

**EVALUATION
RESOURCE
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April 4, 2007

Patient: XXXX
Employer: XXXX
D/I: XXXX
Claim No: XXXX
WCAB:

Mr. XXXX

Ms. XXXX

Dear Mr. XXXX and Ms. XXXX:

AGREED MEDICAL EVALUATION

On 11/17/05, I had the opportunity to interview and evaluate XXXX concerning her complaints of shortness of breath and cough.

COMPLEXITY FACTORS AND FEE JUSTIFICATION

The revised medical-legal fee schedule indicates that ML104 may be billed if four complexity factors exist. The 6 complexity factors here are:

1. Two or more hours of face-to-face time by the physician with the patient;
2. Two or more hours of record review by the physician;
3. A bona fide issue of medical causation discovered in the evaluation and in any event a written request by the requesting party for discussion of the issue of medical causation;
4. A bona fide issue of apportionment discovered in the evaluation;
5. Two or more hours of medical research by physician;
6. Addressing the issue of medical monitoring of an employee following a toxic exposure to chemical, mineral or biological substances.

I verify under penalty of perjury that I spent 2.0 hours in face-to-face interview time with XXXX. I further verify that I spent 4.0 hours reviewing the medical records and especially the MSDS, and 3.0 hours in research. Finally, I spent 4.5 hours preparing this report for a total of 13.5 hours.

This report is being billed at ML104. This was clearly an extraordinarily complex medical-legal evaluation, involving a complex diagnosis and multiple chemical exposures over many years.

GENERAL BACKGROUND

XXXX is a 58-year-old woman who worked as a janitor for XXXX for 24 years.

JOB DESCRIPTION

XXXX worked at XXXX as a janitor from 1981 through February 2005. Her duties included cleaning patient rooms after discharge, staff bathrooms, public bathrooms, and other hospital facilities. She used a variety of cleaning chemicals in performing her job. She worked approximately 40 hours a week, with some overtime in the first few years of her employment. Her duties consisted of wiping down all surfaces in patient rooms, including bed stands and beds, and scrubbing bathrooms twice a day. She also cleaned floors in patient rooms and bathrooms.

She was given a paper mask to wear when she was cleaning in the dialysis unit, where she cleaned for approximately one year, and when she was in patients' rooms with certain diagnoses. Her understanding was this mask was to protect the patient. She was given no protective equipment.

HISTORY OF INJURY

The applicant states that approximately five years ago, she began to have a reaction to chemicals when she opened the bottles of concentrated cleaning chemicals at work. She noted that they smelled very strong, and when she opened the new bottles, it made her cough.

Approximately three years ago, the applicant began to feel very tired at work. Her coworkers noted that she was short of breath. She also began to notice that she was also short of breath. There was no chest pain, but occasionally a feeling of chest discomfort when she became very short of breath. She was referred to Dr. XXXX, and had a workup for her shortness of breath. Subsequently, she was referred to Dr. XXXX, a pulmonologist.

LIST OF CHEMICALS USED:

The applicant brings with her a list of the chemicals that she uses in her job.

1. Glance glass cleaner, used approximately one hour a day.
2. Virex 256-one step disinfectant used approximately three to four hours a day to disinfect patient rooms and bathrooms.

3. Triad disinfectant used approximately one hour a day.
4. Emerol used approximately one to one and a half hours a day for sinks.
5. Stride used for floors, used approximately two hours a day.
6. Spit Fire spray used for counters in bathrooms and some patient rooms for approximately one hour a day.

CURRENT COMPLAINTS

Chief complaint: Shortness of breath and coughing. The applicant is currently short of breath at all times, but this becomes worse when she exerts herself. She is able to walk three to four blocks, but she states she is walking at the urging of her physician and that she walks extremely slowly. She also feels very tired. She has coughing throughout the day, but it is worse in the morning and at night. The coughing keeps her awake at night, especially the last three weeks. In the last three weeks, she has actually slept sitting up in order to avoid worse coughing. There is no wheezing, no chest pain, no significant phlegm production, and no hemoptysis.

CURRENT MEDICATIONS

Prednisone 40 mg a day, since April of 2005.

Advair two puffs bid.

Azathioprine 50 mg a day, prescribed by XXXX physician, and which the applicant discontinued recently because she feels it makes her cough more.

Codeine cough medicine, one teaspoon every six hours prn. Applicant states she takes one teaspoon in the morning and one in the evening for her cough.

Fosamax 70 mg, one q week.

