STATE OF CALIFORNIA

# DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

**Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.**

1. **INSURER NAME AND ADDRESS**: State Comp. Insurance Fund PO Box 92622, L.A, CA 90009-2622 — PLEASE DO NOT USE THIS COLUMN
2. **EMPLOYER NAME**: M R Grant CPA — Case No.
3. Address: No. and Street: 6333 Wilshire Blvd #551 — City: Los Angeles — Zip: CA 90048 — Industry
4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes.): Accounting — County
5. **PATIENT NAME** (first name, middle initial, last name): Tiffany L Chang — 6. Sex: ☐ Male X Female — 7. Date of Birth: Mo. Day Yr. 08/02/51 — Age
8. Address: No. and Street, City, Zip: 20613 Runnymede St. Winnetka, CA 91306 — 9. Telephone number: 818 713-1008 — Hazard
10. Occupation (Specific job title): Accountant/Auditor — 11. Social Security Number: 553 - 77 - 1443 — Disease
12. Injured at: No. and Street, City, County: 6333 Wilshire Blvd., #511, Los Angeles, CA 90048 — Hospitalization
13. Date and hour of injury or onset of illness: Mo. Day Yr. 11/15/2007 Hour _____ a.m. _____ p.m. — 14. Date last worked: Mo. Day Yr. 03/11/2011 — Occupation
15. Date and hour of first examination or treatment: Mo. Day Yr. 03/18/2011 Hour _____ a.m. _____ p.m. — 16. Have you (or your office) previously treated patient? ☐ Yes X No — Return Date/Code

**Patient please complete this portion, if able to do so.** Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. **DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED.** (Give specific object, machinery or chemical. Use reverse side if more space is required.) Employer request her to take over 30 lbs file boxes from high shelf

18. **SUBJECTIVE COMPLAINTS** (Describle fully. Use reverse side if more space is required.)
The pains over the Chest, neck, shoulder, upper and lower back, wrist headache

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)
A. Physical examination
1.sprain of shoulder and arm 2. chest, neck, wrist, and back pain
3. headache

B. X-ray and laboratory results (State if non or pending.)

20. **DIAGNOSIS** (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? X Yes ☐ No
ICD-9 Code ___ ___ ___ - ___ ___

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? X Yes ☐ No If "no", please explain.

22. Is there any other current condition that will impede or delay patient's recovery? ☐ Yes X No If "yes", please explain.

23. **TREATMENT RENDERED** (Use reverse side if more space is required.)
Treatment will be consisted Acupuncture/Electronic, Physical therapy Hot pad, Massage therapy

24. If further treatment required, specify treatment plan/estimated duration.
Frequency of treatment will be 12 x 3 months

25. If hospitalized as inpatient, give hospital name and location: N/A — Date admitted: Mo. Day Yr. — Estimated stay

26. WORK STATUS -- Is patient able to perform usual work? ☐ Yes X No
If "no", date when patient can return to: Regular work / / Modified work 04 01 13 — Specify restrictions: no lifting over 15 lbs no lift level about shoulder

Doctor's Signature _____ — CA License Number AC5600

Doctor Name and Degree (please type) Roger Chan L.Ac, Ph.D — IRS Number _____

Address 206 E Las Tunas Dr. #1, San Gabriel CA 91776 — Telephone Number (626) 285-6373

FORM 5021 (Rev. 4) 1992

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.