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S.C. Supreme Court

THE STATE OF SOUTH CAROLINA
In The Supreme Court

APPEAL FROM THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Andrea C. Roche, T. Scott Beck, Avery B. Wilkerson, Jr.
Workers' Compensation Commissioners

Tracking No. 2012-212326

WCC File No: 1103442

Gayla Ramey, Employee.....Respondent,

v.

Unihealth Post Acute Care Tanglewood, Employer, and
American Zurich Insurance Co., Carrier.....Petitioners

APPENDIX TO PETITION FOR WRIT OF CERTIORARI VOL. I

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THIS OPINION HAS NO PRECEDENTIAL VALUE. IT SHOULD NOT BE CITED OR RELIED ON AS PRECEDENT IN ANY PROCEEDING EXCEPT AS PROVIDED BY RULE 268(d)(2), SCACR.

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

Gayla Ramey, Employee, Appellant/Respondent,

v.

Unihealth Post Acute Care Tanglewood, Employer, and American Zurich Insurance Company, Carrier, Respondents/Appellants.

Appellate Case No. 2012-212326

Appeal From The South Carolina Workers' Compensation Commission

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Unpublished Opinion No. 2014-UP-288
Heard October 10, 2013 – Filed July 16, 2014

AFFIRMED

Mark Calhoun, of Calhoun Law Firm, of Lexington, for Appellant/Respondent.

Daniel Addison, of Hedrick, Gardner, Kinchloe & Garofalo, LLP, of Columbia for Respondents/Appellants.

PER CURIAM: This case involves the cross-appeals of the order of the Appellate Panel of the South Carolina Workers' Compensation Commission ordering Unihealth Post Acute Care Tanglewood and American Zurich Insurance Company (collectively Employer) to pay claimant Gayla Ramey temporary total disability (TTD) benefits. Ramey challenges the Appellate Panel's determination of the compensation rate. Employer argues Ramey should be barred from receiving TTD benefits. We affirm.

(1) We find the Appellate Panel did not err in holding Ramey was entitled to TTD benefits. *See* S.C. Code Ann. § 1-23-380(5) (Supp. 2013) (providing under the Administrative Procedures Act (APA), an appellate court may not substitute its judgment for that of the agency as to the weight of the evidence on questions of fact, but it may reverse when the decision is affected by an error of law or is clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record); *Jones v. Georgia-Pacific Corp.*, 355 S.C. 413, 416, 586 S.E.2d 111, 113 (2003) (stating an appellate court will not overturn a decision by the Commission unless the determination is unsupported by substantial evidence); *Pierre v. Seaside Farms, Inc.*, 386 S.C. 534, 540, 689 S.E.2d 615, 618 (2010) ("Substantial evidence is not a mere scintilla of evidence, but evidence which, considering the record as a whole, would allow reasonable minds to reach the conclusion the agency reached."); *Sharpe v. Case Produce, Inc.*, 336 S.C. 154, 160, 519 S.E.2d 102, 105 (1999) ("The possibility of drawing two inconsistent conclusions from the evidence does not prevent the Commission's finding from being supported by substantial evidence."); *Hall v. United Rentals, Inc.*, 371 S.C. 69, 80, 636 S.E.2d 876, 882 (Ct. App. 2006) ("Where there are conflicts in the evidence over a factual issue, the findings of the Appellate Panel are conclusive."); *id.* ("The final determination of witness credibility and the weight to be accorded evidence is reserved to the Appellate Panel."); *Mullinax v. Winn-Dixie Stores, Inc.*, 318 S.C. 431, 435, 458 S.E.2d 76, 78 (Ct. App. 1995) ("Where the medical evidence conflicts, the findings of fact of the Commission are conclusive."); *Pollack v. S. Wine & Spirits of Am.*, 405 S.C. 9, 15-16, 747 S.E.2d 430, 433-34 (2013) (rejecting claimant's assertion that South Carolina's workers' compensation laws mandate the payment of TTD benefits, regardless of the factual circumstances of the particular case, whenever an employee is discharged from an accommodated, light duty position and noting it is a quintessential factual question for the Commission whether the claimant's inability to earn wages was a result of his termination for cause, not his work-related injury); *id.* at 16, 747 S.E.2d at 434 (explaining employer's denial of TTD benefits must be scrutinized carefully and this is a critically important task for the Commission in its fact-finding role); *id.*

(recognizing the Commission remained sensitive to an employer's possible motivation to "look for" a reason to fire an injured worker).

Ramey testified it was her understanding that she was entitled to be paid for time for doctor visits and that no one had told her differently. She explained that on the day she fell, she was paid for the time she went to the doctor's office. While Ramey admitted she signed the form acknowledging she would not be compensated by Employer for any time lost to doctor's appointments, she explained she did not read everything that day because she was in pain and had to sign the paperwork before she was allowed to go to Doctor's Care. Although Ramey's supervisors knew she had had been at a doctor's appointment but had not deducted the time on her time sheet, they did not indicate they had any problem approving Ramey's time sheet. There is no indication in the record either supervisor was disciplined for signing the sheet. We find substantial evidence supports the Appellate Panel's conclusion that Employer used the incorrect time sheet as an excuse to terminate Ramey's employment.