Calcium 1,500 mg a day.

Iron supplement, unknown dose.

Vitamin D 400 mg a day.

Vitamin C, unknown dose.

PAST MEDICAL HISTORY

Surgery: Gallbladder removal at age 27. Umbilical hernia repair in approximately 1995.

Medical: She denies any history of respiratory problems in the past. She was seen by her primary care physician, Dr. XXXX for approximately 25 years prior to this illness. No hypertension, peptic ulcer disease, diabetes, tuberculosis, hepatitis, or thyroid problems.

Drug Allergies: No known drug allergies.

FAMILY HISTORY

Mother and father were healthy and died in their 80s. Six siblings with no health problems, who all live in Greece. Three children, all healthy.

SOCIAL HISTORY

XXXX was born in Greece, came to this country at age 22. She has been married for 36 years and lives in XXXX. Her husband is 73 years old and retired eight years ago.

Smoking: Nonsmoker. Husband has never smoked. No other passive smoking.

Alcohol: None

Pets: None

ACTIVITIES OF DAILY LIVING (ADLs)

Self Care/Personal Hygiene (toilet, dress, eat, groom): normal

Communication (write, see, hear, speak): normal

Physical Activity (stand, walk, sit, lie, stairs): shortness of breath at rest, worse with minimal exertion

Sensory Function (hear, see, feel, taste, smell): normal

Hand, non-specialized activities (grasping, lifting, tactile discrimination): normal

Travel (car, airplane, public transportation): normal

Sexual (erectile and other forms of male/female dysfunction): Not applicable

Sleep (restful, nocturnal pattern, naps during day): Sleep disrupted due to cough, sleeps a few hours at a time.

REVIEW OF SYSTEMS

- Constitutional: Extreme fatigue X 3 years. She has lost 23 pounds since February 2005.
- HEENT: Negative sinus problems, swallowing problems, vision problems, or hearing problems. She states she has nasal stuffiness when she gets a cold.
- LUNGS: See current complaints. The applicant states she sleeps on three pillows in order to avoid coughing at night. In the past two weeks, her coughing has become worse and she now sleeps sitting up in a chair for much of the night. She states she has had antibiotics for lung infections several times in the past three years.
- HEART: No heavy chest pain, no radiation of pain, no palpitations.
- GI: No current complaints. Several weeks ago, she had nausea and vomiting for one day and diarrhea for five days, which her primary care physician said was an intestinal infection. Presently, no nausea, vomiting or diarrhea. Negative bright red blood per rectum. Negative melena.
- GU: Menopause at age 46, no irregular uterine bleeding. No urinary complaints.
- MUSCULO-SKELETAL: Complaint of some right mid back pain over the area of her incision for the lung biopsy. Otherwise no musculoskeletal complaints.
- SKIN: Negative.

MEDICAL RECORD REVIEW

Reviewed were the Medical records of Dr. XXXX, pulmonologist,

Reviewed were the Medical records of Dr. XXXX.

MSDS sheets are reviewed

- 1/10/04 Chest x-ray ordered by Dr. XXXX. Findings: There is a mild degree of diffuse interstitial prominence with suggestion of mild interstitial reticulation at the bases. Impression: Diffuse interstitial prominence may reflect chronic interstitial changes. No acute infiltrate.
- 5/11/04 Letter from Dr. XXXX to Dr. XXXX requesting pulmonary evaluation.

