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IN THE STATE BAR COURT

HEARING DEPARTMENT – SAN FRANCISCO

In the Matter of: ALLEN C. HASSAN SBN: 104024 A Member of the California State Bar	Case No. 13-O-13004 ANSWER AND OPPOSITION TO NOTICE OF DISCIPLINARY CHARGES ISC: Friday, January 16, 2015@9:30 am LOC. STATE BAR COURT 180 Howard St., 6th Floor San Francisco, California 94105

STATEMENT OF FACTS APPLICABLE TO ALL ALLEGATIONS OF WRONG DOING PURSUANT TO COUNTS ONE THROUGH FIVE OF THE NOTICE OF DISCIPLINARY CHARGES

My name is ALLEN C. HASSAN, and I was admitted to the Practice of Law in the State of California on September 14, 1982, I was assigned the State Bar Number 104024. Prior to becoming an Attorney in the State of California I complete Medical School at University of Iowa, in 1966 and completed my Internship at Mount Zion Hospital in San Francisco, California, and on January 15, 1968 I was issued my California Physician's and Surgeon Certificate No. C 29816. Thereafter I completed Residency in Psychiatry and Nuerology at Mendicino State Hospital from 1967-1970.

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Subsequent to being admitted to the Practice of Law in the State of California in 1982, I attended the College of Legal Medicine from where I graduated in 1984, and was issued my Certificate of Completion.**(Attached as Exhibit "A")**

Having completed my course of Study at the American College of Legal Medicine, Being an Attorney and a Medical Doctor, I am qualified to write Medical Legal Reports for use in Veteran and Social Security disability evaluations as well as to be use in Workers Compensation Evaluations. **(See example of a Medical Legal Evaluation, attached as Exhibit "B")** My ability to use both my legal knowledge and medical knowledge to construct these Medical Legal evaluations are not Governed by the California Workers Compensation System nor are they governed by the California State Bar.

On or about December 28, 2013 I did construct a Medial Legal Evaluation for Ms. Rapatalo, that Medical/Legal evaluation is **attached hereto as exhibit "C".** For that Medical Legal Evaluation I charged Ms. Rapatalo $1,000.00 of which she paid $600.00 and was issued a receipt for her payment. **(See Exhibit "D")** That receipt said Legal since it was for a medical Legal Evaluation not for legal services.

I did not have an agreement to represent Ms. Rapatalo as her Attorney before the Worker Compensation Appeals Board since although I am an Attorney I do not practice Worker Compensation Law. Further since I am not a workers Compensation Attorney Administrative Law Judge Phenix did not have Jurisdiction over me to order me to appear in his Courtroom on any date. Further assuming that Judge Phenix does have Jurisdiction to order random Attorneys to appear in his Court room I was never personally served with a subpoena and I only appeared as a curtesy to Judge Phenix.

OPPOSITION TO COUNT ONE

Case No. 13-O-13004

Rules of Professional Conduct, rule 3-110(A)

[Failure to perform with Competence ???]

All of the allegation of Count one are false and therefore should be stricken, and Trial Counsel should be sanctioned for malicious prosecution and submitting false accusations which he knows to be false to this Court.

On or about December 6, 2012 Ms. Senin Rapatalo hired me the Respondent to do a Medical Legal Evaluation of the injuries that she had allegedly received while working for her employer the Edgewood Apartments. Respondent has never hired or employed me to perform legal services or to represent her before the workers Compensation board. For the services that Ms. Rapatalo hires me to perform I performed flawlessly, efficiently and timely. **(see Medical Legal Report prepared on behalf of Ms. Rapatalo, attached as Exhibit "C")**

Preparing a Medical Legal Report does not violate the Rules of Professional Conduct, rule 3-110(A)

OPPOSITION TO COUNT TWO

Case No. 13-O-13004

Rules of Professional Conduct, rule 4-200(A)

All of the allegation of Count two are false and therefore should be stricken, and Trial Counsel should be sanctioned for malicious prosecution and submitting false accusations which he knows to be false to this Court.

On or about December 6, 2012 Ms. Senin Rapatalo hired me the Respondent to do a Medical Legal Evaluation of the injuries that she had allegedly received while working for her employer the EdgewoodApartments. Respondent has never hired or employed me to perform legal services or to represent her before the workers Compensation board. For the services that Ms. Rapatalo hires me to perform I performed flawlessly, efficiently and timely. **(see Medical Legal Report prepared on behalf of Ms. Rapatalo, attached as Exhibit "C")**

The Worker's Compensation Board does not regulate contractual arrangements between me and my patients/clients that hire me to do a Medical Legal Evaluation. There is nothing in the CCR Section 1077(b) that prohibits me from collecting a fee for preparing a Medical Legal Evaluation without prior approval of the Workers' Compensation Appeals Board.

OPPOSITION TO COUNT THREE

Case No. 13-O-13004

Business and Professions Code, section 6103

[Failure to Obey a Court Order]

All of the allegation of Count three are false and therefore should be stricken, and Trial Counsel should be sanctioned for malicious prosecution and submitting false accusations which he knows to be false to this Court

Respondent did not disobey or violate a Court Order. On May 15, 2013 although Judge Phenix did not have the authority to or Jurisdiction over the Respondent to issue sanctions

against him he did make an order for sanction in the amount of $1,000.00 to be paid by the Respondent. Respondent was not given a deadline in which to pay said sanctions. The Respondent paid the sanctions in the amount of $1,000.00 by check # 1200, on September 12, 2014, to the Workers Compensation Appeals Board, to Ms. Annette L. Gabrielli, as ordered by the Court on 5/15/2013. **(See Exhibit "E")**

Respondent had attempted to pay the Sanctions in the amount of $1,000.00 earlier as he had signed a check so that payment could be made, however, the Board stated that it had not received the check in the amount of $1,000.00 for sanctions. After being informed that the Board did not have record of the Payment, Respondent immediately issued another Check, had it hand carried to San Francisco, California so that he could be assured that the Sanctioned amount was paid in full. **(See Exhibit "E")**

OPPOSITION TO COUNT FOUR

Case No. 13-O-13004

Business and Professions Code, section 6068(o)(3)

[Failure to Report Judicial Sanctions]

All of the allegation of Count Four are false and therefore should be stricken, and Trial Counsel should be sanctioned for malicious prosecution and submitting false accusations which he knows to be false to this Court.

Respondent was not sanctioned as an Attorney on 5/15/2013 for failure to appear and showing up late, Respondent was sanctioned as a Medical Legal Evaluator and as such had no obligation to report said sanctions to the State Bar of California pursuant to BP section 6068(o)(3)

OPPOSITION TO COUNT FIVE

Case No. 13-O-13004

Business and Professions Code, section 6068(i)

[Failure to Obey a Court Order]

All of the allegation of Count Five are false and therefore should be stricken, and Trial Counsel should be sanctioned for malicious prosecution and submitting false accusations which he knows to be false to this Court.

