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RESOURCE  
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November 17, 2006

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

XXXX  
XXXXXXXX  
XXXXXXXX  
XXXXXXXX

XXXX  
Law Offices of XXXX  
XXXXXXXX  
Sacramento, CA XXXXX

Dear Mr. XXXX and Mr. XXXX:

**AGREED MEDICAL EVALUATION**

On October XX, 2006, I had the opportunity to interview and evaluate XXXX regarding the allegation that urinary retention is a derivative industrial injury related to orthopaedic low back and left leg pain.

The applicant arrived to my Albany office on time, alone, having been driven here. She no longer drives an automobile. The applicant was interviewed and examined alone. She was advised that a doctor-patient relationship was not

established today, and that a copy of my AME report would be sent to both requesting parties, Mr. XXXX, and attorney XXXX.

In the cover letter, note was made that medical records from XXXX had been subpoenaed but have not yet been received. When received, they will be forwarded to me for review and supplemental report.

This history and physical is not intended to be construed as a general or complete medical evaluation. It is intended solely for medical-legal purposes and focuses on those industrial issues in question, as requested by the parties. By performing this medical legal examination, no treatment relationship is established or implied.

I explained to the applicant in detail the nature of an Agreed Medical Evaluation, indicating that ex parte communication between the parties is strictly forbidden, and that I would be the sole medical-legal expert evaluating this internal medicine claim. Any communication between the parties is conducted by the joint sending of either a fax or letter or jointly participating in a conference call. I also explained that I would only be reviewing medical records that were agreed upon and jointly provided by both parties.

I would like to take this opportunity to thank both parties for placing their trust in me as an internal medicine Agreed Medical Evaluator. I take such an expert role seriously and always strive to provide an accurate, honest, impartial and thorough medical-legal report regarding the complex issues in internal medicine that I consider.

### **COMPLEXITY FACTORS AND FEE JUSTIFICATION**

The revised medical-legal fee schedule indicates that ML103 may be billed if three complexity factors exist. The three complexity factors here are:

1. Four or more hours of face-to-face time by the physician with the patient, combined with record review constitutes two complexity factors;
2. 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;

I verify under penalty of perjury that I spent 1.0 hours in face-to-face interview time with XXXX. I further verify that I spent 3.0 hours reviewing the medical records and 0.25 hours in research. Finally, I spent 1 hour preparing this report for a total of 5.25 hours.

This report is being billed as an ML103. This was clearly a complex medical-legal evaluation, regarding the allegation that urinary retention is a derivative industrial injury related to orthopaedic low back and left leg pain.

## **GENERAL BACKGROUND**

XXXX is a 50-year-old right-handed Caucasian female born XXXX in XXXX, where she was raised for six years before her family moved to the XXXX area. The applicant only finished 9<sup>th</sup> grade and does not have a GED. She took some business courses in college for one and a half years, but does not have a college degree, nor has she ever served in the US military.

## **JOB HISTORY**

In the 1970s, the applicant worked as a pharmacy clerk, a meat wrapper and meat plant worker and deli clerk. From approximately 1980 to 1994, she ran a children's daycare center at home. For one year in the 1980s, she was also a cleaning worker. From approximately 1994 to June of 2005, the applicant was employed by XXXX as a housekeeper.

## **JOB DESCRIPTION**

XXXX:

Average Day: The applicant states that for most of her career she worked different shifts, but for the last several years she worked in the OB Department on a day shift.

Job Title: Housekeeper.

Job Duties: She wore a uniform. The applicant performed all of the usual and customary duties of a housekeeper in a hospital setting. She cleaned medical offices, stripped and waxed floors, changed linen, moved equipment, picked up trash. As an additional side job, the applicant cleaned houses for hospital staff, usually 1-3 houses per week.

## **CONFLICTS OR HARASSMENT AT WORK**

None.

## **JOB PERFORMANCE EVALUATIONS**

Satisfactory.

## **HISTORY OF INJURY**

Date of injury: XXX, plus CT to XXX regarding spine, left leg, left lower extremity, bladder/internal, psyche.

The applicant states that, on the date of injury, XXX, a hospital linen cart struck the back of her left lower leg and bruised a toe on her left foot. Initially the applicant was seen by the Workers' Compensation physician affiliated with the hospital. She was advised not to climb stairs, to ice the leg, and she continued working. She also began attending physical therapy 3-4 times a week before going into work. There were no fractures.

At some unspecified period of time thereafter, she also developed significant low back pain which became progressively worse, such that in January of 2005, the applicant was taken out of work for six weeks. There was no light duty available at that time. Subsequently, the applicant was then given a desk job in the purchasing department for two months. At a certain point, going around to deliver mail within the hospital caused increased back and leg pain. She was then returned to the Housekeeping Department. It is the applicant's perception that she was given a computer chair and was told to clean baseboards and walls while seated in the chair.

In February 2005, she was taken out of the hospital housekeeping department and was out of work for several weeks. She was then given clerical work in a different hospital department, copying documents. In approximately June of 2005, the applicant developed diarrhea that has persisted intermittently to the present. She was taken out of work and never returned. It is the applicant's perception that physical therapy actually caused her back pain to flare-up and worsen and was therefore discontinued.

Currently the applicant experiences low back pain with numbness down the left leg. There is pain and cramping in the low back. Occasionally the pain radiates to the right leg. Her primary physicians are XXXX, her family physician whom she sees up to three times a week, but usually twice a month. She also sees XXXX, and she has seen this physician four times in the last three months. She sees a urologist XXXX, and last saw this physician three weeks previously. She has a pending appointment with physical therapy for treatment of pelvic muscle spasms to improve bladder function. On a routine basis, she gives urine specimens to XXXX office. She has been prescribed a year's supply of catheters for self-catheterizations. Kegel exercises did not help with her urinary complaints.