- 5/11/04 EKG. Basically normal.
- 5/12/04 CT thorax, high resolution. Findings: Multiple foci of interlobular interstitial thickening. Impression: Interstitial lung disease. Laboratories during this time revealed hemoglobin 13.2, hematocrit 40.5, MCV 94.7, white blood cells 5.5, platelet count 177,000. Chemistry panel was normal. TSH was normal.
- 6/28/04 Dr. XXXX. Patient declined to see Dr. XXXX. Has not had PFTs yet. Impression: Interstitial pneumonia. Plan: PFTs.
- 8/06/04 Mammogram. Impression: Negative.
- 12/16/04 Dr. XXXX. Office visit. Patient coughing, no dyspnea. No chest pain. Impression: Interstitial pneumonia. Plan: Pulmonary function tests, pulmonary consult.
- 12/26/04 Chest x-ray. Findings: Bilateral peripheral interstitial densities, consistent with findings shown on CT of May 2004, likely fibrosis. Further superimposed infiltrate of infectious etiology or of congestive heart failure cannot be ruled out.
- 1/03/05 Dr. XXXX. Office visit. History: Patient got sick on 12/26/04 with cough and fever. Went to the emergency room and given antibiotics. Feels better but still lingering cough. Impression: Cough, likely secondary to reactive airways. Plan: Increase Advair to bid. Phenergan with codeine. Return in two weeks. Patient was given a certificate to return to work on 1/05/05.
- 1/10/05 Pulmonary function tests ordered by Dr. XXXX. Spirometry: FEV1 was 1.3 liters, 63% of predicted. FVC was 47% of predicted. Lung volumes: Reduction in total lung capacity at 54% of predicted and the functional residual capacity was 47% of predicted. Diffusion capacity reduced to 48% of predicted. Impression: The screening pulmonary function studies were compatible with the diagnosis of severe restrictive lung disease.
- 1/19/05 Dr. XXXX. Office visit. Complaint of cough despite Advair, without sputum production. Took course of antibiotics. Impression: Interstitial pneumonia. Plan: Refer to Dr. XXXX.
- 2/03/05 Dr. XXXX. High resolution CT scan of the chest. Findings: Diffuse bilateral changes of interstitial lung disease, which are progressive at both lung bases when compared with the earlier study of 5/12/04. Impression: Diffuse bilateral interstitial lung disease, worsened at the lung bases since 5/12/04. Plan: see Dr. XXXX for biopsy.

- 2/13/05 Dr. XXXX. Consult letter to Dr. XXXX. History: trouble breathing for about a year and a half. This is aggravated by the smells of some of the compounds used at work. She has never smoked. There has been no hemoptysis. Physical examination: Patient had bibasilar rales. Oxygen saturation by pulse oximetry was 93-94%. No murmurs, gallops.
- Chest x-rays were reviewed. Film in 2002 showed a subtle increase in interstitial markings. Chest x-ray from 12/04 showed obvious interstitial lung disease. Lung function tests show evidence of a significant restrictive defect. Total lung capacity is reduced to 54% of predicted. Diffusion capacity is 48% of predicted. Patient was referred for high resolution CT scan and for video assisted thoroscopic biopsy. Impression: Idiopathic interstitial pneumonia versus hypersensitivity pneumonitis.
- 2/16/05 Dr. XXXX. History and physical for lung biopsy. Assessment: 57-year-old female with progressive dyspnea. Repeat high resolution CT scan on 2/03/05 reveals progression of her interstitial lung disease. She is referred for open lung biopsies.
- 2/22/05 Chest x-ray, 2 views. PA and lateral films are compared to previous examination available, 1/10/04. Diagnosis: Diffuse interstitial disease without evidence of active infiltrate.
- 2/22/05 Laboratory studies. CBC. Hemoglobin 12.2, hematocrit 35.9, MCV 89.2, MCH 30.2, MCHC 33.8, platelet count 242, white blood cells 6.4 with normal differential. PT and PTT normal. Chemistry panel with sodium, potassium, chloride, CO₂, glucose, BUN, creatinine all within normal limits. Calcium, total protein, albumin, total bilirubin, SGOT and alkaline phosphatase and SGPT all within normal limits.
- 2/23/05 Dr. XXXX. Procedure: Flexible bronchoscopy, right video assisted thoracoscopy with wedge resection and lung biopsy times three. Indications for procedure: Most recent scan showed progression of interstitial lung disease, and she is admitted for open lung biopsy. Description of procedure: Bronchoscope was used to inspect tracheal bronchial tree and no endobronchial lesions were noted.
- Three incisions were made at the anterior, mid and posterior axillary line. Scope was placed through the mid axillary line and instruments were placed through the other two incisions. There were some mild adhesions between the lower lobe and the diaphragm. Lung was easily visualized. Biopsies were taken from the upper lobe, the middle lobe, and the lower lobe. All three specimens were sent for both culture and pathology. Patient was stable and transported back to the recovery room in stable condition.
- 2/24/05 Portable chest x-ray. Impression: No evidence of pneumothorax, atelectasis or pneumonitis. No significant change postoperatively.

