Any violation of the house rules will result in violation and will result in an immediate eviction from the apartment program.

You are responsible for your own laundry including linens and clothes.

You are responsible for getting you own medication at the nurse's station.

Agreed and understood Carol Molitor

Date: 9-5-17

Witness: [illegible]

MOLITOR,EDWARD
Acct: 00680956 Tm: 517
MRUN: 609-99-28
09/05/17 M 03/26/56
ADMINSURE

fluid. Impression: 1) Rotator cuff tendinosis with superimposed focal full thickness non-retracted tear distal supraspinatus tendon. 2) No labral injury.

12/18/17 – PTP's PR-2 by David Smith, MD. Pt had not improved with extensive conservative tx. Dx: Full-thickness RCT with retraction secondary to injury while on work duty, 05/23/17 with persistent symptomatology. Plan: Requested R shoulder arthroscopy. Given Ibuprofen. Continue modified duty with limited use of R arm.

01/18/18 - Outpatient Anesthesia Record at Anesthesia Service Med Grp.

01/18/18 – Prescription and Certification of Medical Necessity for Continuous Controlled Cold Therapy by David Smith, MD. Requested Pneumatic intermittent compression device/cold therapy and pad purchase.

01/18/18 - Operative Rpt by David Smith, MD at Otay Lakes Surgery Ctr. Pre/Post-op Dx: Internal derangement R shoulder. Operative Procedure: Arthroscopy of R shoulder, debridement of hypertrophic Synovitis with partial synovectomy in GH joint, debridement of anterior and superior glenoid labral tears, arthroscopic subacromial decompression, R shoulder with anterior acromioplasty, excision of distal clavicle R shoulder with at least 5 mm of clearance following excision, debridement of partial RCT R shoulder.

01/22/18 - PTP's PR-2 by Farzaneh Maghsoudy, MD. Pt was here for wound check and dressing change. Pain 5-7/10. Pain was well controlled but was getting constipated. Tape site was itchy and red over R chest wall (part of dressing). On 29th, pt would have suture removal and another recheck. Wound was irrigated with normal saline. Non-stick and dry sterile dressing was applied. Dx: Acute postop pain of R shoulder. Plan: Take OTC Colace and/or Metamucil. Off duty until 01/29/18.

01/29/18 – PTP's PR-2 by David Smith, MD. Complaints remain unchanged. Dx: S/p arthroscopy of R shoulder 01/18/18. Sutures were removed. Recommended to begin PT. Given additional Norco. Off duty until 02/12/18.

01/31/18 – Formal Appeal of Denial of Cold Therapy Unit Rental by Treating Physician by David Smith, MD. It was common practice for postoperative shoulder arthroscopy patients to utilize a cold therapy unit for 7 to 10 days. This was not a purchase of the cold therapy unit, but rather a rental. The use of the cold therapy unit significantly decreased swelling and pain, and postoperative rehabilitation was enhanced by the use of the cold therapy unit. Recommended cold therapy unit rental be certified.

02/12/18 – Physician Progress Rpt by David Smith, MD. Complaints and Dx remains unchanged. Plan: Recommended to finish remaining sessions of PT. TTD.

03/12/18 – PTP's PR-2 by David Smith, MD. Pt had been attending PT but still not achieved FROM of R shoulder. Dx remains unchanged. Plan: Recommended additional PT. TTD. Given Tramadol. TTD until 03/26/18.

03/26/18 – Physician Progress Rpt by David Smith, MD. ROM was improving. Dx: 1) Incomplete RCT/rupture of R shoulder. 2) Other articular cartilage disorders, R shoulder. 3) Primary OA R

2W9537

Law Offices
TOBIN • LUCKS LLP

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www.tobinlucks.com

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Edwin J. Lucks
Frank Christine III*
John Lamoutte*
Robert C. Tobin*
John F. Salisbury
Jeannine M. Arce*
Alan J. Beardsley
Therese M. Walsh*
Jesse R. Perez*
Gregory J. Cameron*
Brent E. Levine*
Mark S. Tobin
Sarah M. Flynn*
Mark G. Stephens*
Bruce M. Toomer

Donald P. Tobin* (Retired)

Jessica J. Jorgenson*
Carolyn M. Lopez*
Yunna Mirolyan*
David A. Lee*
Sam D. Dardashti
Sean V. Rivera*
Timothy S. Tobin*
Debra M. Shackelford
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S. Alfonso Smith

*Certified Specialist, Workers' Compensation Law,
The State Bar of California Board of Legal Specialization

RECEIVED
MAY 08 2020
BY:

April 9, 2020

Arrowhead Evaluation Services
Attention: Harvey R. Wieseltier, MD
1680 Plum Lane
Redlands, CA 92374

RE: **ALICIA ZUNIGA CHAVARRIA vs. BALBOA MANUFACTORY CO. LLC**

WCAB Case No.	:	ADJ12051052, ADJ11666398
Claim No.	:	2019390993, 20173237654
Our File No.	:	145644
Date of Injury	:	CT: 05/23/2017-05/30/2019, 05/23/2017

Dear Dr. Wieseltier:

We sent you a jointly executed letter dated February 13, 2020 which provided further diagnostics. For your convenience, the February 13, 2020 letter and diagnostic testing is attached here.

In further response to the request in your most recent report of January 13, 2019 at page 5, we attach the settlement agreement of November 9, 2019 and a Description of Employee's Job Duties ("Job Analysis").

With respect to the attached Job Analysis, the applicant takes some exception to the description. She would like you to consider her recollection of her job duties which differ from the attached Job Analysis as follows:

1. WALKING: The Job Analysis indicates 2-3 hours, but applicant asserts it was often 6 or more hours per day.

2. BENDING: The Job Analysis indicates "1 hour or less," but applicant asserts she was often required to bend for 2-3 hours on a shift.

3. REACHING ABOVE THE SHOULDER: The Job Analysis indicates "1-2 hours," but the applicant asserts she often did so for 2 or more hours on a shift.

4. PUSHING: The applicant asserts she pushed a cart for her entire shift.

5. OTHER: The applicant asserts that she was required to be in an environment with a lot

0.5"

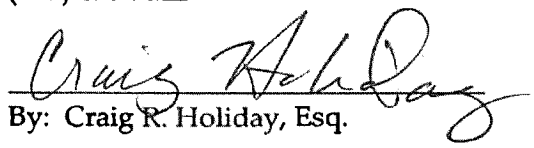
of dust, and the temperature often changed from "really hot" to "really cold".

Thus, as there is some differences with respect to the attached Job Analysis and the applicant's recollection, the parties request that if the discrepancy would lead you to calculate a different Whole Person Impairment, Apportionment or Future Medical Care, then the parties ask that you provide alternative ratings. The trier of fact would then decide which factual scenario is accurate.

Additionally, it does not appear that either party sent you the deposition transcript of the applicant's deposition taken on September 9, 2019. It may shed some light on the applicant's job duties. A condensed version is attached here for your review.

Very truly yours,

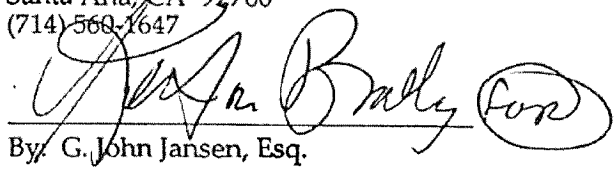
TOBIN • LUCKS LLP
1 MacArthur Place, Suite 700
Santa Ana, CA 92707
(949) 476-9222



By: Craig R. Holiday, Esq.

Very truly yours,

LAW OFFICES OF G. JOHN JANSEN
2114 N. Broadway, Suite 200
Santa Ana, CA 92706
(714) 560-1647



By: G. John Jansen, Esq.