In addition, we find substantial evidence in the record supports the Appellate Panel's conclusion Ramey was temporarily disabled. Ramey's treating physician imposed restrictions on Ramey's ability to work and the independent medical examiner opined Ramey should not return to work until she received further treatment.

(2) We find no error in the Appellate Panel calculation of Ramey's compensation rate using Ramey's earnings from the last four quarters of Ramey's employment rather than her earnings for the last 52 weeks of her employment. *See* S.C. Code Ann. § 42-1-40 (Supp. 2013) (providing the primary method of calculating the average weekly wage as "taking the total wages paid for the last four quarters immediately preceding the quarter in which the injury occurred . . . divided by fifty-two or by the actual number of weeks for which wages were paid, whichever is less"); *id.* ("When for exceptional reasons the foregoing would be unfair, either to the employer or employee, such other method of computing average weekly wages may be resorted to as will most nearly approximate the amount which the injured employee would be earning were it not for the injury."); *Williams v. David Stafford Drywall*, 402 S.C. 173, 179, 739 S.E.2d 892, 896 (Ct. App. 2013) ("The statute provides an elasticity or flexibility with a view toward always achieving the ultimate objective of reflecting fairly a claimant's probable future earning loss."); *id.* at 179-80, 739 S.E.2d at 896 (stating the goal of calculating wages is to arrive at a fair approximation of the claimant's probable future earning capacity). We hold

Ramey failed to establish an exceptional reason that would make the Commission's calculation of her average weekly wage unfair to her.

AFFIRMED.

HUFF, GEATHERS, and LOCKEMY, JJ., concur.

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Andrea C. Roche, T. Scott Beck, Avery B. Wilkerson, Jr.
Workers' Compensation Commissioners

Tracking No. 2012-212326

WCC File No: 1103442

Gayla Ramey, Employee.....Appellant/Respondent

v.

Unihealth Post Acute Care Tanglewood, Employer, and
American Zurich Insurance Co., Carrier.....Respondents/Appellants

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RESPONDENTS'/APPELLANTS'
PETITION FOR REHEARING

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Pursuant to Rule 240, SCACR, Respondents/Appellants (collectively, "Employer") respectfully petition this Court to grant a rehearing to reconsider its July 16, 2014 order ("Order"). In the Order, this Court affirmed the decision of the Appellate Panel of the South Carolina Workers' Compensation Commission ("Commission") that the Appellant/Respondent ("Ramey") is entitled to temporary total disability ("TTD") benefits following her termination. In support of this motion, Employer respectfully contends that the Court misapprehended certain facts in the records and did not fully consider the application of the South Carolina Supreme Court's decision in Pollack v. S. Wine & Spirits of Am., 405 S.C. 9, 747 S.E.2d 430 (2013).

STATEMENT OF THE CASE

This claim arises out of an accident occurring on March 11, 2011, while Ramey was working for Employer. After her fall, Ramey was sent to Doctors Care for treatment. According to Ramey, she clocked-in that morning via a hand-scanning device, but did not clock out when she was sent for treatment. Ramey's belief was that she was to be paid for her normal hours that day despite having to leave work to go to the doctor. Ramey claims that she was not told any differently despite having been given and signing an acknowledgement form on the date of her injury explicitly stating that she would receive no compensation from her employer for time lost to attend doctor appointment. (R. p. 403). Ramey did admit that she was told that she could use PTO time for medical appointments during the waiting period until workers' compensation insurance kicked in. (R. p. 119, ll. 9-20). Ramey was released back to work with certain work restrictions. On March 18, 2011, Ramey came to work but was unable to clock in because of a problem with the hand scanner. Later that morning, she left work to attend an appointment at Doctors Care. At that appointment, Ramey was released back to work at full duty. (R.p. 349).

Ramey returned to work and, at the end of her shift, prepared a "missed punch" form indicating her hours worked that day were 7:00 a.m. to 10:30 a.m. (R.p. 728). Ramey did not

deduct time for leaving work to attend her doctor's visit. The form was approved by her two supervisors that day. According to Ramey, these supervisors knew she had been to the doctor that day and did not indicate they had any problem signing it. (R. p. 113, l. 21- p. 114, l. 3). Claimant, however, did not turn in any records of her doctors visit at the time she submitted the missed time request; those records were turned in later. (R. p. 159, ll. 1-17). As explained by Ms. Lynda Burr, it was not determined that Ramey had submitted a false records until her missed time request and doctors records were shown to the administrator. (*Id.*) Ms. Burr testified that it was company policy for employees not to be paid for doctors visits and that this policy was specifically stated in the forms given to all injured employees. Ms. Burr testified that she has had to terminate employees in the past for submitting false time records and falsification of any document is grounds for immediate termination per corporate policy.