Respondent did not fail to cooperate and participate in the disciplinary investigation being conducted by the State Bar of California. Although the State Bar Investigator knew at all times that the address of my law practice was located at 2929 El Camino Avenue, Sacramento, California 95821, because that is the address on the initiating complaint. Certainly the State Bar Investigators if they had done their job competently, knew that the Building located at 2933 El Camino Ave. in Sacramento, California was a condemned Building that was boarded up and had been in that condition for the past few years. However, the Investigator was apparently sending correspondence to a boarded up building. Therefore I never received any correspondence from the State Bar about this investigation. The State Bar claims to have emailed me on 2/11/14 but they fail to disclose to what email they emailed the correspondence to. The State Bar investigator has always had my phone number, which is (916) 971-3900, but they failed to contact me at that number to inform me of this investigation.

Finally I would like to apologize to the California State Bar and to this State Bar Court for any inconvenience to them for the misunderstanding that may have occurred when a Physician and an Attorney comes into their necessary legal purview, since I realize that it is

difficult at time to distinguish from the instances when I am functioning as an Attorney, a Physician or as in this case a Medical legal Evaluator.

Dated: December 18, 2014

Respectfully Submitted

ALLEN HASSAN
Respondent

EXHIBIT “A”

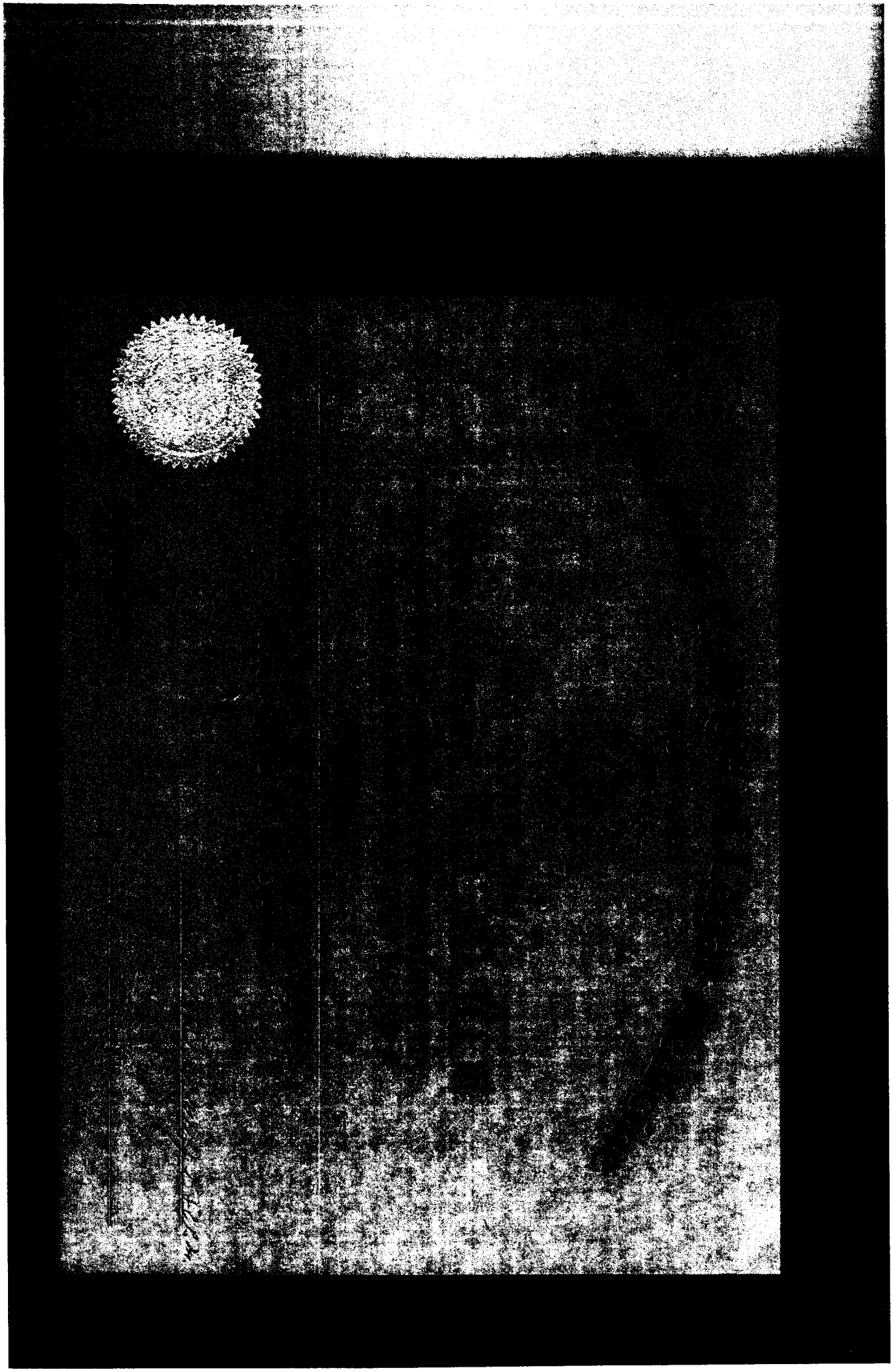

EXHIBIT “B”

Chapter 6

How To Conduct Medical-Legal Evaluations

CHAPTER 6

How To Conduct Medical-Legal Evaluations

Introduction

This chapter is written primarily for Qualified Medical Evaluators (QMEs) or Agreed Medical Evaluators (AMEs) who conduct medical-legal evaluations. It also applies to the rare occasions when a treating physician is required to prepare a medical-legal report. This chapter will provide you with information on the legal requirements for medical-legal evaluations, the types of medical-legal expenses that will be reimbursed, and specifically what needs to be included in a medical-legal report.

The importance of the medical-legal report in any workers' compensation case cannot be overemphasized. Chapters 2 and 3 contain critical concepts and terminology that evaluating physicians need to understand to write adequate reports. Reading this chapter alone will not provide all of the information you need to write a good medical-legal report. What will expedite your reaching that goal is a thorough reading and reflection of the contents of this guide along with some of the selected references.

Overview

Medical-legal evaluations are an essential part of the resolution litigation process when there is a dispute over a medical issue in a workers' compensation claim. Your QME/AME report will play a major role in determining the injured worker's benefits including the worker's entitlement to:

- Medical treatment,
- Job modification, placement, or retraining,
- Partial income maintenance,
- Compensation for permanent disabilities.

As the name implies, medical-legal evaluations take medical information and put it into a legal framework. A medical-legal evaluator is retained to provide expert opinions regarding a medical issue, not to provide medical treatment. This "testimony" is contained within the written report and ***must*** include your findings ***and*** the reasons for all of your opinions.