C_H:meo
Enclosure(s):
November 9, 2018 Award and Stipulation with Request for Award
February 13, 2020 Correspondence to Harvey Wieseltier with diagnostic
Condensed deposition transcript of Alicia Zuniga Chavarria Sept. 9, 2019

DOCUMENT SEPARATOR SHEET

Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title STIPULATIONS WITH REQUEST FOR AWARD DOI POST 1-1-2013

Document Date 10/19/2018
MM/DD/YYYY

Author EMPLOYERS ASSURANCE GLENDALE

Office Use Only

Received Date
MM/DD/YYYY

SAN DIEGO DIR
Received
NOV - 5 2018
C6
DWC/WCAB

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

~~UNASSIGNED~~ ADJ 11666398
Case No.

Date of Injury 05/23/2017
MM/DD/YYYY

622433098
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).)

SDO

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

Applicant (Completion of this section is required)

ALICIA
First Name

MI.

CHAVARRIA
Last Name

13792 HWY 8 BUSINESS SP #27
Address/PO Box (Please leave blank spaces between numbers, names or words)

EL CAJON
City

CA
State

92021-1944
Zip Code

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

x Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

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

9401 WAPLES SUITE 120
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

SAN DIEGO
City

CA
State

92121
Zip Code

SAN DIEGO DIR
Received
NOV – 5 2018
C6
DWC/WCAB

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

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

PO BOX 32036
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

LAKELAND — City
FL — State
33802- — Zip Code

Claims Administrator Information (if known and if applicable)

EMPLOYERS ASSURANCE-GLENDALE
Name (Please leave blank spaces between numbers, names or words)

PO Box 32036
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

LAKELAND — City
FL — State
33802-2036 — 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

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. ALICIA
Employees First Name

CHAVARRIA
Employees Last Name

birth date 08/24/1961
MM/DD/YYYY

while employed at BALBOA MANUFACTURING COMPANY, CA
State

as a (n) BAG AND TAG LEAD, 221 in
Occupation Group

☐ More than 4 Companion Cases

UNASSIGNED
Case Number 1

x Specific Injury
☐ Cumulative Injury

05/23/2017
(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: 450 Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

Case Number 2

☐ Specific Injury
☐ 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:

Case Number 3

☐ Specific Injury
☐ 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:

Case Number 4

☐ Specific Injury
☐ 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

RIGHT SHOULDER

(Please list all body parts injured)

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

9. Other stipulations:

THE PARTIES WISH TO SETTLE THE CLAIM BASED ON THE PRIMARY TREATING PHYSICIAN REPORT OF DR. SMITH DATED 7/16/18. THE CLAIMANT DOES NOT WISH TO PROCEED WITH A PANEL QUALIFIED MEDICAL EVALUATOR.

THE CLAIMANT CONTINUES TO WORK HER USUAL AND CUSTOMARY JOB.

Dated 10/01/2018
MM/DD/YYYY

Olivia Chavonia
Applicant

Applicant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

N/A
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

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney x Non Attorney Representative

JOSIE
First Name

BRITO
Last Name

888-682-6671
Firm Number

EMPLOYERS ASSURANCE-GLENDALE
Law Firm Name

P.O. BOX 32036
Address/PO Box (Please leave blank spaces between numbers, names or words)

LAKELAND
City

FL
State

33802
Zip Code

Dated 10/19/2018
MM/DD/YYYY

Josie Brito
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

surgery appointment. BPH with microcytic hematuria. Dx: 1) B/L carpal tunnel. 2) Pain in L hip. Rx: Gabapentin, Simvastatin, Famotidine and Tamsulosin. Plan: D/c Terazosin. Continue Tadalafil and Zocor. Given splints. Requested EMG/NCS. Advised heat/massage and stretching exercises to L hip. Referred to Nutrition. Motivated to lose weight.

11/16/16 - X-ray of R Wrist by Cande Sridhar, MD at Mid-Valley CHC. Impression: Negative appearing R wrist exam.

11/16/16 - X-ray of L Wrist by Cande Sridhar, MD at Mid-Valley CHC. Impression: Negative appearing L wrist exam.

05/08/17 – F/u Visit by Yuliya Reznikova, NP. B/L hand pain and R foot pain 4/10. Intermittent bothersome B/L N/T and burning, more at night. Using B/L wrist splints at night and taking Neurontin with moderate relief. Symptoms lately started getting worse, and now pain extends to upper arms and shoulders. Occasional R ankle edema and erythema with pain, currently no symptoms. Dx: 1) Frequency of urination. 2) Ankle pain. Rx: Neurontin, Zocor. Plan: Considered Hand/Plastic referral. Ordered labs. Continue meds.

06/16/17 – EMG/NCS by Mimi Lee, MD/Shri Mishra, MD at Olive View Med Ctr. Conclusion: This was an abnormal study. There was electrodiagnostic evidence of mild B/L mononeuropathy at the wrists, left worse than the right with demyelinating features.

07/12/17 – Visit Note by Michelle Zaki, MD at Mid Valley CHC. R ankle pain 7/10. He has had R ankle pain a few years ago, however it resolved on its own. Pain started in 03/2017. Pain waxes and wanes, but is usually present and it sometimes swells to the size of a baseball. Tried Diclofenac and it relieved his pain. PE: Mild edema over the lateral malleolus of RLE. 5 mm lesion on scalp. Dx: R ankle pain. 2) B/L carpal tunnel. 3) Lesion of scalp. Rx: Diclofenac. Plan: Ordered ankle x-ray. E-consulted Podiatry, Ortho hand and dermatology. Return precautions given including inability to bear weight or walk.

07/18/17 - X-ray of R Ankle by Antoinette Roth, MD at Mid Valley CHC. Findings: There are osteophytes extending off the medial malleolus, which may be related to prior trauma. A small ankle joint effusion is present. There is minimal calcaneal bone spurring. Impression: 1) No evidence of acute fx or dislocation. 2) Chronic changes.

08/22/17 - Podiatry Consult by Aisha Ahmed, DPM/Scott Boynton, DPM at Olive View Med Ctr. Chronic R ankle pain, worse with ROM, also hears click in the joint. PE: R Ankle: Mild pain with passive ROM, limited compared to contralateral side. Mild pain also with R STJ ROM. Dx: R ankle pain likely due to underlying OCD medial talar plafond and minimal arthritic changes. Plan: Prescribed ankle brace and recommended ankle high top shoes. Offered ankle injection, but pt refused.

02/22/18 – Podiatry F/u Visit by Thomas Curtis, DPM/Tanler Volkmann, DPM at Olive View Med Ctr. R ankle pain due to talar dome. Pain with ambulation. Works as a waiter, on his feet most of the day. Has to wear non-supportive boots at work. Did not get ankle brace last visit. Dx

surface. 2) Prominent os trigonum noted with minimal degenerative change between this accessory ossicle and the posterior talus and also the adjacent calcaneus.

05/22/19 – F/u Visit by Yuliya Reznikova, NP. B/L hand N/T and burning. Diclofenac helps with R ankle pain. Compliant with all meds. Dx remains unchanged. Plan: Continue wrist splint, neurontin and Zocor. Ordered labs.

08/08/19 – Podiatry F/u Visit by Reece Everson, DPM/Narek Garukyan, DPM at Olive View Med Ctr. Constant R ankle pain 9/10. No longer wants to take Diclofenac because of renal complications. Dx: Chronic R ankle pain due to medial talar OCD demonstrated on both MRI and CT. Plan: Continue lace up ankle brace. Scheduled for surgery.