ARGUMENT

In its Order, this Court determined that the substantial evidence in the record supports the Appellate Panel's conclusion that Employer used the incorrect time sheet as an excuse to terminate Ramey. In reaching this decision, Employer respectfully contends that the Court misconstrued the findings of the Commission and did not adequately consider the guidance from the Supreme Court in Pollack. In reviewing the record in this matter, it is important to note that neither the Single Commissioner, nor the Appellate Panel had the benefit of the guidance set forth in Pollack to cases involving this issue. The Pollack decision was issued on July 17, 2013; well after the Single Commissioner's order of September 28, 2011 and the Appellate Panel's order of May 23, 2012. As such, this Court's standard of review should be as much a review of errors of law as it is a review of the substantial evidence.

In Pollack, the Supreme Court made clear that an employee is entitled to TTD payments only when "an employee has been out of work *due to* a reported work-related injury." Pollack,

405 S.C. at 14, 747 S.E.2d at 433 (emphasis in original). The Court rejected the argument of the claimant that he was entitled to TTD because his termination meant that the employer was not providing suitable employment within his light duty restrictions. In doing so, the Court made clear that "entitlement of TTD benefits is premised on a nexus between the work-related injury and the inability to earn wages." Pollack, 405 S.C. at 15, 747 S.E.2d at 433. The incapacity to earn wages must be "*due to* or *because of* the injury." Id. According to the Court, "[t]his is a quintessential factual question for the fact-finder, the Commission." Pollack, 405 S.C. at 16, 747 S.E.2d at 433.

With all due respect to this Court, there is no finding of fact in the Appellate Panel's decision to support an award of TTD under Pollack. The decision by the Commission in this case was purportedly supported by the following findings of fact:

> 8. The Employer discharged the Claimant for falsifying records for getting paid for the one hour she was at the doctor on March 18, 2011. It was the Claimants clear understanding based upon the acts and information given by the Employer that led the Claimant to believe she was to be paid for time missed from work for her medical appointments.
>
> 12. I find the Claimant was a credible witness. I find further that but for the malfunctioning hand-scanner the Claimant would have clocked out, thereby not having to use the missed time form that the Employer used as an excuse for terminating her.
>
> 13. In the past when the hand scanner was working, the Claimant would clock into work, out for lunch, and back to work. If the hand-scanner had been working on March 18, 2011 the Claimant would not have been terminated.
>
> 14. I do not find it plausible that the Claimant would intentionally put 9 years of service on the line for the one hour that she was at the doctor. She was out of the office for a doctors appointment. This appointment was for an admitted work related injury and the Employer knew the Claimant was at the doctors appointment. The Claimant also gave the Employer the time she was at the Doctors appointment so it was obvious she was not trying to falsify records, deceive the Employer, or hide anything else.

(R. pp. 19 – 20). The decision of the Commissioner, in essence, was based entirely on the Commission's analysis of Ramey's subjective intent to deceive and, finding none, it ordered she was entitled to TTD. Again, it is important to note that Pollack had not been issued yet and neither the Single Commissioner nor the Appellate Panel had the benefit of its guidance in reviewing the evidence. In Pollack, the Supreme Court made it clear that it is the employer's motivations that are at issue, not those of the claimant. See Pollack, 405 S.C. at 16, 747 S.E.2d at 434 (noting the Commission's record of thoughtfully considering the evidence and "remaining sensitive to an employer's possible motivation to 'look for' a reason to fire injured worker."). Importantly, the Court noted that the Commission should recognize "the natural motivations that may be at play *when an employer seeks to deny or terminate TTD benefits*." Pollack, 405 S.C. at 16, 747 S.E.2d at 434, n.5 (emphasis added).

In focusing on Ramey's "intent" to deceive, the Commission failed to appropriately consider Employer's intent and neutral policy-based reason for her termination. While the Commission found that Employer was aware of Ramey's doctor's appointment on March 18, it does not follow that they agreed to pay her for that lost time. Ramey undisputedly submitted a request to be paid for that time and it was expressly against company policy to do so even if Ramey claims to have been unaware of that fact. Her subjective intent aside, Employer received a request by Ramey to be paid for time she was not at work. It was not until later that Ramey submitted the Doctors Care records from that visit (records which showed she had been released to full duty). When the time change request and office visit records were received by management, Employer determined that Ramey had violated company policy and, in accordance with Employer's past handling of similar conduct, Ramey was terminated. There are no finding in the Commission's order, and no evidence in the record, showing that Employer's decision was made *because of* or *due to* Ramey's workers' comp injury. Moreover, such a finding cannot

reasonably be inferred in this case because, at the time of her termination, Ramey had been released to full duty by her authorized treating physician. Thus, at the time of her termination, Ramey was not entitled to or receiving TTD so the "natural motivations" discussed in Pollack were could not have been a factor in the employment decision.