Because the medical-legal evaluation is evidence in a legal dispute, it must address the issues that are in dispute. The request for an evaluation should be accompanied by a referral letter from the applicant's attorney or from the insurer or, in rare cases, the injured worker may send a cover letter (8 Cal. Code Regs §35 (a)). This letter should describe the areas of dispute. If there is no referral letter, the QME will need to determine the relevant issues based on the available records and from discussion with the injured worker. The QME must address ***all disputed*** issues up to the time of the exam. (See Chapter 5, for a discussion of the different processes to follow for different types of disputes). You should always discuss and offer an opinion on all medical issues specifically requested in a referral letter or discussed with the injured worker during the exam. The law is also clear that you may address any issue which is believed to have a direct impact on treating the industrial injury. (8 Cal. Code Regs § 9793(g)(2)) If, for example, the employer is disputing the extent to which a permanent lifting restriction was due to an industrial back injury, then the evaluator, if able, must provide medical evidence on that issue. Extensive discussion of the worker's previous history of hypertension may be relevant if treatment of the orthopaedic condition cannot safely or effectively begin unless the hypertension is under control.

What Are Medical-Legal Expenses?

Disputes over payments for medical-legal reports have become a major political and legal issue. Medical-legal expenses are defined as "any costs and expenses incurred by or on behalf of any party or parties, the administrative director, or the appeals board for X-rays, laboratory fees, other diagnostic tests, medical reports, review of medical records, medical testimony, and as needed, interpreter's fees, for the purpose of proving or disproving a contested claim" (Lab. Code § 4620, 8 Cal. Code Regs. § 9793). The employer is responsible for medical-legal expenses that are "reasonably, actually, and necessarily" incurred (Lab. Code § 4621).

In general, the following conditions must be met before a medical-legal lien will be paid[1] (8 Cal. Code Regs. § 9793):

- The report must be prepared by a physician, as defined in Labor Code section 3209.3;
- The report is obtained at the request of a party, or parties, the Administrative Director or the WCAB; for the purpose of proving or disproving a contested claim;
- There must be an initial indication of a work-related injury for which the employer may be liable;
- The injured worker must have actually been examined and tested by the physician, except in death cases;
- The report must have been performed to address a disputed medical fact specified by the requesting party and the report must be capable of proving or disproving the disputed fact. If no aspect of the claim is in dispute, then there is no need for a medical-legal evaluation. For example, a medical-legal evaluation to determine causation is not required if the employer has not denied the claim and there is no dispute over compensability;
- A diagnostic test should only be performed if it is necessary and relevant to the disputed issue and capable of demonstrating pathology that may have caused, aggravated, or accelerated by the alleged exposure. There is increasing scrutiny of diagnostic testing in medical-legal evaluations. Physicians must provide justification for all diagnostic tests. (See Chapter 7, pp. 122-123, for more discussion of appropriate diagnostic tests);
- The medical-legal examination must have been performed *before* the physician received any notice that the question in dispute had been resolved;
- The medical-legal report and documentation must have been served on (delivered to) the employer and employee (or represented).

The 1993 reforms place strict limits on the employer's liability for medical-legal expenses and the number of medical-legal exams that are allowed. Therefore, for injuries on or after January 1, 1994, the QME must do as thorough and complete a report as possible on all disputed issues. If necessary, the QME can consult, at the employer's expense, with physicians who have treated the patient. If a QME finds that additional consultation is critical for completing a report, the QME should contact the party requesting the exam (or the insurance company for an unrepresented worker) to request authorization. The contact should be done in writing and a copy should be sent to the other party. If authorization is not given, the QME should specify in the report which parts of the report cannot be completed and which determinations cannot be made without additional consultation.

The physician who signs any medical-legal report must personally (Lab. Code § 4628):

- Examine the applicant;
- Take a thorough history;

- Review and summarize prior medical records;
- Compose and draft the conclusions of the report.

Writing The Medical-Legal Report

The required elements of a medical-legal report are listed in the box on page 103. Although there is no required format, you will probably want to develop one that prompts you to include all of the required information.

Medical-legal reports are prepared in the context of workers' compensation law, which has its own logic and definitions. It is *essential* that your report use the terminology and standards of the workers' compensation system. Chapters 2 and 3, and the glossary of this manual includes explanations of many of the key terms.

The law does not require that the report be written in any particular style, but you should keep in mind that the main audience for the report is nonmedical. The applicant, claims administrators, disability raters, attorneys, and workers' compensation judges are relying on your opinion to make decisions that may drastically affect the applicant's life. Your report should be clear, concise, reasoned, internally consistent and objective.

The physician who signs the report must be the only person who examines the injured employee or who participates in the non-clerical preparation of the report. Nurses are permitted to perform those functions that are routinely performed by a nurse, such as taking blood pressure. The Industrial Medical Council requires that examinations by Qualified Medical Evaluators for unrepresented injured workers be conducted only at the office location noted on the Selected Qualified Medical Evaluator Panel Form. ***Examinations may not be performed at another location.***

The Industrial Medical Council has adopted protocols for the methods of measuring certain disabilities. At the date of publication, these evaluation protocols cover the measurement of low back, cervical spine, psychiatric, pulmonary, cardiac, and immunologic disabilities. Physicians evaluating these areas *must* follow these guidelines, which are available free from the IMC or can be downloaded at **www.dir.ca.gov.** Under Lab. Code section 4628, failure to follow the specific evaluation protocol may make the report inadmissable before the WCAB.

The following sections describe the types of information your report should include:

The IMC has enacted the following forensic protocols to be used by Qualified Medical Evaluators in writing a medical-legal report:

Psychiatric (IMC Rule 43)
Pulmonary (IMC Rule 44)
Cardiac (IMC Rule 45)
Neuromusculoskeletal (IMC Rule 46)
Immunologic (IMC Rule 47)

These protocols must be followed in all QME evaluations and set forth the areas which must be addressed or considered in conducting an examination and composing your conclusions.

IDENTIFYING INFORMATION

The heading of the report should provide the information necessary to identify the report, including: the date of the report, the name of the applicant, the date of injury, the claim number, and the WCAB number, when possible.

OPENING STATEMENT

This section should provide information on the context of the report and the performance of the examination. You are required to provide the date, place and, duration of the exam. There are specific minimum time requirements for the "face to face time" spent by the physician with the injured worker. This time includes the time in which the evaluator takes the history, performs the physical, or discusses the worker's medical condition with the worker. Face to face time does not include time spent in performance of diagnostic or laboratory tests (such as blood tests or x-rays) or time spent on records review or report writing.

Face to Face Time

Face to face time does not include time spent in the parking lot, waiting room, or time spent filling out pre-evaluation history forms.

- IMC Rule 49(b).

Face To Face Time Requirements

All QME Evaluations are required to include the amount of time spent face to face with the injured worker in their report. (8 Cal. Code Regs. § 49 - § 49.9)

Examination Type	Minimum Required Minutes
Neuromusculoskeletal	20
Cardiovascular	30
Pulmonary	30
Psychiatric	60
All others	30

SOURCES OF INFORMATION

This section should contain a list of all the medical records that were reviewed in preparation of this report. You must also record any nonmedical information and its source, that was received from either party and reviewed in preparing your report or in formulating your opinion. You should list the names of anyone other than the patient who was interviewed or with whom the case was discussed.