- 2/25/05 Portable chest x-ray. Compared with 2/24/05. Findings: Right chest tubes have been removed. There is no pneumothorax. No change in the chest.
- 2/26/05 Dr. XXXX. Discharge summary. Discharge post right video assisted thoracoscopy with lung biopsy times three. On discharge, her room air saturation was 94% and her laboratories show a hemoglobin of 11, hematocrit 32, platelet count 160,000, white blood cell count 7.1. Patient is afebrile.
- 3/02/05 Dr. XXXX. Patient recovering from biopsy. Impression: Idiopathic interstitial pneumonitis. Plan: Followup in two weeks.
- 3/16/05 Dr. XXXX. Patient has been walking two to three blocks every day. Bothered by cough and feels short of breath. Impression: Idiopathic pulmonary fibrosis. Plan: Avoid work situation. Prednisone 40 mg daily.
- 3/22/05 Dr. XXXX. Progress note. Status post lung biopsy. Impression: Interstitial pneumonia. He notes that Dr. XXXX has concerns about chemical inhalation and has advised no work. Plan: no work for now.
- 3/31/05 Dr. XXXX. Form from XXXX Medical Center, Medical Certification for Reasonable Accommodation. Dr. XXXX answers the following questions: Does the individual have an impairment that limits a major life activity? Answer: Yes. Question: If yes, describe the limitation and suggest reasonable accommodation. Answer: Interstitial lung disease.
- Question: What is the nature and severity of the medical condition? Answer: Limited pulmonary reserve. Question: is the disability permanent? Answer: No. Question: Is the disability temporary? Answer: Yes. Question: If temporary, what is the anticipated duration of the individual's condition? Answer: Indefinite. Question: Has the individual met maximum medical recovery? Answer: No. Question: Specify the job duties/physical restrictions that the individual cannot perform. Answer: No exposure to chemical fumes.
- Question: Please explain how the limitations/restrictions impair the ability of the applicant to perform the essential job functions. Answer: Fumes can worsen lung condition. Recommendations: Extension of medical leave until 1/10/06. The individual is examined and is physically or mentally unable to perform the basic function of the position based on the following medical conclusions: Exposure to fumes.
- 4/12/05 Dr. XXXX. Patient states breathing unchanged. Has lost 12 pounds and is deliberately trying to do so. Nothing at home similar to work exposure to chemicals.

Can walk four blocks slowly. Impression: Idiopathic pulmonary fibrosis. Plan: Continue prednisone 40 mg daily. To seek opinion at XXXX.

4/26/05 Dr. XXXX. Patient states coughing much less frequent since starting steroids, breathing not much different. Impression: Idiopathic pulmonary fibrosis. Question of hypersensitivity pneumonitis. Plan: Consultation with XXXX.

MSDS

Material safety data sheets sent along with medical records are reviewed

There are material data safety sheets for Stride Floral HC, Virex II-256, Triad II disinfectant cleaner, Spitfire NB RTU, Spitfire NB SC, Creme Cleanser, Glance HC, Stride Citrus HC hyper-concentrate.

1. Stride Floral HC. The information on health effects for this compound are missing.
2. Virex II-256. Potential acute health effects include inhalation, may cause irritation and corrosive effects to nose, throat and respiratory tract.
3. Triad II disinfectant cleaner. Under potential acute health effects, inhalation: No health effects known. Toxicological information: No toxic effects known.
4. Spitfire NB RTU. Potential acute health effects: Inhalation. May be irritating to nose, throat and respiratory tract.
5. Spitfire NB SC. Potential acute health effects: Inhalation. May cause irritation and corrosive effects to nose, throat and respiratory tract. Medical conditions aggravated by overexposure: Individuals with chronic respiratory disorders such as asthma, chronic bronchitis, emphysema, etc. may be more susceptible to irritating effects.
6. Creme Cleanser. Potential acute health effects: Inhalation. May be irritating to nose, throat and respiratory tract. Medical conditions aggravated by overexposure: Persons with preexisting skin disorders may be more susceptible to irritating effects.
7. Glance HC. Potential acute health effects: Inhalation. May cause irritation and corrosive effects to nose, throat and respiratory tract. Medical conditions aggravated by overexposure: Individuals with chronic respiratory disorders such as asthma, chronic bronchitis, emphysema, etc. may be more susceptible to irritating effects.
8. Stride Citrus HC. Potential acute health effects: Inhalation. May be irritating to nose, throat, and respiratory tract.