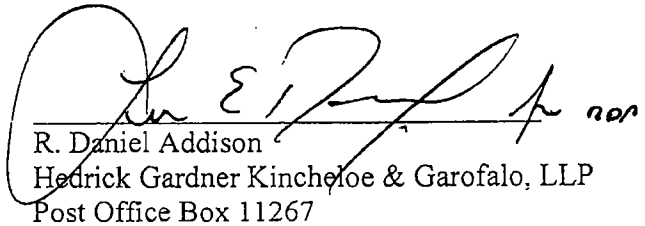
The appropriate analysis under Pollack is similar to that routinely applied in the context of retaliatory discharges. Under S.C. Code § 41-1-80, an employer is prohibited from discharging an employer because the employee has instituted a workers' compensation claim. The burden of proving a retaliatory discharge is on the employee and she must show three elements: 1) institution of workers' compensation proceedings, 2) discharge or demotion, and 3) a causal connection between the first two elements. Hinton v. Designer Ensembles, Inc., 343 S.C. 236, 242, 540 S.E.2d 94, 97 (2000). The statute provides employers with affirmative defenses, including that the employee was terminated for violation of specific written company policy. In this context, the "burden of persuasion never shifts and the employee bears the burden of persuasion that the reason given for termination was pretextual." Id., 343 S.C. at 242-43, 540 S.E.2d at 97. "If the employer articulates a legitimate, nonretaliatory reason for the termination, the proximity in time between the work-related injury and the termination is not sufficient evidence to carry the employee's burden of proving a causal connection." Id. In this case, the evidence shows that Ramey was terminated for violation of company policy. While Ramey contends she did not have the subjective intent to deceive her employer, she has produced no evidence that the termination was retaliatory or that the stated reason was pretextual. As such, the Commission should not have interposed its opinion about Ramey's subjective intent to override a neutral enforcement of company policy. South Carolina remains an "at-will"

employment state and the Commission should not alter that by second-guessing employment decisions merely because the employee has been injured.[1]

Conclusion

For the reasons set forth above, Appellants/Respondents respectfully request that the Court grant a rehearing to reconsider the application of Pollack to this case. The Commission's findings of fact do not support a finding that Employer's action was retaliatory, non-neutral, or the result of her workers' compensation claim. As such, there is no evidence in the record to show that Ramey's inability to earn wages was *due to* or *because of* her work injury. Consequently, the award of TTD benefits was an error of law and should be reversed.

Respectfully Submitted



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July 28, 2014

[1] The Court in Pollack clearly warned against such action: "Appellant's interpretation of the law would essentially insulate injured employees who engage in misconduct while employed in rehabilitative settings and essentially tie the hands of an employer who has sought to accommodate the employee to the best of its ability." Pollack, 405 S.C. at 15, 747 S.E.2d at 433, n. 4.

The South Carolina Court of Appeals

Gayla Ramey, Employee, Appellant/Respondent,

v.

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Respondents/Appellants.

Appellate Case No. 2012-212326

ORDER

After careful consideration of the petition for rehearing, the Court is unable to discover that any material fact or principle of law has been either overlooked or disregarded, and hence, there is no basis for granting a rehearing. Accordingly, the petition for rehearing is denied.

Thomas C. Hoff J.

John D. Geathers J.

J.

Columbia, South Carolina

cc:
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FILED
8/25/14

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Andrea C. Roche, T. Scott Beck, Avery B. Wilkerson, Jr.
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APPELLANTS' FINAL BRIEF

Respondents/Appellants

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TABLE OF AUTHORITIES

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STATEMENT OF ISSUES ON APPEAL

WHETHER CLAIMANT WAS ENTITLED TO TEMPORARY TOTAL DISABILITY BENEFITS?

WHETHER THE FINDINGS OF FACT AND CONCLUSIONS OF LAW DETERMINED BY THE APPELLATE PANEL WERE SUPPORTED BY SUBSTANTIAL EVIDENCE IN THE RECORD?

STATEMENT OF THE CASE

This claim arises out of an accident occurring on March 11, 2011, while Gayla Ramey ("Claimant") was working for Unihealth Post Acute Care ("Employer"). Subsequent to her alleged injury, Claimant was terminated by Employer for falsifying paperwork in order to receive wages for time she was not at work. This claim was initially heard before Commissioner G. Bryan Lyndon on August 10, 2011, in Columbia, South Carolina. The Single Commissioner issued a Decision and Order on September 28, 2011 (R. p. 3), finding that Claimant sustained a compensable injury by accident on March 11, 2011, to her back and right upper extremity; was entitled to continuing temporary total disability compensation from March 24, 2011; and ordering the Employer to provide causally related medical treatment. An Appellate Panel of the South Carolina Workers' Compensation Commission held a hearing on this matter on March 20, 2012, and issued a Decision and Order, dated May 23, 2012 (R. p. 17), affirming the Single Commissioner's Findings of Fact and Rulings of Law in full and adopting the Single Commissioner's September 28, 2011, Decision and Order as the Decision and Order of the Appellate Panel.