HISTORY OF THE PRESENT INJURY OR ILLNESS

The report must include a comprehensive and factual account of the industrial exposure, the applicant's complaints, and the treatment the applicant has received. The nature of the claim will determine how extensive this history must be. Injuries resulting from cumulative trauma or occupational illnesses will require a detailed explanation of the applicant's job duties, the conditions of the injurious exposures, including the approximate time spent on the tasks in question, and the temporal relationship between the exposure and the symptoms. Your discussion should include any occupational exposures, including those from previous jobs, that may have contributed to the condition. You should describe the onset or progression of symptoms experienced by the injured worker, including the time frame in which these occurred.

The history for a specific injury should describe the activity that immediately preceded the accident and how the accident occurred. Wherever possible, you should provide relevant details, such as the approximate weights of objects, the worker's position while

Common Medical-Legal Deficiencies

The most frequent types of problems we have with medical-legal reports are untimeliness, failure to use appropriate terminology, incomplete medical evaluations, and internal inconsistencies in the reports.

The physician has to realize that we don't have the patient standing in front of us. All we have is their report. Since we have to do our best to rate all reports, the physician community has to produce reports that (1) reflect reality and (2) are ratable. There's just no other way to put it.

—DEU Disability Evaluator

Writing For An Audience

Board Rule 10606 sets out what should be included in a medical report. However, it doesn't tell you why that is needed . . . It's because non-medical personnel, such as claims examiners and workers' compensation judges need all that information to properly do their job. A workers' compensation judge's determination based on a medical report that is just a string of unsubstantiated conclusions is no better than judicial dart-throwing. . . For the medical report to be usable it should clearly explain why the medical conclusions are reached in a way that someone who is not a medical expert can understand. Then, the claims examiner, or ultimately a workers' compensation judge, can use that information in making his or her determination.*

—Honorable Alan Eskenazi, Workers' Compensation Judge, San Francisco

** see Appendix C*

performing the task that resulted in injury, the height of a fall, or the names of chemicals to which the worker was exposed. If the worker or employee provides material safety data sheets (MSDS) or other exposure documentation, you should attach them to the report. Include any information about conduct that might indicate that the employer has been seriously or willfully negligent.

The report should describe what happened after the injury. For example, was the applicant transported by ambulance to a hospital, or did the applicant continue working that day and seek treatment later. This section should also summarize the current and past treatment.

If there is more than one injury, the report should clearly describe each injury and the subsequent treatment, or changes in treatment, if treatment was on-going at the time of the second injury.

Workers' Compensation Judge Pamela Foust[2] explains that the purpose of the history section is to provide

> ". . .sufficient information regarding the nature of the injury and the patient's relevant physical or emotional condition before, after, and during the alleged injurious exposure to understand what the applicant is claiming happened to him and why. . . A skilled attorney will know what questions to ask to present his client's story in the best light at trial. Likewise, a skilled forensic doctor who believes there is merit to an applicant's case from a medical standpoint will be able to elicit information and report the facts in such a manner that the reader will understand the basis for applicant's claim."

In some cases, the physician may have an assistant make an initial outline of the patient's history or take excerpts from prior medical records, to prepare the physician for personally taking a thorough history and summarizing the records. However, the physician must review the excerpts and outline with the patient and make any necessary additional inquiries. For psychiatric evaluations, under the IMC Psychiatric protocols, ***only*** the physician may take the patient's history. The physician can assign other trained and qualified individuals to perform diagnostic tests. The name, qualifications, and role of any and all persons involved in making outlines or excerpts, in performing diagnostic tests, or in drafting the report, must be disclosed in the report (see p. 110).

PRESENT COMPLAINTS

This section should explain in detail the patient's current complaints. You should attempt to relate the frequency, duration, and

intensity of the complaints to specific activities and note temporal patterns, such as stiffness in the morning, or pain that increases throughout the day. Pain that interferes with activity is a "ratable" disability in workers' compensation, so it is important that the report give a clear understanding of the extent of any limitations.

Before the examination, the injured worker or representative should have received copies of all materials to be reviewed by the physician, from the employer or insurance carrier. For disability evaluations, the employee should also receive an Employee's Permanent Disability Questionnaire (DEU Form 100). The QME should review this form and discuss any conflicting or missing information with the worker. If the worker does not have this form, the QME should have the worker fill one out at the time of the appointment. The QME should also receive a Request for Summary Rating Determination (DEU Form 101) from the party requesting the disability evaluation. The request form contains the address of the Disability Evaluations Unit office to which the completed medical evaluation, together with DEU Forms 100 and 101, must be sent. The Disability Evaluation Unit will not complete a disability rating unless the two completed forms are submitted with the medical evaluation report.

You should be accurate in repeating the applicant's version of physical limitations. Distinguish between activities that the applicant avoids as compared to activities that the applicant finds impossible to do. Overstating the applicant's claimed limitations may cause the applicant to be discredited, while understating those limitations may limit access to treatment or other benefits.

HISTORY

This section should summarize important medical events or conditions that may have bearing on the applicant's injury, the social history, review of systems, and any other relevant medical information. The applicant should be questioned about any pre-existing injuries or conditions in the affected part of the body. This section should also report other conditions or disabilities that may affect the degree of disability this injury has caused. For example, an applicant who had previously lost the use of his right leg will suffer greater disability from an injury to his left hip than a previously unimpaired person. Workers' compensation recognizes certain combinations of impairments as total disabilities, even though either impairment by itself is not considered totally disabling. You should also include any relevant occupational history in this section.

In preparing this section, you should consider information from medical records that has been provided for this examination. You need not quote extensively from the records, but you should note any important points, especially any pre-existing conditions or treatments. You should discuss with the applicant any discrepancies between the records and information supplied by the applicant and note inconsistencies in your report. Occasionally, your discussion with the patient may reveal the existence of other medical records that you wish to review. ***When the patient is unrepresented,*** the regulations governing QME and AME examinations limit information that is provided to the evaluating physician and limit communications with any party other than the patient. You are not allowed to communicate with either party outside of the evaluation exam, except in writing, and any written communication must be served on the opposing party within 20 days (except for requests for releasing medical records). See Chapter 7, p. 121, for more information on *ex parte communication.*

Required Elements of a Medical-Legal Report

- Summary form (for QME and AME)
- DEU Form 100 is included (unrepresented QME only, report must contain comments about the form)
- DEU Form 101 is included
- Date and location of the exam
- Statement that the physician actually performed the examination
- Time spent face to face with the injured worker
- Listing of material reviewed or relied upon to prepare the report
- History of the present injury or illness
- Present complaints
- Medical history including injuries, conditions and residuals
- Findings of the examination, including laboratory or diagnostic test results
- Diagnosis
- Factors of disability: subjective, objective, work restrictions, estimate of loss of pre-injury capacity
- Opinion on whether permanent and stationary
- Cause of the disability (work caused/work contributed)
- Treatment currently needed
- Future medical treatment where reasonably, medically probable
- Vocational Rehabilitation
- Apportionment of disability, if any
- Reasons for opinions
- Disclose the name and qualifications of anyone who assisted in report
- Mandatory declaration in its entirety
- Statement concerning that physician did not violate LC 139.3
- Original signature of physician with the date signed and county noted

FINDINGS OF THE EXAMINATION

This section should include both your findings on the clinical examination and the results of diagnostic tests that you administer. The IMC has adopted guidelines for the evaluation of psychiatric and certain physical disabilities. (IMC Psychiatric Protocols (Appendix C)).