The applicant states that, on approximately 8/05/05, without warning, she developed acute urinary retention such that she was hospitalized at XXXX Hospital for five days. The etiology of urinary retention was not clear at that time. She was then sent home for six weeks with an indwelling Foley catheter. This was then removed and she then began self-catheterizing herself. She was then hospitalized on another occasion for urinary retention, but does not recall the date. Her last hospitalization on July 8<sup>th</sup> and 9<sup>th</sup>, 2006 was again for urinary retention. Currently she self-catheterizes herself 3-4 times a day.

The applicant states that, from May to August of 2005, she had constant diarrhea, the etiology of which was not clear. The complaint did not respond to anti-diarrheal pills prescribed by XXXX. The urologist then placed her on a high fiber diet and the diarrhea improved. The diarrhea was accompanied by abdominal pain. Also when her bladder “shuts down”, her stomach hurts. Back spasms also cause her bladder to “shut down”.

### **CURRENT WORK STATUS**

Not working since 6/05.

### **PERIODS OF TEMPORARY DISABILITY**

Periods of temporary total disability: Late 2004 for two weeks, : January 2005 for six weeks, and then from 6/05 to the present.

### **PREVIOUS WORKERS' COMPENSATION INJURIES**

The applicant states that she has been noted to have a latex glove allergy in the past, and is sensitive to household chemicals. For this reason, at some point she wore special gloves, but then these were taken away from her. On another occasion, she inhaled a household type cleaner and had burning in her lungs and eyes, but there was no lost work time. Currently when she uses household chemicals, she needs to wear gloves.

### **CURRENT COMPLAINTS**

Low back pain. Left leg pain. Headaches.

### **HISTORY OF PRE-EXISTING DISEASE THAT WAS EXACERBATED BY EMPLOYMENT**

None.

### **PRE-EXISTING PERMANENT DISABILITY**

None.

### **CURRENT MEDICATIONS**

Hydrocodone/APAP 10/650, 0-8 daily.

Alprazolam 0.5 mg, 0-3 daily.

Lyrica 50 mg twice a day.

In the past, the applicant has treated on multiple occasions for urinary tract infections. In the past she has been on Cymbalta, Kadian.

Drug Allergies: Penicillin, Vicodin, Tylenol, and Dilaudid.

### **PAST MEDICAL HISTORY**

Surgery: Cholecystectomy at age 25. Simple hysterectomy. Two C-sections. She is gravida 5, para 4, one miscarriage.

Medical: HPV, vaginal.

Psych: None.

Emotional stress:

Work: None.

Home: That dealing with chronic pain and financial difficulties.

### **FAMILY HISTORY**

Mother - Alive and well at age 76, has had open heart and carotid artery surgery.

Father - Alive and well at age 76, has had open heart surgery.

Siblings - One brother and five sisters. One half-sister died of unspecified cancer.

Children - Two sons and two daughters alive and well; seven grandchildren healthy.

### **SOCIAL ACTIVITIES**

The applicant spends most of her time home in bed. She can do certain household cleaning activities, but needs to do them one activity per day. For example, vacuuming one day, mopping another day. She no longer does yard work.

## SOCIAL HISTORY

School: 9<sup>th</sup> grade.

Marital: First marriage 1982 to 1988. Second marriage 1989 to 2001. She is divorced.

Smoking: She smokes one-half to one pack of cigarettes per day since age 14, but quit for 25 years and restarted in 2001 during her second divorce.

Alcohol: She drink alcohol only occasionally.

Caffeine: One to two cups of coffee daily.

Stress: No bankruptcy, felony convictions, drug abuse or alcoholism.

Home environment: The applicant lives with a gentleman friend in his house located in XXXX. She has one son, age 15, living with her. There are two dogs and one cat.

## 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): She can walk one block, stand for one hour, sit for 0-1 hour. She lies down most of the day. She can walk one flight of stairs.

Sensory Function (hear, see, feel, taste, smell): Normal.

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

Travel (car, airplane, public transportation): The applicant can drive her son to school and back, which is a total of 40 minutes driving.

Sexual (erectile and other forms of male/female dysfunction): The applicant is not sexually active due to pain. She also has HPV for a number of years in the vagina.

Sleep (restful, nocturnal pattern, naps during day): She also has a poor sleep pattern. She naps five days a week up to 4 hours, however, the Epworth Sleepiness Scale only scores a total of 4.

## REVIEW OF SYSTEMS

HEENT: No eyes, ears, nose, throat complaints. No seasonal allergies. No asthma.

LUNGS: No wheezing, cough or shortness of breath.

HEART: No cardiovascular chest pain or palpitations.

GI: Intermittent diarrhea, no constipation. Intermittent abdominal pain.

GU: Urinary retention for which she self-catheterizes herself 3-4 times a day.

Menstrual: Has had a hysterectomy.

Sexual  
function: Unable due to pain.

PSYCH: Anxiety, depression.

Musculo-  
Skeletal: Chronic low back, left leg pain.

Neurologic: Headaches that she attributes to stress.

Skin: Sensitivity to household chemicals.

## MEDICAL RECORD REVIEW

These medical records consist of an 11/16/05 deposition from XXXX, pp. 1-96; an 8/25/06 deposition from XXXX, pp. 46-49; and a miscellaneous clip of medical records that is not numbered. The total medical records received is about an inch in thickness.

XXXX brought in copies of additional medical records consisting of, recent laboratory tests, urologic records from XXXX and a recent report of MRI lumbar spine. I jointly requested permission from both parties to include review of these records in my report and such permission was granted. A copy of these records is appended to my report for both parties to review.

Deposition of XXXX, 11/16/05, pp. 1-96

11/16/05 Deposition of XXXX. For the applicant, XXXX; for the defendants, XXXX. The applicant took hydrocodone and Xanax, prescribed by XXXX. The applicant first starting seeing XXXX, who was the daughter's family physician, in June of 2005.

In the past week, the applicant also took morphine prescribed by XXXX. The applicant rents a house and lives there with her son, who is 14. The applicant is currently single and divorced from XXXX, effective some time between 2000 and 2002. There was one other previous marriage that ended in divorce in 1989.