08/08/19 - Visit Note by Nirbhay Jain, MD at Olive View Med Ctr. Pt with EMG proven B/L CTS. Has tried bracing in past with continual numbness, increasing weakness. PE: Tinel positive over B/L cubital tunnel. Plan: Agreed not to pursue steroid injection. Recommended repeat EMG/NCS to analyze possible B/L cubital tunnel syndrome as well as CTS.

08/15/19 - Urgent Care Note by Roy Harris, MD at Olive View Med Ctr. Total body join pain for 3-4 yrs. CTS of hands have worsened over the last month. PE: DIP joints with mild swelling and subtle deformity on L 2nd digit. Dx: 1) Joint pain, h/o arthralgia r/o CTD. 2) CK mildly elevated. Rx: Motrin, Flexeril and Lidocaine cream. Plan: Ordered labs and B/L hand x-rays. Reduced Lipitor to QOD. Labs showed newly diagnosed Sjogren's and will refer to Rheumatology.

08/15/19 - X-ray of B/L Hand by Soni Chawla, MD at Olive View Med. Ctr. Impressions: 1) Mild medial angulation at the DIP of the 2nd digits bilaterally. 2) Possible mild subluxation at the IP joint of the R thumb. 3) Mild periarticular osteopenia considering technique. 4) No significant degenerative changes. No evidence of any significant joint erosions. 5) No abnormal soft tissue calcifications.

09/05/19 – Visit Note by Margarita Monterde, NP at Mid Valley CHC. B/L wrist pain 8/10 with intermittent numbness. Also continues to c/o R ankle pain. PE: B/L PIP joint swelling and positive Phalen's test. Dx: 1) B/L carpal tunnel. 2) Pain in R ankle. 3) Positive Sjogren's/ANA. Plan: Ordered EMG/NCS. Referred to Rheumatology. Continue supportive treatment.

NOTE: Remainder of the record includes subpoena records, screening for adult immunization, blank pages, home medication reconciliation/health maintenance, single assessment sheet/multidisciplinary teaching record, vaccination detail, demographic sheet, visit for erectile dysfunction, staying healthy assessment questionnaire, dysuria, sore throat and hyperlipidemia, enlarged prostate, clinic tracking log, and laboratory reports.

JM/rpc
02/19/20

REVIEW of MEDICAL RECORDS
Iniguez, Roberto
DOB: 05/01/1976

Pages Reviewed: 110

WC Claim Form dated 08/05/19 w/DOI: CT 04/01/00 – 08/05/19. Repetitive and continued use to B/L hand, B/L wrist, fingers, B/L arm, B/L shoulder, R ankle, R knee and low back.

Application for Adjudication dated 08/09/19 w/DOI: CT 04/01/00 – 08/05/19. Repetitive and continual use to B/L hand, B/L wrist, fingers, B/L arm, B/L shoulder, R ankle, R knee and low back. Employed by La Golondrina as a Waiter Waitress Hotel Restaurant.

Deposition of Roberto Iniguez on 09/01/19.

Page-10 – Pt took Gabapentin, Zocor and Diclofenac in last 24 hours prescribed by primary doctor, Dr. Julia Rosnikova at Mid Valley Clinic. Pages 11-15 – Gabapentin was for pain in hands, Diclofenac was for pain and inflammation in ankle, Zocor was for cholesterol. Drove to deposition. Filed WC claim because hands, R ankle, knee, low back, shoulders and neck were hurting due to repetitive work. Duties were lifting heavy trays, grabbing beer pitchers, gathering all dirty dishes from the patrons. Heaviest trays weighed 15 to 25 lbs. Lightest trays weighed 8 lbs. Pages 16-20 – Pain in hands began in 2016. R ankle pain began 2-1/2 years ago. Pain in neck, low back, shoulders began 6 months ago. Never reported injury to employer because was seeing doctor and getting pain pills. Hands started to burn a lot with N/T and doctor told it was work injury. Felt R ankle was going to break. Felt throbbing pain in lower back. Felt heavy pain in neck. Felt tingling and weakness in shoulders. Currently not working. Stopped working on 10/19/19 because primary doctor put on disability. Hired at La Golondrina on 04/01/00 as host. Was off work around September 2019 for injuries. Also was off for some days because of pain in foot, hands in mid 2019. Pages 21-25 –Became as waiter around 2005 or 2006. Was caregiver for mom through IHSS 11 years ago. Currently being disabled stopped working for mom. Last worked for mom on 10/19/19. As waiter, duties were to get food/beverage orders from people, then had to pick them up, had to pick up dirty dishes after people were done eating and take the trays to the back. At times when we did not have a busboy, had to clean up. Prior to La Golondrina, worked at El Gallo Giro as cashier for 6 or 8 months. Duties were to do all setup in restaurant, had to bring cushions for chairs and plastic for tables. Job required bending/lifting. Pages 26-29 - Just applied cream for pain. Went to ER at Olive View Hospital in September 2019 because ankle/shoulders were hurting a lot and fingers felt very weak, they gave meds for inflammation. Had chest reduction in 2004. Was seeing Dr. David Well and had another appointment in 11/15/19. Pages 34, 35 – Used to go to movies for fun for about thrice a month. Currently spent days in bed. Goes to grocery shopping with partner. Does household chores and take out trash once a while. Was able to make beds, wash dishes, do laundry. Page 37 – Also had varicose veins in L knee because of work.

JM/rpc
12/09/19

MEDICAL INDEX

MEDICAL REPORTS	DATED
B. Sam Tabibian, M.D.	3/18/20; 2/19/20; 2/13/20-EMG
David Jeffrey Weil, M.D.	12/20/19; 12/16/19-RFA; 11/29/19; 11/15/19; 10/18/19
WestStar/Samantha Correia, PT	3/9/20; 2/26/20; 2/24/20; 2/19/20; 2/17/20; 2/10/20 (3)
WestStar/Kurt Burgcbardt, PT	3/2/20 (3); 2/21/20; 2/12/20
Beverly Hills Medical Imaging	1/29/20 (2) MRI-Joint Lower Extremity MRI-Lumbar Spine

PHYSICAL MEDICINE INSTITUTE
Behnam Sam Tabibian MD QME
Physical Medicine and Rehabilitation

14925 Burbank Blvd.
Sherman Oaks, CA 91411
Phone: (818) 905-3355
Fax: (818) 905-0044

WORK STATUS

Mar 18, 2020

LA Golondrina Inc.
W 17 Olvera St.
Los Angeles, CA 90012

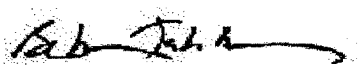
Next Level Administrators
PO Box 1061
Bradenton, FL 34206

PATIENT: Iniguez, Roberto
DATE OF INJURY: CT: 04/01/2000-08/05/2019 08/05/2019
CLAIM NO.: UW1900013388

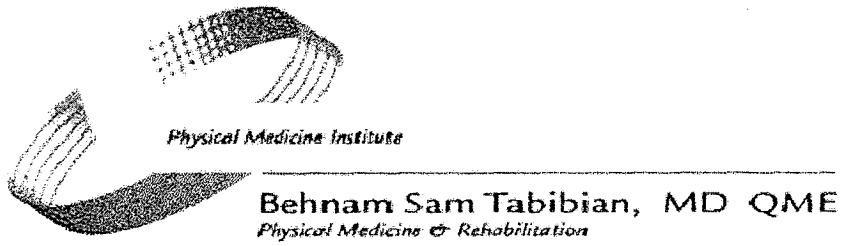
The above named patient is currently receiving medical treatment in our office. His work status is as follows:

Modified Work with the following restrictions:
No Heavy Pushing or Pulling over 5 lbs,
No lifting or carrying over 5 lbs,
Ability to sit and stand as needed to mitigate pain.,
Avoid bending, stooping, twisting, turning, squatting and crouching Frequently,
Standing restrictions include preclusion from continued walking or standing for longer than **15** minutes/hour.,
Patient is completely restricted from climbing.,
Restricted from repetitive gripping, grasping, squeezing, pinching, holding and torquing using the both arms.,
TTD if no mod duty available,
Limited to sedentary light duty work.