Try to present your findings as simply and directly as you can. Findings should be described in accordance with IMC guidelines mentioned above. The physical examination should follow the guidelines presented in *Evaluation of Industrial Disability by Packard Thurber* for any disability that is not covered by IMC guidelines. You should not use the *American Medical Association Guide to the Evaluation of Permanent Impairment* as it outlines different measurement techniques than those used in California.

Describe the purpose of clinical tests rather than referring to the test only by name. Remember, the main function of this report is to enable people who are not physicians to evaluate the case in the workers' compensation system.

If you have performed or reviewed any diagnostic tests, such as x-rays or EMG, you should summarize the findings in this section.

DIAGNOSIS

This section should give a specific diagnosis for each and every condition you are evaluating. If you cannot make a specific diagnosis, you should state an impression or indicate the differential diagnosis.

CAUSE OF THE DISABILITY

This section addresses the relationship between the conditions you found on examination and the injury or occupational exposure. In some situations, this section can be quite brief. For example, "the employee's fracture resulted from the fall he sustained on January 23, 1990." More detailed discussion is required in cumulative trauma cases, occupational illnesses, stress claims, or in cases where additional body parts or systems have become affected since the original injury. You should explain how different exposures or tasks contributed to the condition. If you are discussing symptoms that developed secondary to the original injury, explain how or why they developed. For example, you might state that the applicant developed low back pain due to the altered gait that was caused by his knee injury.[3]

You should be as direct and definite in this section as possible. Avoid the use of terms such as "possibly" or "maybe," because they have no definition in the system. See Chapter 2, pp. 22-26 for further discussion of causation.

It isn't necessary for work activities to be the entire cause of the injury. Work can be a contributing or aggravating cause. If there is permanent disability, and you have described an injury as an aggravation to an existing condition, you should be prepared to address that issue in the apportionment section of the report. (Psychiatric injuries are held to a different standard of causation. (See box on p. 32 "Percentage of Causation in Psychiatric Injuries.") For information on apportionment see Chapter 3.

You should consider all work exposures in determining causation in cumulative trauma or occupational illness cases. However, you must identify the last year that the employee had the hazardous exposure, because the law limits liability to the applicant's employers during that year (Lab. Code § 5500.5).

If conflicting accounts of how the injury happened affect your opinion regarding causation, then you should state your opinion conditionally in each of the possible scenarios. It is not your job to determine which history is correct. However, if your medical evaluation corroborates or is not compatible with one of the histories that has been provided, you should note that in your report.

California law, Labor Code section 3212, contains *rebuttable presumptions* regarding causation for certain injuries in certain occupations (see Chapter 2). In evaluating those injuries, you should give your opinion in support of causation or provide your opinion and evidence to rebut the presumption.

Psychiatric evaluations have one additional requirement. These reports must contain a determination whether work factors were the predominant cause (at least 51%) of the injury.

OPINION ON PERMANENT AND STATIONARY STATUS

In this section you should state whether or not you have determined the patient's condition to be permanent and stationary, along with the reasons for this determination. If the condition is not permanent and stationary, you should indicate what additional treatment is needed, and if possible, estimate when the patient should be reevaluated. Discussion of disability factors, Qualified Injured Worker status, future medical needs, and apportionment may not be possible until the patient's condition has become permanent and stationary.

FACTORS OF DISABILITY

This section should describe any permanent disability that you believe will result, or has resulted from, the injury. (See Chapter 3, p. 36 for a complete discussion of permanent disability.) It is very important that you be thorough and specific in this section, because it will be a basis for the DEU rating. For each body part being evaluated or systems, you should give an opinion on the:

- Subjective Factors
- Objective Factors
- Work Restrictions
- Estimate of limitations or loss of pre-injury capacity.

Your opinion in this section should relate to the information you provided in the findings section of your report. Based on the patient's subjective complaints and on your examination, you should describe any subjective disability. For example, limitations due to pain should be identified by a description of the activity that produces the disability, the duration of the disability, the activities that are precluded by the disability, those that can be performed with the disability, and the means necessary for relief. (See box, p. 44, for further discussion on describing subjective disability.)

If your physical examination revealed a restricted range of motion, in this section you should describe the resulting range of motion. You should describe any loss of a body part, disfigurement, atrophy, or measurable loss of function, including range of motion or strength, as well as any device or prosthesis that should be used. (See Chapter 3, pp. 41-49, for further discussion on describing permanent disability.)

This section should also describe any work restrictions that you determine should be placed on the worker, regardless of whether they are specifically relevant to the applicant's current job. Work restrictions can be actual or preventive (prophylactic). Actual work restrictions are those that the employee cannot perform, either because the employee is physically prevented from doing so, such as being unable to bear weight on an injured ankle, or because the activity causes severe pain. Preventive work restrictions are appropriate to:

- Avoid or prevent undue pain,
- Avoid causing an increase in symptoms that would lead to a period of temporary disability,
- Avoid causing increased permanent disability,
- Prevent exacerbations that would increase the need for medical care.

Review Chapter 3, pp. 44-46, for further discussion of how to write work restrictions.

Once you have clearly defined the actual work restrictions, you should also ***separately*** describe, to the best of your ability, the worker's loss of pre-injury capacity. You should describe what the worker could do before the injury, as compared to what the worker can do after the injury. Based on that description, estimate the percentage of loss of capacity. (See Chapter 3, pp. 46-47, for more information on how to estimate loss of pre-injury capacity.)

APPORTIONMENT OF DISABILITY

This section should describe the degree to which any permanent disability is due to pre-existing conditions or underlying disease. Apportionment is a legal concept and applies only to permanent disability. It is never applied to medical treatment, temporary disability, vocational rehabilitation, or death benefits. Apportionment can only be based on disability. It is not correct to base apportionment on personal risk factors, asymptomatic disease, or pathology. You are being asked to determine the portion of the disability that would have existed without the current injury. (See Chapter 3, pp. 50-58 for discussion of apportionment.)

You should address the issue of apportionment if you have described pre-existing conditions or underlying disease, or if you have indicated in your causation section that the injury is an aggravation of an existing condition or previous injury. Explain the portions of your findings that affect your opinion on apportionment. The existence of underlying disease or pre-existing injury does not automatically justify apportionment to those factors, but the issue should be addressed.

The chief method to apportion permanent disability is to use the "subtraction method." (See Chapter 3, p. 51)

MEDICAL TREATMENT INDICATED

Labor Code section 4600 provides that an injured worker is entitled to treatment reasonably required to cure or relieve the effects of the injury.