The applicant only finished 9<sup>th</sup> grade and does not have a GED. She is not currently working and last worked for XXXX on 6/08/05. The applicant's current source of income is child support from XXXX and State Disability, which she began receiving in July 2005, certified by XXXX. Disability is related to numbness in left leg and back, as well as inability to sit or walk too long.

The applicant first began employment with XXXX 3/XX/93 as a cleaning worker, called a "environmental specialist". Previous work history was reviewed prior to employment with XXXX. The applicant's only prior Workers' Compensation claim was regarding the inhalation of a chemical at work in 2003. Also the applicant has a previous history of latex allergy affecting her hands, that also manifested in 2004. For the entire time the applicant worked for XXXX, she also had side work cleaning houses for employees of XXXX, using items such as Comet, Windex, furniture polish and an item similar to Mop-N-Glow. She never wore latex gloves.

The applicant described her cleaning duties at XXXX, including picking up trash, dirty linens, stripping beds, washing walls and windows, cleaning the lab, respiratory therapy office, conference room, patient showers, nurses station, medication room. The 11/XX/04 injury was described. As she was pushing a linen cart through double doors, a door hit the cart, the cart slammed into her and it went over her left foot. The full part of her calf was hit. There was also a bruise on her middle toe of the left foot and on top of the left foot.

After the industrial accident, her leg was hurting and she was bruised. The applicant has back problems that she attributes to this accident, and she received physical therapy in January of 2005. Back symptoms did not start until three weeks after the 11/XX/04 accident. The applicant finished her scheduled shift after the November 2004 accident. The accident was first reported on 11/XX/04, and she was initially treated for the injury by XXXX, part of XXXX Industrial Clinic. The applicant also underwent orthopaedic consultation with XXXX, as well as a consultation with podiatrist, XXXX. The applicant also saw a neurologist, XXXX, for evaluation.

The applicant received medical treatment from XXXX up to August 2005. The applicant was referred to a neurologist by XXXX and a urologist, XXXX. The applicant saw a urologist because "my bladder shut down and I was hospitalized". The hospitalization occurred at XXXX and was for four days in August or September of 2005. No doctor expressed the opinion that the applicant was over utilizing

medication. The applicant is scheduled to see AME evaluator, XXXX, and AME psychiatrist, XXXX.

The applicant's medical condition was about the same three months ago as it is now. No doctor has ever told her that she was disabled from work due to a physical condition that is nonindustrial. Previously the applicant had an MRI of the back and neck in the summer of 2004, ordered by XXXX. The MRI was obtained because the applicant was involved in a car accident, 6/20/04, that injured her neck and shoulder. The applicant sees a cancer doctor, XXXX, for treatment of papilloma virus discovered by her gynecologist. After the car accident, the applicant went to physical therapy for treatment of right shoulder and neck.

The applicant received physical therapy for six weeks and fully recovered from the effects of the car accident within a couple of months. After the car accident in the summer of 2004, the applicant was told that she had degenerative lumbar disease. Prior to the car accident, she never had back pain. There have been no other motor vehicle accidents.

Before the work injury, she had never seen a chiropractor nor since that time. Back pain waxes and wane and is sometimes not present. The left leg is painful with radiation of pain down to the foot and numbness. The applicant used to go hunting, fishing, bowling, roller-skating, camping and hiking, but not since her work accident.

At home, the applicant can do some moderate housecleaning, but cannot mow her yard. Her last physical therapy was in January 2005. In May of 2005, the applicant's body went completely numb and she was refused treatment at the emergency room, except for being given a shot and a pill. The applicant has also been to the XXXX and the XXXX Emergency Room in 2005.

The applicant described an incident with XXXX at his office, at which time XXXX told the applicant that there was nothing wrong and that she should go to her home physician if she wanted drugs. She has not had a psychiatry or psychology evaluation or treatment since the time of her injury. The applicant has been told that she has a lumbar disc problem that is causing numbness and pain in her left leg. The applicant states that being unable to work hard, as she did formerly, is affecting her.

Before the work accident, the applicant was experiencing anxiety, and XXXX prescribed Xanax. The applicant never attempted suicide nor had been diagnosed with depression. The applicant last used recreational drugs more than 30 years ago. She has had one abortion and one miscarriage. At age 16, she put up a child for adoption. Although from a physical point of view she cannot do her regular job at XXXX, from a mental standpoint she could.

After the injury, the applicant was placed on light duty in February of 2005 in the purchasing office. She sat at a desk. This assignment lasted two months. Despite the fact that there is no light duty in housekeeping, the applicant was then put back in housekeeping. The applicant only lasted one day in housekeeping because the work activity caused increased pain. The applicant was then put at the Cancer Center, where she performed light duty for awhile. The applicant then developed diarrhea and had trouble urinating.

In August of 2005, the applicant was unable to urinate and she was placed in the hospital by XXXX. XXXX believed that her bladder failed because of her back problem. After discharge from the hospital, the applicant went home with a catheter bag for three weeks and had to retrain herself to urinate. She is still using a catheter. She still has diarrhea. Although a Cam-boot was prescribed, the applicant could not wear it at work, because it was an open toe type.

Deposition of XXXX, 8/25/06, pp. 46-49.

8/25/06 Deposition of XXXX. For the applicant, XXXX; for the defendants, XXXX. The deposition concerned an amended application for alleged internal and bladder injuries. The applicant is currently taking Flagyl, hydrocodone, and Xanax prescribed by XXXX. No medications have helped her condition. The applicant is treating pain in her legs and back. She was hospitalized in July of 2006, overnight at XXXX because her bladder shut down. She did not take hydrocodone on the morning of the deposition. The applicant has been taking Xanax since the year 2000, and the medication is currently prescribed by XXXX.

Prior to the 7/08/06 hospitalization, the applicant was taking morphine and Lorazepam. Since November 2005, the applicant has not worked. She last worked 6/04/05. She has been off work for a little over a year. From August of 2005, the applicant's bladder shut down. She was hospitalized and went home with a catheter for six weeks, and then retrained herself. She does perform self-catheterization when she is unable to urinate. The applicant has seen a urologist, XXXX, at XXXX Hospital. She is now seeing another urologist, XXXX. Testing is under way. XXXX and XXXX both believe that the back is causing the bladder condition. XXXX has said the same thing.