The primary issue before the Full Commission was whether or not Claimant was entitled to temporary total disability benefits from the date of her termination to the present and continuing. Claimant asserted that she was entitled to temporary total disability compensation as her termination by the employer is not tantamount to refusal of suitable employment. S.C. Code

Ann. §42-9-190. Defendants, however, argued that they fully accommodated Claimant's restrictions until she was released to full duty by her treating physician. After Claimant was released to full duty, Claimant was terminated for falsifying paperwork in contravention of company policy. Defendants argued that Claimant left work for a doctor's appointment without clocking out. When Claimant later submitted a time sheet correction form, she failed to deduct the time away from work from her submitted hours for that day. Employer terminated Claimant for this falsification in line with its company policy. Employer had terminated other employees based on similar acts in the past.

In his September 28, 2011 order, the Single Commissioner found that Claimant was entitled to temporary total disability benefits from March 24, 2011, the date of Claimant's termination, to the present and continuing. The Single Commissioner found that Claimant was a credible witness and that he did not believe that her failure to deduct the time for her medical appointment from her pay was done intentionally for the purpose of being deceitful, but was merely an error in procedure due to malfunction of the scanner that would typically be used to clock in and out. He found that the Employer led Claimant to believe that she would be paid for the time she was at her causally-related medical appointments.

Defendants thereafter filed for review of the Decision and Order of the Single Commissioner by the Appellate Panel of the Full Commission based on thirteen (13) exceptions. (R. p. 45). Defendants took exception to the Single Commissioner's findings and conclusions regarding the circumstances of Claimant's termination; whether Claimant's termination was justified; and whether Claimant's conduct was sufficient to bar Claimant from receiving temporary total disability benefits in accordance with S.C. Code Ann. §42-9-190. The Appellate Panel affirmed the Single Commissioner's Decision and Order and adopted his findings of fact and conclusions of law verbatim. This appeal followed.

STANDARD OF REVIEW

"The Administrative Procedures Act establishes the standard of review for decisions by the South Carolina Workers' Compensation Commission." *Forrest v. A.S. Price Mech.*, 373 S.C. 303, 306, 644 S.E.2d 784, 785 (Ct. App. 2007) (citing *Lark v. Bi-Lo, Inc.*, 276 S.C. 130, 134-35, 276 S.E.2d 304, 306 (1981)). "In workers' compensation cases, the [Appellate Panel] is the ultimate fact finder." *Shealy v. Aiken County*, 341 S.C. 448, 455, 535 S.E.2d 438, 442 (2000) (citation omitted). This court reviews facts based on the substantial evidence standard. *Thompson v. S.C. Steel Erectors*, 369 S.C. 606, 612, 632 S.E.2d 874, 877 (Ct. App. 2006). "Under the substantial evidence standard, the appellate court may not substitute its judgment for that of the [Appellate Panel] as to the weight of the evidence on questions of fact." *Forrest*, 373 S.C. at 306, 644 S.E.2d at 785 (citing S.C. Code § 1-23-380(A)(5)). The appellate court may reverse or modify the Appellate Panel's decision only if Claimant's substantial rights have been prejudiced because the decision is affected by an error of law or is clearly erroneous in view of the reliable, probative, and substantial evidence in the record. *Id.* at 306, 644 S.E.2d at 785-86. "Substantial evidence is not a mere scintilla of evidence nor evidence viewed from one side, but such evidence, when the whole record is considered, as would allow reasonable minds to reach the conclusion the [Appellate Panel] reached." *Shealy*, 341 S.C. at 455, 535 S.E.2d at 442. The possibility of drawing two inconsistent conclusions does not prevent the Appellate Panel's conclusions from being supported by substantial evidence. *Tiller v. Nat'l Health Care Ctr.*, 334 S.C. 333, 338, 513 S.E.2d 843, 845 (1999). The final determination of witness credibility and the weight to be accorded evidence is reserved to the Appellate Panel. *Shealy*, 341 S.C. at 455, 535 S.E.2d at 442.

STATEMENT OF THE FACTS

At the hearing, Claimant testified on her own behalf. She testified that she is 50 years old and that she completed her Associate's Degree to obtain her RN. (R. p. 105, l. 25 – R. p. 106, l. 12) She explained that she received a scholarship from Employer in 2008 to go to nursing school. (R. p. 106, ll. 13-15) She also noted that she has further educational background prior to obtaining her RN degree. (R. p. 106, ll. 9-10) Claimant asserted that her job as an RN with the Employer involves administering treatment to residents and also includes activities like turning residents who are bedridden, assisting residents get in and out of beds and wheelchairs, and pushing wheelchairs to get residents from one part of the facility to another. (R. p. 106, l. 21 – R. p. 13, l. 1) She also stated that she did clerical duties such as medical charting and working with residents' family doctors to coordinate their care needs. (R. p. 107, ll. 1-4).