PHYSICAL EXAM

Blood pressure	128/78 left arm sitting.
Pulse	88 and regular.
Respiratory rate	36.
Height/Weight	181 pounds.
General Appearance	The applicant is a well nourished, well developed female.
Head	Cranium was atraumatic without tenderness to palpation of the TMJs, temporal arteries or occipital prominences.
Eyes	Pupils were round and equal in size and shape; reaction to light and accommodation was normal. No lid lag, exophthalmos, conjunctivitis, nystagmus or icterus was seen. The extraocular movements were intact.
Nose	Nasal mucosa was normal, without evidence of inflammation, polyps or lesions. No rhinorrhea. Nares were unremarkable.
Sinuses	Maxillary sinuses slightly tender to pressure, no other tenderness.
Ears	Unremarkable. Canals clear, tympanic membranes normal.
Oropharynx	Mucous membranes were well hydrated; no oropharyngeal lesions were seen.
Neck	Thyroid was normal in size and non-tender to palpation. No masses.
Heart	Heart sounds were normal S1, S2 and rhythm was normal. No murmurs, rubs or gallops were heard.
Lung Fields	Coughing produced by deep inhalation. Lung sounds were diminished but clear to auscultation. No percussion dullness. There were no rhonchi, rales, rubs or wheezes appreciated with shallow inspiration.
Abdomen	Abdomen was flat; there was no tenderness to abdominal palpation. Liver and spleen were not enlarged; liver span was normal to percussion. Normal bowel sounds were appreciated.
Skin	Skin exam was unremarkable. No rash present.
Back	No tenderness to palpation. No spasming appreciated.

Extremities	No clubbing, cyanosis or edema was seen. The applicant has varicose veins in the lower extremities.
Neurologic	Gait was grossly normal.
Musculoskeletal	Normal strength, no deformities.

DIAGNOSES

1. Usual interstitial pneumonia versus hypersensitivity pneumonitis.

DISCUSSION

This is a 58-year-old woman who was exposed to chemicals at her workplace for 24 years. She has had respiratory symptoms for more than three years. The applicant has been diagnosed with a chronic and debilitating lung condition. The differential diagnosis, based on her pathology, is hypersensitivity pneumonitis versus usual interstitial pneumonia.

Hypersensitivity pneumonitis is an immunologically mediated inflammatory disease of the lungs. It can be caused by a variety of agents, including bacteria, fungi, amoeba, animal proteins and several chemicals. The key to treatment is avoidance of the agent causing the condition. Steroids also can be of benefit.

According to an article on hypersensitivity pneumonitis by Bourke, et al., in 2001, the list of etiological agents in hypersensitivity pneumonitis is long and new sources of antigens are constantly being identified. An article by Kirchner in 2002 states that low molecular weight chemicals have been reported to cause type III hypersensitivity reactions such as those seen in hypersensitivity pneumonitis. XXXX was exposed to low molecular weight cleaning chemicals at work for 24 years.

In addition, several of the compounds to which this applicant was exposed are respiratory irritants. These include: Virex, Spitfire, Glance HC, creme cleanser, and Stride Citrus. At least one of the chemicals she worked with, ethylene glycol mono-n-butyl ether, is associated with case reports of respiratory symptoms in those exposed, including adult respiratory distress syndrome. Another chemical she was exposed to, ammonium hydroxide, was associated with interstitial lung fibrosis in a janitor exposed for many years to inhalation of this chemical. (Information on human effects of specific chemicals from: toxnet.nlm.nih.gov)

XXXX does not have a history of exposure to other substances outside of work that could cause her symptoms. She is a nonsmoker, has no history of passive smoking, and has no history of significant

exposure to pets, bacteria, fungi, or other possible antigens. She has no childhood history of asthma or other allergies and has no history of respiratory symptoms prior to her employment.

Therefore, it is medically probable that her chronic lung condition, whether hypersensitivity pneumonitis or interstitial pneumonia, was caused by or had contribution from her exposure to chemicals at work.

DISABILITY STATUS/DATE OF MAXIMAL MEDICAL IMPROVEMENT

As far as I can determine, the applicant's symptoms were severe enough to prompt a medical visit beginning in approximately December 2003. She went to her primary care physician, and was referred for an x-ray on 1/10/04. After further workup and treatment, Dr. XXXX took the applicant off work on 2/22/05. She has been on disability since then. XXXX, for the purposes of rating became permanent and stationary on 3/16/05, when Dr. XXXX prescribed prednisone on a daily basis.

In spite of Dr. XXXX's assertion that this is temporary disability for an indefinite period, it is medically probable.

FACTORS OF DISABILITY

SUBJECTIVE: The applicant states that she is able to walk only three or four blocks very, very slowly. She cannot keep up with other people of her age. She states that she must sleep sitting up due to coughing occurring when she lies down flat.