Patients next appointment date is on 05/06/2020 @ 01:15 PM



B. Sam Tabibian, MD, QME
Diplomate, American Board of
Physical Medicine and Rehabilitation
State of California License A61974



February 19, 2020

Next Level Administrators
PO Box 1061
Bradenton, FL 34206

Sessoms Law Firm
Diallo-Alan Sessoms,Esquire
4944 Vineland Ave Ste 21
North Hollywood, CA 91601

PATIENT:	Iniguez, Roberto
DATE OF INJURY:	CT: 04/01/2000-08/05/2019
CLAIM NO.:	UW1900013388
DATE OF EXAM:	Feb 19, 2020

PRIMARY TREATING PHYSICIAN'S
PROGRESS REPORT (PR2) AND REQUEST FOR AUTHORIZATION

INTERIM HISTORY:

The patient returns to this office today for follow up visit. Since his last visit, he did start physical therapy and also had injection to the right knee on January 29, 2020. Unfortunately, he said that following the injection his right knee is worse. He has ongoing pain to the knee with difficulty, walking, bending, stooping and squatting type of activities. Patient also has continued back pain with difficulty bending, stooping and squatting, problem with sitting and laying down. Patient also states ongoing shoulder pain with stiffness and soreness that also extends into his neck. Patient also reports white ankle pain which is manageable. Patient does have numbness tingling, weakness in both hands. Patient reports that since his last visit, he did also undergo diagnostic testing including MRI scans and nerve studies to be reviewed today. Patient states that he's currently not working.

14925 Burbank Boulevard, Sherman Oaks, CA 91411 (P) 818-905-3355 (F) 818-905-0044 backpainla.com

07/21/17 – PTP's PR-2 by Farzaneh Maghsoudy, MD. Pt's injury was 70% better. Pain 4/10. Dx remains unchanged. Continue modified duty.

06/05/17-07/24/17 (12 visits) – PT Notes from U.S. HealthWorks. Pt completed 12 sessions of PT for R shoulder. Decreased spasms on R scapular muscles.

07/28/17 – PTP's PR-2 by Farzaneh Maghsoudy, MD. Pt's injury was 75% better. R shoulder pain 3/10. Dx remains unchanged. Plan: Ordered acupuncture. Continue modified duty.

08/15/17 – PTP's PR-2 by Ganna Breland, DO. Pt's injury was 75% better. Pain 4/10. Dx remains unchanged. Plan: Continue acupuncture therapy. Continue modified duty.

08/28/17 - PTP's PR-2 by Farzaneh Maghsoudy, MD. Pain 3/10. Dx remains unchanged. Plan: Continue acupuncture therapy. Referred to Ortho Dr. Smith on 09/11. Continue modified duty.

08/15/17-09/07/17 (6 visits) - Acupuncture Therapy Notes from U.S. HealthWorks. Completed 6 visits of acupuncture therapy to R shoulder. Felt better overall. R shoulder still heavy and work with lifting. Pain 2/10.

09/19/17 – Initial Comprehensive Ortho Med Eval by David Smith, MD at U.S. HealthWorks. DOI: 05/23/17. During the course of work duty, she began to experience considerable pain in R shoulder. X-ray of R shoulder was felt to be within normal limits. Give anti-inflammatory and analgesic meds and PT. C/o persistent pain in R shoulder. Weakness with lifting of her R arm above shoulder level. PE: Painful ROM of R shoulder. Weakness with abduction and forward flexion in R shoulder. Positive Drop Arm sign in R shoulder. X-ray of R shoulder on 05/25/17 reveal some mild degenerative changes in AC joint but were otherwise within normal limits. Dx: R shoulder S/S secondary to repetitive use of R arm while on work duty with persistent symptomatology despite activity modification, anti-inflammatory meds, and PT with positive Drop Arm sign and passive ROM greater than active ROM. Rx: Lodine. Plan: Requested MRI of R shoulder. Modified duty. Causation: Pt did sustain an injury to R shoulder arising out of and caused by industrial exposure of 05/23/17.

10/17/17 – PTP's PR-2 by David Smith, MD. Still had pain in R shoulder. Attempted to undergo MRI scan of R shoulder but was severely claustrophobic and was unable to undergo the MRI scan. Dx: Strain unspecified muscle/fascia/tendon at R shoulder/upper arm. Continue modified duty.

10/31/17 – PTP's PR-2 by David Smith, MD. Pt would need to undergo MRI scan in an open MRI scanner and given Valium to be taken prior to MRI scan. Dx remains unchanged. Plan: Recommended to undergo open MRI scan of R shoulder. Continue modified duty.

12/15/17 - MRI of R shoulder w/o contrast by James Collins, MD at XDi Medical Diagnostic Imaging. Findings: Rotator Cuff: Thickening with increased signal of supraspinatus and infraspinatus tendons. Focal full thickness non-retracted tear leading edge distal supraspinatus with tendon gap of 10 mm. Fluid extended into the subacromial subdeltoid bursa. Tear appears recent. AC Joint: Degenerative changes AC joint with lateral downsloping of acromion with subacromial spurring. Physiologic joint

shoulder. 4) Synovitis and tenosynovitis, unspecified. Plan: Recommended to finish remaining PT session. Off duty until 04/09/18.

04/09/18 – Physician Progress Rpt by David Smith, MD. Still had R shoulder pain and had not yet achieved FROM of R shoulder. Dx remains unchanged. Rx: Flexeril. Plan: Recommended additional PT. Continue modified duty at this time with no use of R arm. No overhead work and a 5 lbs lifting restriction.

05/21/18 – PTP's PR-2 by David Smith, MD. Pain level was diminished with PT. Still had some muscular spasm in her cervical and trapezius musculature on R side. Dx remains unchanged. Plan: Recommended to finish PT. Continue modified duty.

06/04/18 – PTP's PR-2 by David Smith, MD. Complaints and Dx remains unchanged. Plan: Requested additional PT. Regular duty.

07/03/18 – RFA by David Smith, MD. Requested other/cold therapy unit.

01/31/18-07/12/18 (30 visits) - PT Notes from U.S. HealthWorks. Completed 30 visits of PT to R shoulder. Pt s/p R shoulder scope. Pt felt about 95% better. Still had c/o sore and stiffness. Needs more PT.

07/16/18 - PTP's P&S Rpt by David Smith, MD. DOI: 05/23/17. S/p arthroscopy on R shoulder on 01/18/18. She had now finished her course of PT and she had done well. Dx: 1) R shoulder S/S secondary to repetitive use of R arm while on work duty with persistent symptomatology despite activity modification, anti-inflammatory medication, and PT with positive drop arm sign and passive ROM greater than active ROM. 2) Partial RCT, R shoulder secondary to injury while on work duty 05/23/17. 3) S/p arthroscopy of R shoulder 01/18/18. Causation: Pt did sustain an injury to R shoulder arising out of and caused by the industrial exposure of 05/23/17. Apportionment was not a consideration. Disability Status: Consider P&S. Impairment Rating: RUE 3% WPI. Functional Capacity Assessment: Capable of performing her regular work duties. Future Medical Care: Physician re-evaluation should her symptoms worsen.

12/03/18 – PTP's PR-2 by David Smith, MD. Pt had been experiencing increased symptomatology in her R shoulder. Dx: Recent worsening of symptomatology, R shoulder, secondary to repetitive use of R arm while on work duty. Rx: Ibuprofen and Flexeril. Plan: Recommended PT. Modified duty consisting of 10 lb lifting restriction and limited overhead use of R arm.