The applicant completed a course of antibiotics for urinary tract infection. The applicant has taken multiple antibiotics. The applicant has also been seen in the XXXX ER recently, over a three week period, at least 10 times, when a urinary catheter was inserted. When the applicant first began experiencing symptoms in August 2005, she had burning in her stomach, inability to urinate and diarrhea. There was also abdominal bloating. The applicant has vaginal blood before they inserted the urinary catheter, and while the catheter was still in.

The applicant has pain and numbness regarding her back and leg. The applicant normally weighs 116 pounds, but since her accident went up to 132 pounds, but now weighs 129 pounds. The applicant has taken multiple antibiotics. The applicant has also been seen in the XXXX ER recently over a three-week period, at least 10 times, when a urinary catheter was inserted.

The applicant had two vaginal deliveries and two C-sections for her four children. C-sections were required because of placenta previa. The applicant does not have urinary urgency. She has had no abdominal trauma. The applicant has no history of kidney problems nor any family history of kidney disease. The applicant has had an abnormal PAP smear in 2003. The applicant had a hysterectomy 15 years ago. When her bladder shuts down, the applicant is unable to urinate and she gets abdominal bloating. There is increased pain in the back and legs.

The applicant uses a urinary catheter to self-catheterize herself four times a day. She urinates with the assistance of the catheter. The applicant is not receiving any psychiatric treatment or counseling at present, merely taking Xanax. The applicant's emotional feelings are the same as they were back in November of 2005. Since November 2005, the left foot is the same, as is the left ankle.

The whole left leg, however, has increased shooting pains and cramping. To a point, staying on the couch, putting pillows between her legs, taking hydrocodone and Xanax help. The right hip remains unchanged since November 2005. There have been no motor vehicle accidents or other traumatic events since November 2005.

The applicant is receiving child support, but no longer State Disability.

#### Miscellaneous clip of medical records

- 11/11/04 XXXX. PR-2 report. X-rays of tibia, fibula, ankle negative for fracture or dislocation. Old resolved fracture medial malleolus that pre-dates industrial injury. Assessment: Contusion posterior lower left leg, resulting in Achilles traumatic tendinitis and hematoma. Given Daypro. Area should be iced. Modified duty. Doctor's first report of injury filed 11/XX/04 regarding the injury that occurred on 11/XX/04 and first examination by XXXX was 11/XX/04 with diagnosis of contusion posterior lower left leg resulting in Achilles traumatic tendinitis and hematoma.
- 11/11/04 XXXX. Left ankle x-ray. Old fracture medial malleolus. No acute fractures noted. The left tibia/fibula normal.
- 11/15/04 XXXX. PR-2 report. Treatment of contusion of left posterior leg and ankle. Pain is located in the posterior Achilles area. Can return to modified duty.

11/17/04,  
11/22/04 XXXX. PR-2 reports. Treatment of Achilles tendon injury. Contusion left Achilles tendon and posterior leg. Continue Naproxen. Restricted activities.

11/29/04 XXXX. PR-2 report. Treatment for soft tissue injury of the posterior distal third of left Achilles tendon. Patient on restricted duty, but has pain in the left foot. Also some low back pain due to her limping gait. X-rays are negative. Start physical therapy.

11/29/04 XXXX. X-ray left third toe, negative.

12/01/04 -  
1/12/05 Physical therapy notes from XXXX Hospital.

12/07/04 XXXX. PR-2 report. Follow up contusion of left Achilles tendon and heel. With physical therapy, there is continued pain. She should have modified activity. Start on Naproxen and Ultracet.

12/21/04 XXXX. Patient is 60-70% better regarding contusion, Achilles tendon. Patient can return to modified duty.

1/03/05 XXXX. Patient continues to work at two jobs, but continues to complain of left leg and foot pain. Continue Naprosyn and Ultracet. Add Flexeril. Continue physical therapy.

1/04/05 XXXX. PR-2 report. Left foot pain. Needs orthopaedic consultation.

1/13/05 XXXX. Orthopaedic consultation. Patient appears to have had a significant soft tissue injury to her left ankle that has not adequately healed. Discontinue physical therapy. Recommend a CAM walker. Should be off work for one to two weeks to allow injury to heal. Once pain improves, restart physical therapy. Continue anti-inflammatory medications.

1/13/05 XXXX. Resolving contusion of the left Achilles tendon. Persistent right foot and heel pain. Plan: Patient seen by XXXX. Recommendation for CAM walker. No physical therapy at this time.

1/27/05 XXXX. X-rays of foot and toes unremarkable. Have bone scan to rule out stress fracture of left metatarsals.

2/03/05 XXXX. PR-2 report. Resolving Achilles contusion and tendinitis. Persistent metatarsalgia of second and third metatarsals. Possible tarsal tunnel syndrome. Rule out stress fracture with bone scan. Continue restricted duties.

2/09/05 XXXX. Bone scan of the feet. Increased soft tissue activity present for unclear reason. There is no significant increased bony activity. There is no fracture.

2/14/05 XXXX. Continue limited duties. Bone scan was negative. Left foot pain persists.

2/23/05 XXXX. PR-2 report. Resolved Achilles contusion. Persistent left foot pain. Metatarsalgia with normal bone scan. Continued reduced duties. Refer to orthopaedist.

2/28/05 XXXX. PR-2 report. Persistent left foot pain after normal bone scan. Increase sitting time from 50-70%. Needs orthopaedic referral.

3/22/05 XXXX. Left foot pain. Normal x-rays. Normal bone scan.

4/13/05 XXXX. Persistent left foot pain. Treated with Vicodin and Neurontin. Needs a neurology evaluation.

4/19/05 XXXX. Unscheduled visit regarding work restrictions.

4/20/05 XXXX. Left foot pain. Normal bone scan. Questionable neuroma. Metatarsalgia due to antalgic gait from injury. New onset myofascial lumbosacral strain. New onset right hip pain. Given Lodine. Continue Flexeril and Vicodin.