Thus, this section should include your recommendations for current and future treatment. If the patient is currently receiving treatment, indicate whether the treatment is necessary to either improve or prevent deterioration of the current condition. Refer to both subjective and objective factors (see Chapter 3, pp. 42-44). If you believe that additional treatment is indicated to achieve maximum improvement, you should explain the type of treatment indicated, the reasons for the treatment, and the possible benefits of the treatment. The way you phrase this need for treatment and the definitions used are critical to the injured worker receiving proper benefits for the work injury.

PROVIDING FOR FUTURE MEDICAL TREATMENT

A worker may still require further medical treatment after the worker's condition is permanent and stationary and workers may receive awards which include future medical care if the treatment is needed:

- To maintain the worker's optimum condition;
- To relieve or cure the effects of the injury;
- To relieve the effects of exacerbations or recurrences that are reasonably expected from the worker's condition.

Treating and evaluating physicians should carefully consider and calculate the need for future medical treatment and include as much detail on this as possible in their reports, without including finite numbers and dollar amounts. When medically appropriate, future medical treatment must be awarded by the WCAB. The physician is in the best position to estimate what the needs might be (see box p. 110). This estimate should include check-ups, anti-inflammatory or pain medication, splints, future surgery, future hospitalization, and any other necessary medical care. The WCAB will not be bound by estimates of an injured workers' medical needs in a P&S report. The WCAB will look at the reports of the treating physician, and possibly a QME, at the time medical care is requested by the injured worker.

REASONS FOR THE OPINION

For each opinion, you must provide a clear description of why you have reached that opinion. You should also provide explanations for any unusual findings. This should be done throughout the report, in the appropriate sections. Avoid meaningless summaries such as "My opinion is based upon the patient's history, the examination findings, and the available medical records." A medical-legal report that does not contain the reasoning behind the medical opinions reached is worthless in the workers' compensation system.

The Report Should Be Internally Consistent

I can handle it when the report's findings are inconsistent as long as the physician tells me why. If the work restrictions don't logically match what you've said in your findings, you need to explain why . . . to give your reasoning. Otherwise the rater has no possible idea of what may be going on with that worker. Without the explanation the rater is basically left to guess, which may well not be to the benefit of the worker.

— disability rater

The Rushing Decision Defines Forms of Treatment

"Section 9785 uses the terms continuing treatment and further treatment; not future treatment. The terms are not interchangeable. Continuing means constant, needing no renewal: lasting, enduring. (Webster's Third New Internat. Dict. (16th ed. 1971) p. 493.) "Further" indicates "going or extending beyond what exists." (Id. at p.924.) The terms "continuing" and "further" denote treatment protocol that is ongoing, uninterrupted and unceasing. By contrast, future is "existing or occurring at a later time." (Id. at p. 926.) Hence, "future" medical care suggests medical attention which would be required at a later date."

-Tenet/Centinela Hospital Medical Center v. WCAB (Rushing) 80 Cal. App. 4th 1041; 65 C.C.C. 477

Excerpts from Inadequate Reports

Many medical-legal reports do not provide the information necessary for raters or judges to make decisions about worker's cases. Following are several excerpts of inadequate medical-legal reports, with accompanying comments on how the report should be changed.

WORK PRECLUSIONS:
I would preclude any heavy lifting or prolonged repetitive activities with her right upper extremity and any gripping with her right hand.

Comment:
These work restrictions are too vague. Work restrictions should be more specific to the actual precluded tasks and limits. (i.e. keyboarding) % loss of pre-injury capacity for lifting or gripping activities.

DEGREE OF DISABILITY:
The left foot complaints preclude him from prolonged weightbearing activities and limit him to semi-sedentary work. However, this does not affect such things as stooping or bending or lifting capability, and the raters should take this into account when considering his overall working capacity. The left knee and low back complaints appear to represent minimal hindrance to his activity and would not add significantly to his disability level.

Comment:
These work restrictions are too vague, and internally inconsistent. If a patient is precluded from weight-bearing activities, this would likely affect lifting capability.

FUTURE MEDICAL TREATMENT:
As was stated previously, based on present findings on examination, there is no clinical indication to warrant any further diagnostic studies or active treatment, other than on a simple supportive and symptomatic basis. It is felt, however, that, based on symptoms over this period of time of some six years, and with the pathology as noted from the previous arthroscopic procedures performed, medical care should be afforded to him in the future with any settlement in the event that his symptoms do progress or become intolerable where he would need a more active treatment program, including the possibility of further surgery.

Comment:
Future medical care needs to be much more specific. What kind of treatment? How frequent? What kind of surgery?

Excerpts From Inadequate Reports, cont'd

DISCUSSION:
The patient sustained a serious injury on January 17, 1992. It is very likely that he has had subclinical psoriatic arthritis for a long time prior to the injury. It is very possible for the psoriatic arthritis to precipitate as a result of trauma.

In consideration of the patient's overall medical condition, it is reasonable to assume that the patient has reached the permanent and stationery status. The objective factors and the patient's disability rating are very minimal, perhaps less than 5 percent of the right upper extremity. The subjective complaint plays a significant role in the range of about 10 percent of the right upper extremity. However, there is a contributing factor which is his psoriatic arthritis and history of his gout. I would estimate that 20 percent of his disability is contributed by the underlying medical problem, and 80 percent by the injury itself.

Comment:
It is not correct to apportion to an underlying condition unless the physician can demonstrate that the symptoms would have occurred regardless of the industrial injury. The physician has not done so in this report.

The End Result of Inadequate Reports: Rejection and Delay

EVALUATION OF QME REPORT

Physician Name: Dr. Smith

This QME report could not be used for disability rating because:

✓ Report failed to provide adequate information on factors of disability.

___ Report failed to address necessary legal issues.

___ Report was internally inconsistent.

___ Other:

Comment:

Dr. Smith indicates decreased range of motion of wrist, but does not provide measurements. Says there are symptoms on use, but doesn't describe what these symptoms are. Report is unratable necessitating writing to the QME.

Calculating Future Medical Costs

A 45 year-old worker has an episode of back pain resulting from a disc problem. It is not a surgical problem at this time. The physician writes the following in the medical-legal report under *"Need for Future Medical Care."*

I estimate that this patient will need the following care:

- Two to three office visits per year to evaluate progression of the back problem;
- Physical therapy for periodic recurrence of the problem (approximately six sessions per year);
- Four tablets per day of anti-inflammatory medication, on-going;
- It is possible the problem may progress to the point at which the patient may need an L5-S1 laminectomy and discectomy, to be determined by treating and consulting physicians.

DISCLOSURE OF OTHER INDIVIDUALS INVOLVED

Your report must disclose the name, qualifications, and roles of other individuals who participated in the evaluation by performing such tasks as:

- ▲ Taking and outlining the medical history.
- ▲ Reviewing and summarizing medical records.
- ▲ Administering diagnostic studies.
- ▲ Drafting or editing any part of the report.