01/08/19 – PTP's PR-2 by David Smith, MD. C/o R shoulder pain. Dx remains unchanged. Plan: Requested acupuncture therapy. Continue modified duty.

01/14/19 - Initial Visit by Woong Jeon, L.Ac. at New Life Acupuncture Clinic. C/o sharp, dull, throbbing, burning, constant, frequent, intermittent, occasional R shoulder/neck pain, 8/10. Dx: R shoulder pain, neck and migraine. Plan: Continue acupuncture.

03/25/19 – PTP's PR-2 by David Smith, MD at CMC. Pt was still experiencing R shoulder pain. For that reason, decreased her lifting restriction to 5 lbs or less. Dx remains unchanged. Plan: Requested

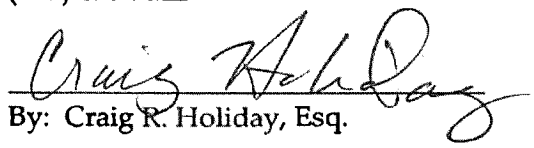
of dust, and the temperature often changed from "really hot" to "really cold".

Thus, as there is some differences with respect to the attached Job Analysis and the applicant's recollection, the parties request that if the discrepancy would lead you to calculate a different Whole Person Impairment, Apportionment or Future Medical Care, then the parties ask that you provide alternative ratings. The trier of fact would then decide which factual scenario is accurate.

Additionally, it does not appear that either party sent you the deposition transcript of the applicant's deposition taken on September 9, 2019. It may shed some light on the applicant's job duties. A condensed version is attached here for your review.

Very truly yours,

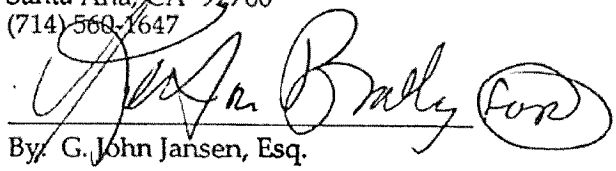
TOBIN • LUCKS LLP
1 MacArthur Place, Suite 700
Santa Ana, CA 92707
(949) 476-9222



By: Craig R. Holiday, Esq.

Very truly yours,

LAW OFFICES OF G. JOHN JANSEN
2114 N. Broadway, Suite 200
Santa Ana, CA 92706
(714) 560-1647



By: G. John Jansen, Esq.

C_H:meo
Enclosure(s):
November 9, 2018 Award and Stipulation with Request for Award
February 13, 2020 Correspondence to Harvey Wieseltier with diagnostic
Condensed deposition transcript of Alicia Zuniga Chavarria Sept. 9, 2019

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF ORANGE

I am employed in the County of Orange, State of California. I am over the age of 18 and not a party to the within action; my business address is 1 MacArthur Place, Suite 700, Santa Ana, CA 92707.

On May 5, 2020, I served the foregoing document(s) described as

CORRESPONDENCE TO HARVEY R. WIESELTIER, M.D. DATED APRIL 9, 2020
NOVEMBER 8, 2018 AWARD AND STIPULATION WITH REQUEST FOR AWARD
FEBRUARY 13, 2020 CORRESPONDENCE TO HARVEY WIESELTIER, M.D. WITH DIAGNOSTICS TESTING
CONDENSED DEPOSITION TRANSCRIPT OF ALICIA ZUNIGA CHAVARRIA DATED SEPTEMBER 8, 2019
ALICIA ZUNIGA CHAVARRIA VS. BALBOA MANUFACTORY CO., LLC

on the interested parties in this action by placing a true copy thereof enclosed in sealed envelopes addressed as follows:

VIA UPS
Arrowhead Evaluation Services
Attn: Harvey R. Wieseltier, MD
1680 Plum Lane
Redlands, CA 92374

Law Offices of G. John Jansen
Attn: G. John Jansen, Esq.
2114 N. Broadway, Suite 200
Santa Ana, CA 92706

Employers Assurance Company - Glendale
Attn: Josie Brito
P.O. Box 32036
Lakeland, FL 33802

BY MAIL

As follows: I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with U.S. Postal Service on that same day with postage thereon fully prepaid at Santa Ana, 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 date of deposit for mailing in affidavit.

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

Executed on May 5, 2020, at Santa Ana, California.

Margarete Oertel

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

~~UNASSIGNED~~ ADJ 11666398
Case No.

Date of Injury 05/23/2017
MM/DD/YYYY

622433098
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).)

SDO

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

Applicant (Completion of this section is required)

ALICIA
First Name

MI.

CHAVARRIA
Last Name

13792 HWY 8 BUSINESS SP #27
Address/PO Box (Please leave blank spaces between numbers, names or words)

EL CAJON
City

CA
State

92021-1944
Zip Code

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

x Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

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

9401 WAPLES SUITE 120
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

SAN DIEGO
City

CA
State

92121
Zip Code

SAN DIEGO DIR
Received
NOV – 5 2018
C6
DWC/WCAB

	Provider Plan	Pt. stable. CKD secondary to DM. GFR >90 with increased microalbumin . Pt. educated regarding HTN, diet and NSAID avoidance.
11.	Assessment	Body mass index (BMI) 29.0-29.9, adult (Z68.29), Controlled.
	Provider Plan	Pt. stable. Recommend decrease calorie intake, low fat diet. Recommend daily exercise routine.
	Plan Orders	Today's instructions / counseling include(s) Dietary management education, guidance, and counseling.Giving encouragement to exercise
12.	Assessment	Tinnitus (H93.19), chronic.
	Provider Plan	Moderate. Recommend over-the-counter Lipoflavinoid Plus 2 tabs twice a day for 1 month, then continue 1 tab twice a day. Referred to ENT for further eval. Pt to call office sooner if sx do not improve or increased hearing loss, dizziness, sudden numbness occurs.
	Plan Orders	Referrals: Audiology Clinic Desert Oasis Healthcare. Consult.

Medications

Medications reviewed.

Medications *(Added or Continued this visit)*

Medication Name	Instructions	Note	Start Date	Prescribed Else Where
atorvastatin 20 mg tablet	take 1 tablet by oral route every day	taking as directed	04/11/2017	N
tamsulosin 0.4 mg capsule	take 1 capsule by oral route every day 1/2 hour following the same meal each day	taking as directed	04/11/2017	N
metformin ER 1,000 mg 24 hr tablet,extended release	take 1 tablet by oral route 2 times every day with the evening meal		04/11/2017	N
losartan 100 mg tablet	take 1 tablet by oral route every day	taking as directed	04/11/2017	N
Humulin 70/30 100 unit/mL subcutaneous suspension	inject by subcutaneous route 50 units before breakfast and 30-35 units before dinner. (max dose = 100 units/day)	taking as directed	03/30/2017	N
insulin syringe-needle U-100 0.5 mL 31 gauge x 5/16"	Use as directed with Novolin 70/30 insulin.	taking as directed	12/27/2016	N
Aspirin Low Dose 81 mg tablet,delayed release	take 1 tablet by oral route every day	taking as directed		Y

Medications *(Stopped this visit)*

Medication Name	Instructions	Rx Comment
FreeStyle Freedom kit	please dispense 1 meter for pt to test 2-3xday	taking as directed

FreeStyle Lite Strips	Test 2-3 times daily.	taking as directed
lancets	test blood sugar 2-3 times daily.	taking as directed

The patient was checked out at 3:06 PM by Isabel Zaragoza.