Claimant asserted that prior to the work accident she never had any problems with her back. (R. p. 107, ll. 5-7). She noted in 2008 that she was treated for muscle spasms in her right shoulder. (R. p. 107, ll. 8-11). She stated that she was having a lot of stress at the time and was having muscle spasms in the right shoulder. (R. p. 107, ll. 13-19). Claimant testified that she went to the doctor and received some steroid injections in the muscle and the spasms relaxed and the problem went away. (*Id.*). Claimant asserted that her previous problems were muscular only and not in her spine. (R. p. 107, ll. 20-24).

Claimant fell on some steps while at work on March 11, 2011. (R. p. 29). She testified that, immediately after her fall, she was sent to Doctor's Care for treatment. (R. p. 108, ll. 6-8). She testified that she had clocked-in that morning via hand-scanning device, but did not clock out when she was sent for treatment. (R. p. 108, ll. 1-11). She further stated that her understanding is that she was paid for her normal hours that day despite having to leave work to go to the doctor. (R. p. 108, ll. 12-14).

Claimant went on to testify that she was given work restrictions by the providers at Doctor's Care on that first visit. (R. p. 108, ll. 15-17). She stated that she was told not to spend more than 30 minutes per hour on her feet; to limit the use of her back; no use of her right arm; no lifting greater than ten pounds; and no repetitive bending, twisting, stooping, squatting, or pushing. (R. p. 108, ll. 18-24). Claimant asserted that she continued working as normal and her restrictions were not accommodated. (R. p. 108, l. 25 – R. p. 109, l. 2). She asserted that she was required to walk all over the facility, do a great deal of paperwork, pull charts from overhead to file forms, and sometimes she had to push residents in wheelchairs. (R. p. 109, ll. 6-13). Claimant stated that she felt that the tasks she was doing were in violation of her restrictions, but that she was scared of losing her job. (R. p. 109, ll. 14-17; R. p. 110, ll. 18-21).

Claimant testified regarding her March 18, 2011 appointment with Doctor's Care. Claimant stated that she had discussed her appointment previously with Lynda Burr, the facility Human Resources Director. (R. p. 111, ll. 2-4). She stated that she came in early that morning because she needed to see Ms. Burr about the appointment and knew that Ms. Burr was leaving early that day. (R. p. 111, ll. 4-12). Claimant stated that Ms. Burr was not at the facility by the time she had to leave to go to her appointment and she had to go ahead and leave without speaking to Ms. Burr. (R. p. 111, ll. 16-24).

Claimant asserted that she attempted to clock-out around 7:30 that morning using the hand scanner, but that the scanner would not work when she tried to use it. (R. p. 112, ll. 1-2). Claimant stated that she left without doing anything further to sign out because she needed to get to the appointment. She stated that she returned at 9:45 that morning, and was told to go home about 45 minutes later by her supervisor Tonya Shepherd because Ms. Shepherd wanted her to work the next two days. (R.p.1112, ll. 6-16). Claimant stated that when she returned from the doctor, she completed a Request for Missed Time form to note the time she missed that would

not be reflected on the punch clock due to the scanner malfunction. (R.p.113, ll. 11-14). She indicated on the form the time period of 7:00 a.m. to 10:30 a.m. and asserted that was meant to reflect her time missed for the appointment. (R. p.113, ll. 15-17). She stated that she got the form approved by her supervisors, Carrie Ray and Tonya Shepherd, and that both of those supervisors knew that she had an appointment that morning. (R. p. 113, ll. 18-22).

Claimant testified that on the day she was initially injured, she was not told to punch out before she was sent to the doctor. She further stated that she was paid her regular wages for the time that she left and went to the doctor on the date of her injury. (R. p. 113, ll. 4-10). Claimant testified that it was her understanding from those events that she would be paid for work time that she missed for appointments related to her work injury and that no one had advised her any differently. (*Id.*) Claimant asserted that neither Ms. Ray nor Ms. Shepherd indicated there was any problem when she asked for approval of her missed time form on March 18th. (R. p. 114, ll. 1-3).

Claimant stated that she was fired three days later on March 21, 2011. (R. p. 114, ll. 6-8). She explained that she was called to Lynda Burr's office and told that she was not allowed to be on the clock while she was out for a doctor's appointment and was terminated. (R. p. 114, ll. 11-14).

Claimant stated that since her termination from Employer, she has not been able to find work within her restrictions. (R. p. 115, l. 20 – R. p. 116, l. 48). She asserted that since she has not had any treatment she was afraid of doing something that would cause further injury. (*Id.*). Claimant asserted that in looking for work she has looked through newspapers to see if there are any available jobs within her restrictions. (R. p. 1116, ll. 15-22).

On cross examination, Claimant was asked about the paperwork that she completed at the time of her injury. Claimant was shown a notice informing her that she would not be paid for

time spent at doctor's visits which she signed as part of her initial workers' compensation paperwork. (R. p. 117, l. 8 – R. p. 118, l. 23). Claimant admitted that she signed all of the paperwork that she was given, but she didn't actually read all of it closely. (*Id.*). Claimant recalled being told that she could use PTO time for medical appointments during the waiting period until workers' compensation insurance kicked in. (R. p. 119, ll. 9-20). Claimant confirmed that the appointment on the March 18th that led to her termination was in fact her third doctor's appointment regarding her work injury. (R. p. 119, l. 21 – R. p. 120, l. 1).