The name of the transcriptionist is not required. Violation of this provision can result in your suspension or termination as a Qualified Medical Evaluator. (Lab. Code § 139.3, 8 Cal. Code Regs. § 4628).

MANDATORY DECLARATION

Since all reports, whether comprehensive medical-legal, supplemental, or follow-up reports are submitted to the WCAB and may be used in evidence, the following declaration in its entirety must be included in every medical-legal report:

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

SIGNATURE

The report must be signed by the physician who prepared the report, under penalty of perjury (Lab. Code § 4628(j)). If you sign the report, you must have examined the applicant, taken the applicant's history or reviewed with the applicant an outline of the history, reviewed the medical records, and composed and drafted the conclusions of the report. Include the date and county where the declaration was signed.

DISCLOSURE OF ANY SIGNIFICANT BENEFICIAL INTEREST

Your report must disclose any proprietary interest or co-ownership you have in any laboratory, pharmacy, clinic, or health care facility you used in the evaluation. QME's and AME's are

generally prohibited from most self-referrals, with some exceptions (Lab. Code § 139.31). Your report must contain the statement that you have not violated Labor Code section 139.3 in that you have not made an illegal referral(s). Failure to include this statement however, is not necessarily fatal and may be cured by a later amendment (*Leyba v. LSI Logic Corp.* (1995) 23 CWCR 230). See Chapter 7, for more information on prohibited self-referrals. Violation of this section can result in your suspension or termination as a QME.

An example of a declaration listing the above information can be found in Appendix C.[4]

Required Forms

Several forms must be attached to the medical-legal report. For QME and AME reports, the reporting physician must include a copy of the summary form (Form 111) that is found in Appendix D. If the injured worker is unrepresented, DEU Form 100 and 101 must also be included, and the report must contain comments about DEU Form 100. If the injured worker is represented, only DEU Form 101 must be included, but no comment about it is required nor are you required to complete the Summary Form.

Timeliness

The timely submission of reports is mandated by law. For injuries between January 1, 1991 and December 31, 1993 the report must be prepared and submitted within 45 days after the evaluator has seen the employee or otherwise commenced the evaluation procedure. For injuries on or after January 1, 1994, the report must be submitted within 30 days. Forty five day extensions (for injuries between 1/1/91 and 12/31/93) and 30 day extensions (for injuries on or after 1/1/94) shall be approved only when the evaluator has not received test results or a consulting physician's evaluation in time to meet the initial deadline. In this instance, the evaluator must notify the employee and the employer/insurer/claims administrator no later than five days before the end of the initial 30 or 45-day period that an extension is needed. A copy of this notice must be sent to the Executive Medical Director at the Industrial Medical Council. If the extension requires more than an additional 30 or 45-day period, approval must be granted by the Executive Medical Director. A copy of the QME and AME Time Frame Extension Request form is in Appendix D.

Payment for the Report

The employer must pay for medical-legal expenses within 60 days after receiving the written billing and report, unless the employer contests the reasonableness or necessity for incurring the expense. When the payment is not made as required, the "unreasonably unpaid" amount can be increased by 10 percent. The employer is also liable for 7 percent interest per annum retroactive to the date the bill was received (Lab. Code § 4622). (For information on filing lien claims see

What Can Physicians Do If They Have A Dispute Over Payment Of Medical Legal Bills?

- Make sure you are performing a valid medical-legal evaluation (see Lab. Code § 4621 and 8 Cal. Code Regs.§ 9793). For example, for claims accepted by the employer, the report will be inadmissible if performed during the first 60 days after the notice of claim has been filed. If you perform an exam before then, you are asking for a fee dispute.
- Do not perform unnecessary diagnostic tests or x-rays. If tests are necessary, offer a specific reason for them when requesting approval from the claim adjustor. If unusual or expensive testing is required, or if you think it is medically necessary to repeat tests performed in the recent past, notify the insurer in advance. Be able to provide a sound medical justification for doing the testing.
- Follow the medical-legal fee schedule honestly. This should resolve many problems before they start. The employer is required to pay all reasonable charges within 60 days. Under the fee schedule, this means that the employer should pay a minimum of $500 for a standard uncomplicated medical-legal report (ML 102). Even if the payor disputes a charge above this level, the basic medical-legal fee must be paid within 60 days.
- If the dispute over the validity or the amount of payment cannot be resolved, the provider must file a lien and litigate the matter before the Appeals Board.

Chapter 8.) Medical-legal reports must be billed in accordance with the medical-legal fee schedule (Appendix C). You can reduce delays and facilitate speedy payment by including supporting information in your report as to how you achieved the level billed (i.e., hours present or elements included).

End Notes

1. 8 California Code of Regulations section 9793 and description by Honorable Pamela Foust, Workers' Compensation Judge, *"Handling Medical-Legal Issues: An Analysis and Proposal,"* Conference of California Workers' Compensation Judges, Los Angeles (1992).
2. Honorable Pamela Foust, Workers' Compensation Judge, *"Handling Medical-Legal Issues: An Analysis and Proposal,"* Conference of California Workers' Compensation Judges, Los Angeles (1992) p. 32.
3. Honorable Pamela Foust, Workers' Compensation Judge, *"Handling Medical-Legal Issues: An Analysis and Proposal,"* Conference of California Workers' Compensation Judges, Los Angeles (1992) p. 39.
4. Honorable David O'Brien, Workers' Compensation Judge (ret), Work. Comp. Claims & Benefits, 10th Ed. (1996), p. 300.

EXHIBIT “C”

AI EN CLARENCE HASSAN, MD, AE

Specializing in Orthopedic and Neurological Assessments
Fellow American Academy of Disability Evaluating Physicians
Fellow American Academy of Legal Medicine
Diplomat American Board of Forensic Examiners
Diplomat American Academy of Experts in Traumatic Stress

MEDICAL ACCIDENT DICTATED REPORT

Re: Senin Rapatalo
D.O.B.: [redacted]
D.O.S.: 12/28/2012

This lady return to the office after having first being seen on December 15, 2012, and a review of the records indicate that the patient had a right and left shoulder rotator cuff tears with persistent neck pain. She described on that date that she had had an MRI scan performed on January 20, 2010, on the right shoulder, and although that study is not available, there is a note by Dr. Cometo that he had scheduled her for surgery of the rotator cuff tear on the right.

I do note that a left shoulder MRI scan was performed and the results are present as the date of May 4, 2011. The patient states that she had fallen approximately a year earlier, which would be compatible with the scan findings of rotator cuff tear of that time. There was a 2+ cm supraspinatus rotator cuff tear, which was retracted to plus cm with a significant atrophy of the supraspinatus muscle; infraspinatus and subscapularis muscles appeared intact as was the biceps tendon intact. There was no significant glenoid labral tear, but minor AC joint arthritis and edema was noted.

The patient's PR2 form that was filled out on December 15, 2012, noted the issues and timeline of the right and left rotator cuff tears with persistent cervicalgia and persistent arthralgia with inability to abduct her shoulders past 70 degrees out of 170 degrees. The patient notes internal and external rotational movements are likewise painful.