Electronically signed by Edith Gonzalez Werner MD on 04/24/2017 05:21 PM

Radiology/Diagnostics

Patient Name: DE SANTIAGO, RAFAEL
Date of Birth: 01/28/1943

Exam Date: 04/25/2019
Performed at: Desert Advanced Imaging Indio
81880 Doctor Carreron Blvd.
Suite A-102
Indio,CA 92201

EXAM: X-RAY BILATERAL KNEES, 3 VIEWS EACH

HISTORY: Knee pain

COMPARISON: None available.

TECHNIQUE: Three views of the bilateral knees were obtained.

FINDINGS:

The bony structures are unremarkable. There is no evidence of fracture. There is no evidence of lytic or blastic lesions.

There is minimal bilateral knee degenerative joint disease. There is normal alignment. There is no subluxation or dislocation.

There is no focal soft tissue swelling. No abnormal calcific densities are appreciated.

IMPRESSION:
1. Minimal bilateral degenerative joint disease.

IF THE REFERRING PHYSICIAN WOULD LIKE TO SPEAK TO THE INTERPRETING RADIOLOGIST, PLEASE CALL 951-238-6046.

Dictated by: Danh Nguyen MD
ELECTRONICALLY SIGNED ON: 04/27/2019

RetinaVue® Care Delivery Model

Professional Medical Service

Diagnostic Report

Patient Information

Name: De Santiago, Rafael

Medical Record Number: 147971

Date of Birth: 1/28/1943

Referring Physician: Marc Hoffing, MD

Referring Clinic: Clinical Performance And Outcomes

Exam Date: 10/25/2018

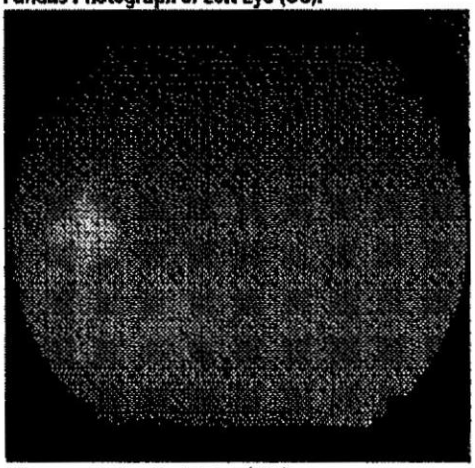
Submission Date: 10/31/2018 6:23:

Report Date: 11/9/2018

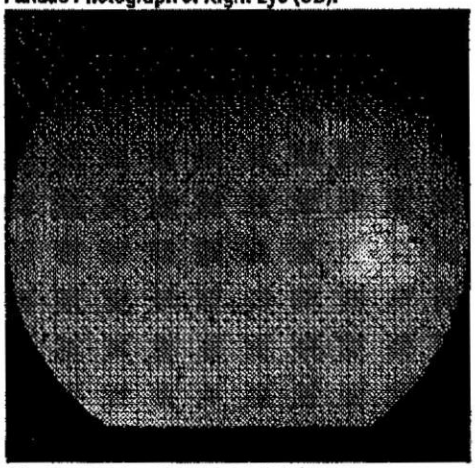
Exam ID: 353265

Retinal Image Assessment and Management Plan

Fundus Photograph of Left Eye (OS):



Fundus Photograph of Right Eye (OD):



Diagnosis for Left Eye (OS):

Image inadequate for assessment of retinal pathology

Diagnosis for Right Eye (OD):

No diabetic retinopathy

ICD-10 Diagnosis Codes:

Image inadequate for assessment of retinal pathology, E11.9 Type 2 diabetes mellitus without complications

Recommendation and Management Plan:

One or more images were inadequate to assess the presence of retinal pathology. Dilation might be required to acquire better quality images. Please reacquire images after application of dilation drops or refer the patient to an Optometrist/ophthalmologist for a dilated exam.

Comments:

No DR OD. blurry image OS

Reviewing Physician: Ashley Alden, OD

CA License Number: OPT33536TLG

Ashley Alden

WelchAllyn

This report specifies the presence of disease in the posterior pole of the retina for diagnostic, management and referral purposes. It does not take the place of a regular eye examination for the purpose of assessing the presence of glaucoma, cataract, anterior segment diseases, peripheral retina disease or other possible vision threatening conditions. For customer support, please call 1-866-422-2220 Opt #2

Desert Advanced Imaging Indio
81880 Doctor Carreron Blvd. Suite A-102
Indio, CA 92201
Phone: (760) 863-3857
Fax: (760) 863-5249

Ordered By

CAROL YAGHER, PAC
47250 WASHINTON ST, STE A
LA QUINTA CA, 92274

FAX: (760) 564-8581

DE SANTIAGO, RAFAEL
MRN: 101912BR1
DOB: 01-28-1943 Sex: M
Phone:(760) 863-1159

Date of Service: 06-07-2019

EXAM: X-RAY BILATERAL ANKLE, MINIMUM 3 VIEWS

HISTORY: Bilateral ankle pain

COMPARISON: None available.

TECHNIQUE: Three views were obtained.

FINDINGS:

The bony structures are unremarkable. There is no evidence of fracture. There is no evidence of lytic or blastic lesions. There are small bilateral plantar calcaneal spurs.

The joint space is well preserved. There is normal alignment. There is no subluxation or dislocation.

There is no focal soft tissue swelling. No abnormal calcific densities are appreciated.

IMPRESSION:

1. Small bilateral plantar calcaneal spurs.

IF THE REFERRING PHYSICIAN WOULD LIKE TO SPEAK TO THE INTERPRETING RADIOLOGIST, PLEASE CALL 951-238-6046.

End of diagnostic report for accession: 19252512
Dictated: 06-08-2019 9:19:45 AM
Electronically Signed By: Nguyen, Danh T, MD 06-08-2019 9:19:45 AM

Confidential

Desert Advanced Imaging Indio
81880 Doctor Carreron Blvd. Suite A-102
Indio, CA 92201
Phone: (760) 863-3857
Fax: (760) 863-5249

Ordered By

CAROL YAGHER, PAC
47250 WASHINTON ST, STE A
LA QUINTA CA, 92274

FAX: (760) 564-8581

DE SANTIAGO, RAFAEL
MRN: 101912BR1
DOB: 01-28-1943 Sex: M
Phone:(760) 863-1159

Date of Service: 06-07-2019

EXAM: X-RAY BILATERAL FOOT, MINIMUM 3 VIEWS

HISTORY: Bilateral foot pain

COMPARISON: None available.

TECHNIQUE: Three views were obtained.

FINDINGS:

The bony structures are unremarkable. There is no evidence of fracture. There is no evidence of lytic or blastic lesions. There are small bilateral plantar calcaneal spurs.

The joint space is well preserved. There is normal alignment. There is no subluxation or dislocation.

There is no focal soft tissue swelling. No abnormal calcific densities are appreciated.

IMPRESSION:
1. Small bilateral plantar calcaneal spurs.

IF THE REFERRING PHYSICIAN WOULD LIKE TO SPEAK TO THE INTERPRETING RADIOLOGIST, PLEASE CALL 951-238-6046.

End of diagnostic report for accession: 19252511
Dictated: 06-08-2019 9:20:18 AM
Electronically Signed By: Nguyen, Danh T, MD 06-08-2019 9:20:18 AM

Confidential

Electronically Signed By: Gonzalez Werner, Edith MD 09/27/2017 02:48:45 PM

Desert Advanced Imaging
A RadNet Imaging Center

Desert Advanced Imaging Bermuda Dunes
41120 Washington Blvd.
Bermuda Dunes, CA 92203
Phone: (760) 200-4168
Fax: (760) 200-4387

Ordered By

EDITH GONZALEZ-WERNER, MD
47250 WASHINGTON ST, STE A
LA QUINTA CA, 92253

FAX: (760) 564-8581

DE SANTIAGO, RAFAEL
MRN: 101912BR1
DOB: 01-28-1943 Sex: M
Phone:(760) 863-1159

Date of Service: 09-20-2017

EXAM: X-RAY LUMBAR SPINE, 2 OR 3 VIEWS

HISTORY: Low back pain.