Claimant noted that she had been having problems with the hand scanner for several days prior to March 18th. (R. p. 120, ll. 5-8). She stated that she did not even try to clock in using the scanner that morning because there was a certain procedure that had to be done by Ms. Burr to fix it and that since Ms. Burr was not there, she didn't bother to try using the hand scanner. (R. p. 120, ll. 9-23). Claimant was read her time correction form whereupon she had written that she was correcting her time because the "clock would not accept punch" which indicated that she was requesting to be paid for the time indicated on the form. (R. p. 122, ll. 2-18). Claimant denied that as her intention and asserted that she was attempting to confirm missed time for a medical appointment. Claimant confirmed that she listed her time for the day of March 18th as 7:00 a.m. to 10:30 a.m. and that she had to complete the form because the hand scanner was not working, and agreed that she was listing that time period as her work hours for that day. (R. p. 124, ll. 8-19).

Claimant admitted that she has had to miss work for medical problems previously during the time she has been employed with the Employer. (R. p. 124, l. 19 – R. p. 125, l. 1). She confirmed that she had gallbladder surgery in 2007 and was also out for about a month when her mother passed away. (R. p. 125, ll. 1-10). Claimant noted that she did not get fired for those periods of missed time, and it was even after dealing with those issues that she was offered her

nursing school scholarship. (R. p. 125, ll. 9-13). She also admitted that there is at least one other person in the facility who has a workers' compensation claim and continues working on light duty. (R. p. 125, ll. 14-22). Claimant agreed that she was treated fairly up until the point that she was terminated. (R. p. 125, l. 23 – R. P. 126, l. 2).

Claimant went on to testify that on her initial visit to Doctor's Care that she reported that her right arm, mid back, neck, and "tail" where she had landed where hurting. (R. p. 126, ll. 17-19). Claimant was pointed to her own APA, page 109, reflecting that first where there is discussion of the right arm and back, but nothing regarding any neck complaints. (R. p. 126 – R. p. 128). She was also pointed to her return visit on March 14, 2011, where she reported to the providers at Doctor's Care that she was "very improved." There was no discussion of neck pain and no indication from Claimant that she was not capable of performing her job or that the defendant/employer was not complying with the work restrictions. Claimant was then directed to the report from March 18th, which was the first indication that she was experiencing neck pain, but again noted that there was improvement in her condition.

Claimant agreed that the doctor's restrictions did not prevent her from walking on the job, but merely indicated that she should not walk more than 30 minutes of each hour. (R. p. 129, ll. 11-23). She disagreed that it was primarily the duty of the CNA's to move the residents around the facility and that the nurses more so supervised the CNA's. (R. p. 130, ll. 7-12). Claimant admitted that she did not have to routinely do things like changing residents, but stated that it was in her job description. (R. p. 130, l. 15 – R. P. 131, l. 4). Claimant also agreed that the defendant/employer's facility is a no-lift facility and there are Hoyer lifts to help them move residents and the staff is required to obtain help before moving the residents. (R. p. 131, ll. 5-12). Claimant insisted that her job went well beyond assessing residents' medical conditions and administering medications. (R. p. 131, ll. 20-25). She insisted that she was required to do more

hands-on care tasks and was required to assist in "any and all" aspects of resident care. Claimant further asserted that, in her opinion, the facility was understaffed. (R. p. 132, ll. 2-8). She stated that the two CNA's on the hall cannot see to all 40 residents at all times, so she did a lot of CNA duties. (R. p. 132, ll. 9-15).

Claimant admitted that her only efforts to find another job have been through looking at listing in the newspapers and on the internet. (R. p. 133, ll. 10-13). She admitted that she has not actually applied for any jobs. (R. p. 133, ll. 14-22). Claimant stated that based on the job descriptions that she feels that the jobs she has seen would be beyond her work restrictions, but she has not gone in person to inquire about the job duties. (R. p. 133, l. 23 – R. p. 134, l. 2).

Claimant was next questioned regarding her annual physical assessment with the Employer. She recalled going through the questionnaire from 2009 and indicating that she was taking some medication for swelling in her feet. (R. p. 135, ll. 12-25). Claimant was also read medical reports from her family doctor from December 2006 wherein she presented with complaints of neck pain and trapezius muscle tenderness. (R. p. 136, ll. 8-24). Claimant stated that she recalled only having muscle spasms, but did not recall the dates indicated in 2006. (I.). Claimant clarified from her prior testimony that she has had problems with muscle spasms on more than one occasion. (R. p. 138, l. 6). Claimant confirmed that she has not previously had an MRI of her cervical spine and did not know what was causing the muscle spasms. (R. p. 138, ll. 17-19).