4/20/05 XXXX. Pain left foot. DVT ruled out by negative scan. Check lab work. Rule out rheumatoid arthritis. Also nerve conduction study.

4/21/05 XXXX. MRI left ankle, negative.

4/22/05 XXXX. PR-2 report. Severe pain left ankle, foot, toes, middle of left calf. Rule out chronic deep vein thrombosis. Administer posterior tibial nerve block and send for lower extremity venous duplex Doppler scan to rule out DVT.

4/25/05 XXXX. Status post crush injury from cart. Symptoms of RSD or possibly fibromyalgia. Should rule out rheumatoid arthritis. Also sent for EMG/nerve conduction studies.

4/26/05 XXXX. PR-2 report. Recalcitrant left foot pain. Normal bone scan. Normal MRI foot and ankle. Normal Doppler studies. Normal plain films. Continue with sedentary work. Recommend nerve conduction study and then reevaluation.

5/13/05 XXXX. EMG/nerve conduction studies normal. No latency. Rheumatoid factor negative. Hemoglobin A1C normal. Liver enzymes elevated. Assessment: Possible

fibromyalgia or RSD. Patient is asking for pain medication. Recommend a course of physical therapy.

- 5/18/05 XXXX. PR-2 report. Patient's chronic persistent pain and subjective complaints are not documented by objective findings nor objective testing. Patient needs a neuropsychological evaluation to look for somatization disorders that may be contributing to her chronic left foot pain. Patient may need treatment with other pain medications and/or antidepressants.
- 6/04/05 Illegible signature. XXXX Hospital ER. Evaluation for chest pain and chronic pain syndrome.
- 6/04/05 XXXX. Chest x-ray normal.
- 6/06/05 XXXX. PR-2 report. Anterior chest wall pain, non work related. No evidence of myocardial damage. Chronic pain syndrome. Patient can return to sedentary duty. She should be evaluated by neuropsychology.
- 6/14/05 Illegible signature. XXXX Hospital ER. Back strain secondary to antalgic gait.
- 6/14/05 XXXX. PR-2 report. Pain left side of body out of proportion to objective findings. Chest wall pain and palpitations. Anxiety disorder. Depression. Possibly personality disorder. Chronic pain syndrome with somatization disorder. Possible substance dependence on Vicodin. Patient can return to sedentary work only. Should follow up with family physician regarding her nonindustrial complaints.
- 6/27/05 XXXX. XXXX Hospital ER. Evaluation and treatment of acute low back pain with Demerol, Phenergan. Given a prescription for Vicodin and Soma.
- 7/07/05 XXXX. Panel QME. Patient extremely poor historian. Patient presents with sharp pain left arm, dull low back pain, posterior left leg pain and right knee is "going to give out". There are headaches. She has given up all nonindustrial pursuits, remaining sedentary at home. She is unable to work. Impression: History of contusion left posterior ankle, November 2004. Multiple musculoskeletal complaints.

Even with the medical records, difficult to reconstruct the exact chronology of XXXX history. It does appear that she suffered a simple contusion to the posterior aspect of the left ankle and leg in November 2004. This is normally a self-limited, two week injury, but is not the case in this patient. Examination shows no significant objective findings. Her complaints are disproportionate to any objective abnormalities.

She does not have complex regional pain syndrome. The expanded set of complaints in the low back, mid and upper back, shoulder and neck are not related to the industrial accident on 11/XX/04. She is not permanent and stationary. She should be evaluated by an orthopaedist. (**Editor's note:** No mention of urinary complaints in this report).

- 7/12/05 XXXX. Persistent left foot ankle, lower extremity pain. Subjective complaints: Back, neck pain and left arm numbness. Somatization syndrome. Chronic pain syndrome. Given Midrin and Soma, compound renewed.
- 7/20/05 XXXX Hospital ER. Urinalysis normal. Refuses Dilaudid which causes difficulty urinating. Diagnosis: Chronic pain. Workers' Comp case.
- 7/26/05 XXXX. PR-2 report. Patient continues to complain of pain on the entire left side of the body. No change since last visit. Patient does not have chronic regional pain syndrome. There are no objective findings. Patient should be evaluated by an orthopaedist for permanent and stationary status. Patient can work half time in sedentary work.
- 7/27/05 XXXX. Acute low back strain. Dexamethasone IM and Medrol dose pack. MRI lumbar spine.
- 8/02/05 XXXX. Patient has depression, suicidal ideation, insomnia. Steroids caused pedal edema. Severe low back pain. Depression. Start Zoloft.
- 8/04/05 XXXX. MRI lumbar spine. Small disc protrusions L3-4, L4-5. L5-S1 degenerative disc changes. Mild bilateral neural foraminal narrowing, left greater than right.
- 8/22/05 XXXX. PR-2 report. Persistent leg pain. Assessment: Persistent left foot, ankle, lower extremity pain with no objective findings or diagnostic findings to substantiate her subjective complaints. Somatization syndrome. Multiple musculoskeletal complaints unrelated to the original injury. Chronic pain syndrome due to traumatic contusion of the Achilles tendon. Persistent left foot pain. Patient can start transitional duty.
- 12/02/05 XXXX. Agreed Medical Examination, neurology. Diagnosis: Chronic metatarsal pain. Lumbar musculoskeletal pain associated with disc changes. Causation for left foot pain - specific injury of 11/XX/04; back pain - aggravation of preexisting condition secondary to altered gait. Maximal medical improvement 6/14/05. There is no further need for medical care or treatment. (**Editor's note:** Dr. Ansel does not discuss the applicant's urinary complaints).

12/15/05 XXXX. Psychiatric AME. Psychiatric diagnoses: Axis I - major depressive disorder, single episode, moderate severity. Pain disorder associated with both psychological factors and general medical condition. Factitious disorder, stress related physiological response affecting medical condition. Axis II - dependent personality disorder. Axis III - general medical conditions: evidence of musculoligamentous spasm, hyperactive gastrointestinal tract relating to irritable bowel syndrome. Axis IV - psychosocial stressors; chronic physical disease; discord with boss and her coworkers; threat of job loss; job change; single parent; inadequate finances; iatrogenic issues of interpersonal conflict. Axis V - present GAF 52. Highest GAF during the past year 79.