TECHNIQUE: 3 views.

COMPARISON: None available.

FINDINGS:
A minimal scoliosis convex right is noted. Lateral alignment is within normal limits.
Lumbar interspaces are well-maintained with minor degenerative changes anteriorly at the lower lumbar levels L4-S1.
There is arthritic disease of facet joints at all levels especially L3-L5.
No acute fracture.
SI joints and soft tissues within normal limits.

IMPRESSION:
Minimal lumbar scoliosis.
There is degenerative change at the all lumbar levels most pronounced at L4-S1 without significant disc space narrowing. See above.

End of diagnostic report for accession: 11851836
Dictated: 09-22-2017 11:07:39 AM
Dictated By: Thayer, Joel H, MD
Signed By: Thayer, Joel H, MD 09-22-2017 11:07:39 AM

Confidential

Electronically Signed By: Gonzalez Werner, Edith MD 09/27/2017 02:48:00 PM

Desert Advanced Imaging Bermuda Dunes
41120 Washington Blvd.
Bermuda Dunes, CA 92203
Phone: (760) 200-4168
Fax: (760) 200-4387

DE SANTIAGO, RAFAEL
MRN: 101912BR1
DOB: 01-28-1943 Sex: M
Phone:(760) 863-1159

Date of Service: 09-20-2017

Ordered By

EDITH GONZALEZ-WERNER, MD
47250 WASHINGTON ST, STE A
LA QUINTA CA, 92253

FAX: (760) 564-8581

EXAM: X-RAY CHEST, PA AND LATERAL

HISTORY: Cardiopulmonary evaluation.

TECHNIQUE: PA and lateral views.

COMPARISON: 2/4/2014.

FINDINGS: The bony thorax appears intact.

The lungs are clear and show a normal vascular pattern.

There is no evidence of pleural effusion.

The heart and mediastinum are within normal limits for age.

No change from prior study.

IMPRESSION:
There is no evidence of active intrathoracic disease.

End of diagnostic report for accession: 11851835
Dictated: 09-20-2017 5:28:09 PM
Dictated By: Thayer, Joel H, MD
Signed By: Thayer, Joel H, MD 09-20-2017 5:28:09 PM

Confidential

Laboratory

Werner Gonzalez Medical Group
47250 Washington St
La Quinta, CA, 922532105

De Santiago, Rafael
82193 Kenner St
Indio, CA, 92201
Person #: 44001
Sex: M
DOB: 01/28/1943

Ordering: Gonzalez Werner MD, Edith **Performing #:** LabCorp **Location:** Werner Gonzalez Medical Group

Tests Ordered : Urinalysis, Routine (003038), Urine Culture, Routine (008847)

Urine Culture, Routine (Collection Date: 07/13/2018 17:03, Status: Final)
Performed At: SO, LabCorp San Diego
13112 Evening Creek Dr So Ste 200, San Diego, CA, 921284108
Jenny, Galloway, MD, Phone: 8586683700

Component	Result	Units	Flag	Range	Comment
Result 1	Comment		A		Beta hemolytic Streptococcus, group B 25,000-50,000 colony forming units per mL Penicillin and ampicillin are drugs of choice for treatment of beta-hemolytic streptococcal infections. Susceptibility testing of penicillins and other beta-lactam agents approved by the FDA for treatment of beta-hemolytic streptococcal infections need not be performed routinely because nonsusceptible isolates are extremely

				rare in any beta-hemolytic streptococcus and have not been reported for Streptococcus pyogenes (group A). (CLSI 2011)
Urine Culture, Routine	Final report		A	

Microscopic Examination (Collection Date: 07/13/2018 17:03, Status: Final)

Performed At: SO, LabCorp San Diego
13112 Evening Creek Dr So Ste 200, San Diego, CA, 921284108
Jenny, Galloway, MD, Phone: 8586683700

Component	Result	Units	Flag	Range	Comment
Bacteria	Few			None seen/Few	
Cast Type					
Casts					
Comment					
Crystal Type					
Crystals					
Epithelial Cells (non renal)	None seen	/hpf		0 - 10	
Epithelial Cells (renal)					
Mucus Threads	Present			Not Estab.	
RBC	0-2	/hpf		0 - 2	
Trichomonas					
WBC	0-5	/hpf		0 - 5	
Yeast					

Urinalysis, Routine (Collection Date: 07/13/2018 17:03, Status: Final)

noemail@mydohc.com
Performed At: SO, LabCorp San Diego
13112 Evening Creek Dr So Ste 200, San Diego, CA, 921284108
Jenny, Galloway, MD, Phone: 8586683700

Component	Result	Units	Flag	Range	Comment
Appearance	Clear			Clear	
Bilirubin	Negative			Negative	
Glucose	3+		A	Negative	
Ketones	Trace		A	Negative	
Microscopic Examination	See below:				
Nitrite, Urine	Negative			Negative	
Occult Blood	Negative			Negative	
pH	5.0			5.0-7.5	

Protein	1+	A	Negative/Trace	Urine tubes with preservative submitted for urinalysis which are not adequately filled may give falsely elevated protein.
Specific Gravity	>=1.030	A	1.005-1.030	
Urine-Color	Yellow		Yellow	
Urobilinogen,Semi-Qn	0.2 mg/dL		0.2-1.0	
WBC Esterase	Negative		Negative	

Werner Gonzalez Medical Group
47250 Washington St
La Quinta, CA, 922532105

De Santiago, Rafael
82193 Kenner St
Indio, CA, 92201
Person #: 44001
Sex: M
DOB: 01/28/1943

Ordering: Gonzalez Werner MD, Edith **Performing #:** LabCorp **Location:** Werner Gonzalez Medical Group

Tests Ordered : Comp. Metabolic Panel (14) (322000), Lipid Panel (303756), CBC With Differential/Platelet (005009), TSH (004259), Microalb/Creat Ratio, Randm Ur (140285), Vitamin B12 & Folate (000810), Prostate-Specific Ag, Serum (010322), Vitamin D, 25-Hydroxy (081950), Hemoglobin A1c (001453), GFR, Estimated (100768), PTH, Intact (015610), Vitamin B1 (Thiamine), Blood (121186)

Cardiovascular Report (Collection Date: 02/05/2019 07:48, Status: Final)
Performed At: LITTL, Lithoiink Corporation
2250 West Campbell Park Drive, Chicago, IL, 606123502
John, Aspin, MD, Phone: 3122430600

Component	Result	Units	Flag	Range	Comment
Interpretation	Note				Supplemental report is available.
PDF Image	.				

PTH, Intact (Collection Date: 02/05/2019 07:48, Status: Final)
Performed At: SO, LabCorp San Diego
13112 Evening Creek Dr So Ste 200, San Diego, CA, 921284108
Jenny, Galloway, MD, Phone: 8586683700

Component	Result	Units	Flag	Range	Comment
PTH, Intact	31	pg/mL		15-65	

Vitamin B1 (Thiamine), Blood (Collection Date: 02/05/2019 07:48, Status: Final)
Performed At: BN, LabCorp Burlington
1447 York Court, Burlington, NC, 272153361
Sanjai, Nagendra, MD, Phone: 8007624344

Component	Result	Units	Flag	Range	Comment
Vit. B1, Whole Blood	133.2	nmol/L		66.5-200.0	This test was developed and its performance characteristics determined by LabCorp. It has not been cleared or approved by the Food and Drug Administration.