This confirms the patient's notes that the MRI scan of the right shoulder was performed on March 14, 2011, through Advantage Imaging and the MRI scan of the left shoulder was performed on May 4, 2011, again at Advantage Imaging.

A deposition had been taken on June 16, 2011, at attorney Fluss office.

There are multiple notes that were taken by the patient that shows the fact that Dr. Larry Magnussen, a QME workup was performed on June 21, 2011. The patient also saw Dr. Luong on June 22, 2011, who advised her that left shoulder surgery should be performed.

The patient has been on hydrocodone, ibuprofen, and other medications including a muscle relaxant as prescribed by Dr. Lam and others.

The patient has been extremely frustrated by both the employer, the father and daughter team Andrade. They have warned her not to submit this to work comp apparently attempting to avoid responsibility for the injuries. The patient feels she has been taken advantage of because of her

2929 El Camino Ave, Sacramento, CA 95821
P- 916-971-3900 F- 916-971-3618

ALLEN CLARENCE HASSAN, MD, ABFP

Specializing in Orthopedic and Neurological Assessments
Fellow American Academy of Disability Evaluating Physicians
Fellow American Academy of Legal Medicine
Diplomat American Board of Forensic Examiners
Diplomat American Academy of Experts in Traumatic Stress

lack of a very good English comprehension, although she does keep meticulous records in spite of having some difficulty with language and cultural barrier as the patient is of Filipino.

The patient has a scheduled court hearing on January 10, 2012, at 8:30 a.m. In order for this physician and attorney to attend to this hearing, it is a $2500 charge not necessarily to be paid totally at the time of the appearance.

Allen Clarence Hassan, M.D., A.B.F.P.

2929 El Camino Ave, Sacramento, CA 95821
P- 916-971-3900 F- 916-971-3618

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the box (es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stat (i.e., has reached maximum medical improvement), do not use this form. You may DWC form PR-3.

O Periodic Report (required 45 days after last report) O Change in treatment plan O Release form care
O Change in work status O Need for referral or consultation O Response to request of information
O Change in patient condition O Need for surgery or hospitalizing O Request for authorization O Other

Patient: Date: 1-3-13
Last: Rapatalo First Senin M.I.
Address: City States: Zip:
Date of Injury: Date of Birth:
Occupation: SS# - - Phone: ( )

Claims Administrator:
Name: Claim Number:
Address: City: State: Zip:
Phone: ( ) FAX: ( )
Employer Name: Employer Phone: ( )

The information below must be providing. You may use this form or you may substitute or append of narrative report
Subjective complains: pain (B) shoulders lifting wheel chair

Objective findings: (include significant physical examination, laboratory imaging, or other diagnostic finding)

MRI (R) + (L) +

Diagnoses:
1. (B) shoulder RCT - ICD-9 3/18/2011 5/4/11
2. Severe ICD-9
3. Work harassment caused ICD-9
↑ B.P. + Depression
HBP

Treatment Plan: (include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Sp consultation/ referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and of physical medicine services (e.g. physical therapy, manipulation, acupuncture). Use of CPT codes in encouraged. Have there been changes in treatment plan? If so, why?

metoprolol 50 mg TBP 600 Q 6° Norco 10/325 Q8° pm

Pt. "keeps Diary"

Work Study: this patient has been instructed to:
☐ Remain off work until 2-3-13
☐ Return to modified work on _____ with the following limitations of restrictions (list all specific restricti standing, sitting, bending, use of hands, etc)
☐ Return to full duty on _____ with no (limitation on restrictions)

Primary Testing Physician ;(original signature, do not stamp) Date: 1/3/13

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not vi labor code 139.3

Signature: Cal. Lic. C29816
Executed at: 2933 El Camino Ave Sacramento, CA 95821 Date 1-3-13
Name: Allen C Hassan, MD Specialty: FE
Address: 2933 El Camino Ave Sacramento, CA 95821 Phone: (916)971-3900
Next report due no later than:
DWC Form PR-2 (Rev. 01/01/05) 2/3/13

EXHIBIT “D”

RECEIPT DATE 12-4-12 No. 762053

RECEIVED FROM Senin Rapatalo $600.00

$600 out of $1000. DOLLARS

FOR RENT
FOR Legal / DR Hassan

ACCOUNT	
PAYMENT	600 00
BAL. DUE	

CASH
CHECK
MONEY ORDER
CREDIT CARD

FROM DT TO DR

BY DR

3-11

Friday Dec. 28.2012
@ 11:20am

Thursday, Jan 3, 2013
@ 3:40pm

EXHIBIT “E”

Confirmation of Delivery Receipt

Confirmation that letter was received on 9/12, 2014. Time: 9:53 AM/PM

From:
Allen C. Hassan, M.D.
2929 El Camino Avenue
Sacramento, CA 95821

To:
Workers' Compensation Appeals Board
Att: Annette L. Gabrielli
455 Golden Gate Avenue, 9th FL
San Francisco, CA 94102

RE: Check #1200 / Pay to the order of: Workers' Comp Appeals Board - $1000.00

Name (please print): A. GABRIELLI Company: DCAB

Signature: [signature] Date: 9/12/14

Sacramento

Workers' Compensation Appeals Board

160 Promenade Circle,

Suite 300

Sacramento, CA 95834

Annette L. Gabrielli, Regulations Coordinator
Department of Industrial Relations
Workers' Compensation Appeals Board
455 Golden Gate Avenue, 9th floor
San Francisco, CA 94102

E-mail: WCABRules@hq.dir.ca.gov.

The telephone number of the contact person is (415) 703-4580.

IN THE STATE BAR COURT

HEARING DEPARTMENT – SAN FRANCISCO

In the Matter of:	)	Case No. 13-O-13004
	)	
ALLEN C. HASSAN	)	PROOF OF SERVICE BY MAIL
	)	
SBN: 104024	)	
	)	
	)	
	)	
A Member of the California State Bar	)	

I am employed and/or reside in the City and County of Sacramento, State of California. I am over the age of 18 and not a party to the within cause or claim, my business address is:

2929 El Camino Avenue
Sacramento, California 95821

I served the foregoing document

"Answer and Opposition to Notice of Disciplinary Charges"

by depositing a true copy thereof in the United States Mail in Sacramento, California, State of California, on December 22, 2014, enclosed in a sealed envelope, with the postage thereon fully prepaid, addressed as follows:

California State Bar
Office of the Chief Trial Counsel
Manuel Jimenez, Esq, Senior Trial Counsel
180 Howard Street
San Francisco, California 94105-1639

And by Faxing it to the California State Bar at Fax #: (415) 538-2284 and by emailing it to Manuel Jimenez at MANUEL.JIMENEZ@CALBAR.CA.GOV

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

Executed this 22nd day of December 2014, at Sacramento, California.

THOMAS DIXON
~~MELISSA ANDERSON~~