OBJECTIVE: Pulmonary function tests 1/21/05 reveal FVC of 1.39, which is 47% of predicted. FEV1 was 1.38, which is 63% of predicted. Vital capacity was 1.55, or 52% of predicted. Functional residual capacity 1.22, or 47% of predicted. Diffusion capacity 48% of predicted.

WORK RESTRICTIONS/PERMANENT DISABILITY/IMPAIRMENT

Discussion utilizing California Schedule for Rating Permanent Disabilities (April 1997) and/or IMC guidelines for evaluation of cardiac and pulmonary disability (July 1998).

The applicant has dyspnea after walking approximately three blocks at her own slow pace. This would put her between a Class III and Class IV for subjective factors. On pulmonary function tests from 1/21/05, she has a FVC of 47%, an FEV1 of 63%, and a diffusion capacity of 48%. These put her Class III -IV based on pulmonary function tests. However, the applicant has been using 40 mg of prednisone per day for many months, which is more than the 20 mg listed in the modifying

factors. Therefore, this would advance her 0-2 classes and would therefore rate her as a Class V under the 7/98 California Pulmonary Guidelines. This is listed as “Sedentary Only” in those Guidelines.

Discussion utilizing AMA Guides to the Evaluation of Permanent Impairment, 5th edition.

The applicant has an FVC of 47%, FEV1 of 63% and diffusion capacity of 48% from her pulmonary function tests of 1/21/05. Based on her FVC and her diffusion capacity, she would be between Class III and Class IV, giving her between a 26-100% impairment of the whole person.

APPORTIONMENT OF PERMANENT DISABILITY BASED ON CAUSATION

(Relying on guidelines set forth in Escobedo vs. Marshalls; and CNA Insurance Inc. WCAB en banc. 4/19/05.)

SEC. 34. Labor Code Section 4663

©) In order for a physician’s report to be considered complete on the issue of permanent disability, it must include an apportionment determination. A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. If the physician is unable to include an apportionment determination in his or her report, the physician shall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. The physician shall then consult with other physicians or refer the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division in order to make the final determination.

SEC. 35. Labor Code Section 4664

(a) The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment.

(b) If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. This presumption is a presumption affecting the burden of proof.

The applicant’s disability is presumed to be entirely due to her workplace exposure to chemicals. There is no apportionment to other causes. She has no underlying asthma, non-occupational chemical exposure, nor smoking history to have contributed to her pulmonary condition.

VOCATIONAL REHABILITATION

This applicant is medically eligible for vocational rehabilitation at this time, as she is unable to do more than sedentary activity.

FUTURE MEDICAL CARE

This applicant will need future medical care/ monitoring for this condition, estimated to be a visit to a pulmonary specialist once a month, pulmonary function tests two to three times a year, and CT

scan or other diagnostic scan in the future. She has already been told that she is a candidate for a lung transplant by her pulmonologist.

RECOMMENDATIONS

Low fat diet and regular exercise are still recommended.

If you have any other questions, please feel free to contact me.

END OF REPORT

DECLARATION/SIGNATURE PAGE

I personally took the history from the applicant on the date indicated at the beginning of the report in the medical-legal office located at 1498 Solano Ave, Albany, California, performed the physical examination, reviewed the medical records and prepared this report with the help of Dr. Miriam Shipp. The medical-legal opinions expressed in this report are solely my own. If medical testing is required, authorization will be requested first and the tests will be performed by an outside hospital or medical entity completely unaffiliated with myself. The results of any medical testing will be addressed by an appropriate supplemental report. For QME reports, additional medical records may be requested and reviewed.

For AME reports, if either additional medical records or medical testing are required to complete the report, a request will be made simultaneously to both requesting parties to avoid the prohibition on ex parte communications for AMEs.

I declare under penalty of perjury that the information obtained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to the information that I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true to the best of my knowledge.

The evaluation of this applicant and the time spent performing the evaluation was in compliance with the guidelines established by the Administrative Director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code or any other relevant sections or revisions of the Labor Code.

I further declare under penalty of perjury that I have not knowingly violated the provisions of the California Labor Code Section 139.3 with regards to the evaluation of this applicant or the preparation of this report. I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage, dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred exam or evaluation.

In summary, I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. All statements on this declaration page are made under penalty of perjury.

**PERSONALLY DICTATED, REVIEWED, EDITED AND MEDICAL LEGAL OPINION
VERIFIED AS ATTESTED HERETO BY MY ORIGINAL SIGNATURE:**

Signed: ___ / ___ /200__ in _____, California, County of _____.

Adam Duhan, MD
Internal Medicine