Vitamin D, 25-Hydroxy (Collection Date: 02/05/2019 07:48, Status: Final)
Performed At: SO, LabCorp San Diego
13112 Evening Creek Dr So Ste 200, San Diego, CA, 921284108
Jenny, Galloway, MD, Phone: 8586683700

Component	Result	Units	Flag	Range	Comment
Vitamin D, 25-Hydroxy	28.2	ng/mL	L	30.0-100.0	Vitamin D deficiency has been defined by the Institute of Medicine and an Endocrine Society practice guideline as a level of serum 25-OH vitamin D less than 20 ng/mL (1,2). The Endocrine Society went on to further define vitamin D insufficiency as a level between 21 and 29 ng/mL (2). 1. IOM (Institute of Medicine). 2010. Dietary reference intakes for calcium and D. Washington DC: The National Academies Press. 2. Holick MF, Binkley NC, Bischoff-Ferrari HA, et al. Evaluation, treatment, and prevention of vitamin D deficiency: an Endocrine Society clinical practice guideline. JCEM. 2011 Jul; 96(7):1911-30.

Prostate-Specific Ag, Serum (Collection Date: 02/05/2019 07:48, Status: Final)
Performed At: SO, LabCorp San Diego
13112 Evening Creek Dr So Ste 200, San Diego, CA, 921284108
Jenny, Galloway, MD, Phone: 8586683700

Component	Result	Units	Flag	Range	Comment
Prostate Specific Ag, Serum	2.2	ng/mL		0.0-4.0	Roche ECLIA methodology.

According to the American Urological Association, Serum PSA should decrease and remain at undetectable levels after radical prostatectomy. The AUA defines biochemical recurrence as an initial PSA value 0.2 ng/mL or greater followed by a subsequent confirmatory PSA value 0.2 ng/mL or greater.
Values obtained with different assay methods or kits cannot be used interchangeably. Results cannot be interpreted as absolute evidence of the presence or absence of malignant disease.

TSH (Collection Date: 02/05/2019 07:48, Status: Final)
Performed At: SO, LabCorp San Diego
13112 Evening Creek Dr So Ste 200, San Diego, CA, 921284108
Jenny, Galloway, MD, Phone: 8586683700

Component	Result	Units	Flag	Range	Comment
TSH	1.580	uIU/mL		0.450-4.500	

Hemoglobin A1c (Collection Date: 02/05/2019 07:48, Status: Final)
Performed At: SO, LabCorp San Diego
13112 Evening Creek Dr So Ste 200, San Diego, CA, 921284108
Jenny, Galloway, MD, Phone: 8586683700

Component	Result	Units	Flag	Range	Comment
Hemoglobin A1c	11.3	%	H	4.8-5.6	Prediabetes: 5.7 - 6.4 Diabetes: >6.4 Glycemic control for adults with diabetes: <7.0

Vitamin B12 and Folate (Collection Date: 02/05/2019 07:48, Status: Final)
Performed At: SO, LabCorp San Diego
13112 Evening Creek Dr So Ste 200, San Diego, CA, 921284108
Jenny, Galloway, MD, Phone: 8586683700

Component	Result	Units	Flag	Range	Comment
Folate (Folic Acid), Serum	18.4	ng/mL		>3.0	A serum folate concentration of less than 3.1 ng/mL is considered to represent clinical deficiency.
Vitamin B12	634	pg/mL		232-1245	

Albumin/Creatinine Ratio,Urine (Collection Date: 02/05/2019 07:48, Status: Final)
Performed At: SO, LabCorp San Diego
13112 Evening Creek Dr So Ste 200, San Diego, CA, 921284108
Jenny, Galloway, MD, Phone: 8586683700

Component	Result	Units	Flag	Range	Comment
Alb/Creat Ratio	103.0	mg/g creat	H	0.0-30.0	Normal: 0.0 - 30.0 Albuminuria: 31.0 - 300.0 Clinical albuminuria: >300.0
Albumin, Urine	115.3	ug/mL		Not Estab.	
Creatinine, Urine	111.9	mg/dL		Not Estab.	

Lipid Panel (Collection Date: 02/05/2019 07:48, Status: Final)
Performed At: SO, LabCorp San Diego
13112 Evening Creek Dr So Ste 200, San Diego, CA, 921284108
Jenny, Galloway, MD, Phone: 8586683700

Component	Result	Units	Flag	Range	Comment
Cholesterol, Total	134	mg/dL		100-199	
Comment:					
HDL Cholesterol	43	mg/dL		>39	
LDL Cholesterol Calc	79	mg/dL		0-99	
Triglycerides	61	mg/dL		0-149	
VLDL Cholesterol Cal	12	mg/dL		5-40	

Comp. Metabolic Panel (14) (Collection Date: 02/05/2019 07:48, Status: Final)
Performed At: SO, LabCorp San Diego
13112 Evening Creek Dr So Ste 200, San Diego, CA, 921284108
Jenny, Galloway, MD, Phone: 8586683700

Component	Result	Units	Flag	Range	Comment
A/G Ratio	1.4			1.2-2.2	
Albumin	3.7	g/dL		3.5-4.8	
Alkaline Phosphatase	111	IU/L		39-117	
ALT (SGPT)	28	IU/L		0-44	
AST (SGOT)	23	IU/L		0-40	
Bilirubin, Total	0.6	mg/dL		0.0-1.2	
BUN	12	mg/dL		8-27	
BUN/Creatinine Ratio	18			10-24	
Calcium	8.7	mg/dL		8.6-10.2	
Carbon Dioxide, Total	22	mmol/L		20-29	
Chloride	106	mmol/L		96-106	
Creatinine	0.67	mg/dL	L	0.76-1.27	
eGFR If Africn Am	108	mL/min/1.73		>59	
eGFR If NonAfricn Am	93	mL/min/1.73		>59	
Globulin, Total	2.6	g/dL		1.5-4.5	
Glucose	195	mg/dL	H	65-99	
Potassium	4.0	mmol/L		3.5-5.2	

Protein, Total	6.3	g/dL	6.0-8.5
Sodium	142	mmol/L	134-144

CBC With Differential/Platelet (Collection Date: 02/05/2019 07:48, Status: Final)

NOEMAIL@MYDOHC.COM
Performed At: SO, LabCorp San Diego
13112 Evening Creek Dr So Ste 200, San Diego, CA, 921284108
Jenny, Galloway, MD, Phone: 8586683700

Component	Result	Units	Flag	Range	Comment
Baso (Absolute)	0.0	x10E3/uL		0.0-0.2	
Basos	0	%		Not Estab.	
Eos	1	%		Not Estab.	
Eos (Absolute)	0.1	x10E3/uL		0.0-0.4	
Hematocrit	43.7	%		37.5-51.0	
Hematology Comments:					
Hemoglobin	14.4	g/dL		13.0-17.7	
Immature Cells					
Immature Grans (Abs)	0.0	x10E3/uL		0.0-0.1	
Immature Granulocytes	0	%		Not Estab.	
Lymphs	33	%		Not Estab.	
Lymphs (Absolute)	1.6	x10E3/uL		0.7-3.1	
MCH	31.4	pg		26.6-33.0	
MCHC	33.0	g/dL		31.5-35.7	
MCV	95	fL		79-97	
Monocytes	9	%		Not Estab.	
Monocytes(Absolute)	0.4	x10E3/uL		0.1-0.9	
Neutrophils	57	%		Not Estab.	
Neutrophils (Absolute)	2.7	x10E3/uL		1.4-7.0	
NRBC					
Platelets	163	x10E3/uL		150-379	
RBC	4.59	x10E6/uL		4.14-5.80	
RDW	13.1	%		12.3-15.4	
WBC	4.8	x10E3/uL		3.4-10.8	

General/Admin

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