At the time of the examination, patient suffered from temporary total psychiatric disability, which started 6/04/05 and has continued to the present time. Causation is 100% industrial, either flowing from the issues of derivation relating the patient's psychiatric disease to the original industrial physical injury or flowing from those elements of her interpersonal industrial environment that directly contributed to the intensity of confusion and conflict existing as clinical components of the patient's psychiatric disability. Apportionment may apply after permanent and stationary status has been attained. Patient needs psychiatric treatment, including counseling and a monitored program of psychotropic medication.

6/01/06 XXXX. AME supplemental report. 11/16/05 deposition transcript review regarding XXXX testimony does not change opinions expressed by XXXX in previous report, 12/02/05.

7/07/06 XXXX. Letter. Work related injury causes chronic low back pain and urinary retention. Despite seeing a neurosurgeon and urologist, there has been no significant improvement in her symptoms. She is fully disabled.

Miscellaneous clip of medical records provided to me by XXXX

7/7/06 Lab. Urine positive for protein, RBCs and urobilinogen.

7/8/06 Lab. Urine culture: 10,000 cfu/ml K. Pneumoniae. CBC, chem panel normal.

7/8/06 XXXX. CT abdomen and pelvis. Left kidney: hemorrhagic cyst. Normal pelvis.

7/31/06 XXXX. Urology consultation. Long history of chronic back pain and urinary retention which started about 1 year ago. Previously seen by urologist XXXX. Was on intermittent catheterization. Recent recurrence of urinary retention and catheter placed for residuals of 500-600 cc. Constant pelvic pain, dysuria and occasional urgency. Normally constipated due to pain medication but recent diarrhea. No

evidence of cauda equina syndrome. Pelvic exam not done. Recent UTI and catheter change.

Impression: Chronic urinary retention most likely related to chronic back pain. May also be related to constipation. Also has pelvic spasm. Start Kegel exercises. Catheter removed. Resume intermittent urinary catheterization. Because of history of smoking tobacco needs cystoscopy.

- 8/30/06 XXXX. Catheterizing 4 times daily. Can void in between. Cystoscopy negative except for bladder redness consistent with catheter irritation. Minimal post void residual. On pelvic exam, mild pain levator muscles. Continue present treatment: catheterization, intermittent, Kegel exercises, decrease dietary irritants.
- 9/14/06 XXXX. PT evaluation for back pain.
- 9/25/06 XXXX. MRI lumbar spine. Broad based left foraminal disc protrusion at L3-4 superimposed upon a diffuse disc bulge and mild facet arthropathy. No evidence for spinal stenosis or nerve root compression. Mild disc bulge L4-5. Diffuse disc bulge L5-S1 with right posterolateral annular tear.

### **SUMMARY OF RELEVANT INTERNAL MEDICINE DIAGNOSTIC STUDIES**

Abnormal MRI lumbar spine.  
Normal EMG/Nerve conduction studies.  
Normal MRI of left foot and ankle.  
Normal bone scan left foot.  
Normal cystoscopy.

### **PHYSICAL EXAM**

Blood pressure 124/74.  
Pulse 86.  
Height/Weight (without shoes)5'7.5"/ 130 pounds. The applicant states she has gained 14 pounds since her industrial problems.

General Appearance This applicant is alert, oriented and appears to be in acute distress from pain. She appears to be an accurate and reliable historian.

HEENT Pupils are equal and reactive to light and accommodation. Sclera anicteric. Fundoscopic exam normal. Ear canals clear. Tympanic membranes are normal. Nose is patent. Pharynx unremarkable.

Neck	Supple, no masses. Carotids equal without bruit. No jugular venous distension. Thyroid not palpable.
Heart	Regular rate. No murmur, gallop or rub. The peripheral pulses are intact in the lower extremities.
Lung Fields	Lungs are clear to auscultation and percussion. There is no wheezing on forced expiration.
Abdomen	Soft, nontender. No guarding or rebound. No masses. No organomegaly. Bowel sounds are normal.
Extremities	No cyanosis or edema.
Lymphatics	No abnormal lymph glands.
Musculoskeletal	Gait: Slow and halting. There is full range of motion of all joints. Muscle strength, muscle bulk and tone appear to be normal in the upper and lower extremities 5/5 including hand grip bilaterally.
Neurologic	Cranial nerves II-XII intact. Deep tendon reflexes are symmetric and preserved in the lower extremities. Light touch sensation is preserved. She is shaky, intermittently tearful and uncomfortable.
Skin	There is some nonspecific scarring over the dorsums that she attributes to latex problems and irritation from household chemicals.

### **DIAGNOSES**

1. Chronic back pain syndrome with radiation to the left leg.
2. Urinary retention.
3. Intermittent diarrhea.
4. Anxiety/depression.
5. Pelvic floor dysfunction

### **DISCUSSION**

XXXX is a 50-year-old right-handed Caucasian female born XXXX in XXXX. The applicant was raised in the XXXX area, where she only finished 9<sup>th</sup> grade and does not have a GED nor college degree. She has never served in the US military.

In the 1970s, the applicant worked as a pharmacy clerk, meat wrapper, meat plant worker and deli clerk. From approximately 1980 to 1994, she ran a children's daycare center at home. For one year in the 1980s, she was also a cleaning worker. From approximately 1994 to June of 2005, the applicant was employed by XXXX as a housekeeper.

The applicant performed all of the usual and customary duties of a housekeeper in a hospital setting. She cleaned medical offices, stripped and waxed floors, changed linens, moved equipment and picked up trash. As an additional side job, the applicant cleaned houses for hospital staff, usually one to three houses per week. There were no conflicts or harassment at work, and job performance evaluations were satisfactory.

The applicant states that on the date of injury, 11/XX/04, a hospital linen cart struck the back of her left lower leg and bruised a toe on her left foot. The applicant was seen at the hospital's industrial clinic, was advised not to climb stairs, to ice the leg, and she continued working. She was referred to physical therapy. X-rays were negative for fracture.

At some unspecified period of time thereafter, she also developed significant low back pain which became progressively worse, such that in January of 2005, the applicant was taken out of work for six weeks, since there was no light duty available at that time. Subsequently, the applicant was given a desk job in the purchasing department for two months. At a certain point, walking within the hospital to deliver mail caused increased back and leg pain. She was then returned to the Housekeeping Department, given a computer chair and told to clean baseboards and walls while in the seated position.

In approximately February of 2005, she was taken out of work again for several weeks. She was then given clerical work in different departments, copying documents. In approximately June of 2005, the applicant developed diarrhea that has persisted intermittently to the present. She was therefore taken out of work and has never returned. Physical therapy worsened her back pain and was therefore discontinued.

Review of the medical records indicates a PR-2 report from XXXX, dated 11/11/04, in which a diagnosis of contusion posterior lower left leg was made, with additional diagnoses of Achilles traumatic tendinitis and hematoma. The applicant was prescribed Daypro and it was recommended that the area should be iced. A doctor's first report of injury was filed. The applicant continued to see XXXX in November and December of 2004, regarding this injury. By February of 2005, symptoms were persistent, but a bone scan was negative and the applicant continued to experience left foot pain.

On 4/20/05, XXXX noted for the first time that the applicant complained of new onset myofascial lumbosacral strain and new onset of right hip pain. She was given Lodine and continued on Flexeril and Vicodin. On 4/21/05, an MRI of the left ankle was negative. The applicant then began seeing XXXX, a podiatrist. On 5/13/05, it was noted that EMG/nerve conduction studies were normal. On 5/18/05, XXXX noted in a PR-2 report that the applicant's chronic persistent pain and subjective complaints were not documented by objective findings nor objective testing. The question of somatization disorder was raised at that time.

On 6/27/05, the applicant was treated at XXXX Hospital Emergency Room for acute low back pain with Demerol and Phenergan and then given a prescription for Vicodin and Soma. XXXX previously raised the issue of possible substance dependence regarding Vicodin. On 7/07/05, XXXX, a panel QME, noted that the applicant's complaints were disproportionate to any objective abnormalities. The simple contusion to the posterior aspect of the left ankle/leg that the applicant suffered in November 2004 would normally be a self-limited two-week injury. However, XXXX did not conclude that the applicant had complex regional pain syndrome.

On 12/02/05, XXXX, Agreed Medical Evaluator for Neurology, made the diagnosis of chronic metatarsal pain and lumbar musculoskeletal pain associated with disc changes. XXXX concluded that the back pain was an aggravation of a preexisting condition secondary to altered gait regarding her left foot pain. There was maximal medical improvement on 6/14/05 and there was no further need for medical care or treatment. On 12/15/05, XXXX, psychiatric AME, made a diagnosis of major depressive disorder, single episode, moderate severity, pain disorder associated with both psychological factors and general medical condition, also factitious disorder, stress related physiological response affecting medical condition. XXXX concluded that the causation of psychiatric injury was 100% industrial.

XXXX, urologist, evaluated the applicant on 7/31/06 and concluded that: chronic urinary retention was most likely related to chronic back pain. On 8/30/06, cystoscopy was negative. XXXX recommended Kegel exercises and continuation of intermittent self-catheterization.

The AME cover letter indicated that subpoenaed records from XXXX Hospital are still being pursued and will be provided to me, at which time these records will be reviewed and a supplemental report can be issued.

The applicant states that, on approximately 8/05/05, without warning, she developed acute urinary retention and was hospitalized at XXXX Hospital for five days. The etiology of urinary retention was not clear to the treating physicians at that time, in the applicant's perception. She was then sent home for six weeks with an indwelling Foley catheter. This was then removed and she began self-catheterizing herself up to four times a day.

She was then hospitalized on another occasion for acute urinary retention, but does not recall the exact date. Her last hospitalization on July 8<sup>th</sup> and July 9<sup>th</sup> 2006 was again for urinary retention. Currently she self-catheterizes herself three to four times a day. She currently is followed by a

urologist in XXXX, XXXX, and has a pending appointment with physical therapy for treatment of pelvic muscle spasms to improve bladder function. Kegel exercises did not help with her urinary complaints.

The applicant states that from May to August of 2005, she had constant diarrhea, the etiology of which was not clear. The diarrhea was accompanied by abdominal pain. The treating urologist placed her on a high fiber diet and the diarrhea improved. It is the applicant's perception that back spasms are the etiology of her urinary retention. Prior to employment at the XXXX Medical Center, there were no urinary complaints. The applicant is currently treated with hydrocodone/APAP 10/650, 0-8 daily, Alprazolam 0.5 mg 0-3 daily, Lyrica 50 mg twice a day. Intermittently in the past, the applicant, as the result of her urinary complaints, has experienced urinary tract infections that have been treated with antibiotics. Cauda equina syndrome has been ruled out for this applicant and previously considered in the differential diagnosis.

Although MRI of the lumbar spine is abnormal, as best as I can determine, the applicant does not have a spinal impingement syndrome of the type that would cause neurologic deficits. There is a paucity of medical literature concerning the relationship of urinary retention to low back pain. Urinary retention can be a side effect of chronic narcotic use. Assuming that the low back pain and abnormal lumbar MRI findings are a derivative industrial injury, as concluded by AME XXXX, it is more likely than not, or reasonably medically probable, that the applicant's urinary retention and need for self-catheterization is due to the combined effects of chronic low back pain and use of narcotics to control her pain. I was unable to uncover any nonindustrial causes for her urinary retention. Pelvic floor dysfunction is probably related to her chronic low back pain. Treating urologist XXXX also links the applicant's chronic lumbar back pain to her urinary retention. Review of the most recent PDR does not list urinary retention as a side effect of either Lyrica therapy or Alprazolam.

If additional information becomes available at a later date, then supplemental reports can be issued as required to assess these factors. Such information may or may not change the opinions rendered in this evaluation. The above analysis is based upon the subjective complaints, the history given by the applicant, the review of medical records and tests provided, the physical findings and review of the appropriate medical literature. It is assumed that the material provided is correct.

The examiner's opinions are based upon reasonable medical probability and are totally independent of the requesting party. Medicine is both an art and science. There is no guarantee that the applicant will not be re-injured or suffer additional injury or disease. If applicable, the employer should follow the process established in the Americans with Disabilities Act, Title 1. The opinions expressed here do not constitute a recommendation that specific claims or administrative functions be made or enforced.

This evaluation is definitely not meant for use in any other civil proceedings. The medical issues discussed are approached solely from the perspective of a licensed Qualified Medical Evaluator writing an industrial evaluation report for the California workers' compensation system. For this

reason, when medical issues pertaining to the applicant arise in a different legal forum, such as a civil suit, obtaining a separate medical legal report to evaluate such medical issues from a different perspective would be mandatory.

### **DISABILITY STATUS/DATE OF MAXIMAL MEDICAL IMPROVEMENT**

With regard to urinary retention, the applicant was temporarily and totally disabled in August of 2005 for approximately one week. She was then temporarily and totally disabled on one or two other occasions between 2005 and 2006, when she was re-hospitalized for treatment of acute urinary retention.

I would not consider the applicant permanent and stationary with regard to urinary retention since there is the potential for improvement with physical therapy and reevaluation of pain management to consider possible elimination of narcotics and substitution of alternative analgesic treatment. Kegel exercises, according to the applicant, were not helpful.

I would suggest AME internal medicine reevaluation in six months. At that time, permanent and stationary status with regard to chronic urinary retention can be addressed and probably finalized at that time.

### **FACTORS OF DISABILITY**

SUBJECTIVE: Chronic pain. Orthopaedic pain syndrome. Urinary retention.

OBJECTIVE: Abnormal MRI lumbar spine.

### **CURRENT DISABILITY FINANCIAL STATUS**

Social Security Disability: She has applied for SSI, which is pending, but has not yet been determined.

Workers' Compensation: None.

State Unemployment: No.

Vocational Rehabilitation: No.

State Disability Insurance: No.

Disability Retirement: No.

Long-term Disability: No.

She is currently receiving child support from her ex-husband.

### **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 is not yet permanent and stationary with regard to urinary retention. As long as the employer can accommodate the applicant self-catheterizing herself as needed, there are no work restrictions that need to be formulated in this regard, except to provide ready access to bathroom facilities.

#### **Discussion utilizing AMA Guides to the Evaluation of Permanent Impairment, 5<sup>th</sup> edition.**

The applicant is not yet permanent and stationary with regard to urinary retention. Provisionally, at her current level of urinary symptoms one looks at page 151, Table 7-3: Criteria for rating permanent impairment due to bladder disease. The applicant falls in Class 2, 16-40% impairment of the whole person, in that she has signs and symptoms of bladder disease and requires continuous treatment. Based on her current need to self-catheterize herself four times daily, but with ability to void in between, I would provisionally assign her a 35% impairment of the whole person based on this rating scheme for the bladder.

### **APPORTIONMENT OF PERMANENT DISABILITY BASED ON CAUSATION**

(Relying on guidelines set forth in Escobedo v. Marshalls and CNA Insurance Inc. WCAB en banc., 4/19/05; Rio Linda School District v. Scheftner, July 2005 and Sherman v. Los Angeles Unified School District, October 2005).

SEC. 34. Labor Code Section 4663

(c) 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 is not yet permanent and stationary with regard to urinary retention. Provisionally, there were no urinary complaints prior to the presumed industrial back injury that occurred after the

November 2004 traumatic workplace injury. I did not identify definite nonindustrial factors impacting on urinary retention.

From a medical legal point of view, it would be prudent to request and have me review XXXX medical records prior to 11/XX/04 to be sure that there is in fact no prior history of urinary complaints nor urinary retention. Perhaps the pending XXXX records will address this time period.

With the information that I currently have available, 100% of the permanent impairment/disability related to urinary retention is the direct result of industrial injury and 0% is attributable to nonindustrial risk factors.

### **VOCATIONAL REHABILITATION**

Strictly from an internal medicine point of view, the applicant is not medically eligible for vocational rehabilitation.

### **FUTURE MEDICAL CARE**

The applicant should remain under the industrial care of a urologist and be seen quarterly or more frequently if there are increased urinary symptoms. Urinary tract infections would be considered derivative injuries related to self-catheterization and should also be treated as they manifest, on an industrial basis.

Provision should be made for the industrial prescription of adequate home supplies for the applicant to continue urinary self-catheterization four times per day. The applicant apparently has physical therapy pending regarding pelvic muscle spasm resulting from chronic low back pain. Treatment of accompanying pelvic spasm may help alleviate urinary retention.

If possible, it would be prudent to switch the applicant from narcotic-based pain management to some other form of pharmacologic treatment of her industrial back pain. Weaning the applicant off narcotics may help diminish or even eliminate urinary retention.

### **RECOMMENDATIONS**

A low fat, low cholesterol diet and aerobic activity that does not exacerbate the underlying disease process are always desirable.

Thank you for allowing me to interview and examine XXXX regarding her complex and challenging internal medicine case. If you have any other questions, or require further clarification of any of the comments I have made regarding XXXX case, please feel free to jointly call, write or fax me at any time and I will be happy to respond in a timely manner.

**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 entirely myself. The medical-legal opinions expressed in this report are solely my own.

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. Any tests will be performed by an outside hospital or medical entity completely unaffiliated with myself. The results of any medical testing and/or review of additional medical records will be addressed by an appropriate supplemental report unless there is sufficient time available to incorporate them in the original report.

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 \_\_\_\_\_.

\_\_\_\_\_  
Ira B. Fishman, M.D.

Diplomate: American Board of Internal Medicine (Board certified in Internal Medicine 1980)  
California Medical License #A32949