On re-direct examination, Claimant asserted that she was released at full duty on March 18, 2011, because she asked to be. (R. p. 141, ll. 16-21). She asserted that she told the providers at Doctor's Care that her arm felt better but that she was still having trouble with her back, but that she wanted to try being on full duty because she was needed at the facility. (R. p. 142, ll. 1-6). Claimant asserted that she did this because she was afraid that she would lose her job if she

did not get back to full duty. (R. p. 142, ll. 7-17). Claimant was again questioned about the March 18th report on re-cross examination. She insisted that she did not tell the doctor that she was 85% improved, as indicated in the report. (R. p. 143, l. 23 – R. p. 144, l. 5). Claimant also asserted that the statement on the work note that "she feels comfortable performing full work duties" was not entirely accurate and that she only requested to try her full duties. (R. p. 144, l. 17 – R. p. 145, l. 48).

The Commissioner questioned Claimant regarding the hand scanner. Claimant confirmed that it has malfunctioned in the past and would not accept her hand scan. (R. p. 147, ll. 18-20). She explained that she has always been paid when the hand scanner failed to work and that the procedure is to fill out a time correction form and have it approved by a supervisor to confirm that she was actually at work during the time indicated on the form. (R. p. 147, ll. 21-25). Claimant also confirmed that it is standard to punch out anytime she leaves the facility for any reason. (R. p. 148, ll. 1-6). Claimant stated that on the days prior to March 18, 2011, when the scanner was not working, that she clocked in and out manually and that she was in the facility during her entire shift those days performing her job duties as reflected on her manual time forms. Claimant also confirmed that the time form for March 18th only indicated that she worked and needed to be paid for the time indicated on the form, it did not specify that she had left for a doctor's appointment at any point during the hours indicated on the form. (*Id.*)

Defendants called Lynda Burr to testify on their behalf. Ms. Burr is the Human Resources Director at the Tanglewood facility and has been in that position for nine years. (R. p. 155, l. 23 – R. p. 156, l. 1). Ms. Burr stated that her duties include the handling of all personnel records and any workers' compensation claims in the facility. (R. p. 1156, ll. 8-10). She further confirmed that she was dealing with Claimant's workers' compensation claim. (R. p. 156, ll. 8-10). Ms. Burr stated that someone else, possibly Ms. Elkins the unit supervisor, arranged for

Claimant to go to the doctor for treatment on the date of the injury. (R. p. 1157, ll. 14-18). Ms. Burr talked to Claimant on subsequent occasions about her injury.

Ms. Burr explained that the facility works with injured employees to meet the needs of their individual restrictions. (R. p. 157, l. 23 – R. p. 158, l. 5). She noted that they do not create new jobs, but they often move people to other positions to suit their restrictions during light duty. Ms. Burr stated that it is policy to do everything possible to accommodate restrictions assigned by the doctors for injured employees.

Ms. Burr confirmed that she was involved in Claimant's termination. (R. p. 158, ll. 23-258). She explained that the hand scanner was not working for Claimant to clock in and out on the date in question, March 18, 2011. (R. p. 158, ll. 1-17). She stated that Claimant turned in a time correction form stating that she was present at work from 7:00 a.m. to 10:30 a.m. on that date. However, she later turned in a doctor's note reflecting that she was not present at work for part of the time indicated on the March 18th time form. The doctor's excuse and the time form were shown to the facility administrator, who made the decision that Claimant was to be terminated for falsifying her time sheet. (*Id.*).

Ms. Burr further confirmed that employees on workers' compensation are not paid for time that they leave work to attend doctor's appointments. (R. p. 159, ll. 18-22). She stated that workers are given a packet when injuries occur giving them all the procedural information and someone goes over the materials with the worker. (R. p. 159, l. 23 – R. p. 160, l. 4). She also confirmed that these materials include a notice to workers that they will not be paid for time during medical appointments. (R. p. 160, ll. 18-21). Ms. Burr confirmed that Ms. Elkins had gone over this paperwork with Claimant, but noted that in her subsequent conversations with Claimant that Claimant never asked any questions or expressed a lack of understanding of the materials that she was given.

Ms. Burr went on to testify that in the days following Claimant's injury, she never expressed any inability to perform her assigned tasks or expressed any concern about her restrictions not being properly met. (R. p. 161, l. 23 – R. p. 163, l. 22). She stated instead that Claimant only told her that she wanted to get back to work on the floor and that she was fine. Ms. Burr stated that she informed Claimant that she could not put her back to regular duty without a release to do so from her doctor. (R. p. 162, ll. 9-11). Ms. Burr noted that Claimant had restrictions against pushing so that she could not push the medication cart. (R. p. 162, ll. 13-14). She stated that the nursing supervisor had Claimant doing paperwork while she was on restricted duty. (R. p. 162, ll. 14-16). She further explained that she always advises employees with restrictions to self-monitor their activities to stay within their restrictions and if they are given a task that is outside their restrictions to come to her to adjust their duties. (R. p. 163, ll. 7-11). Ms. Burr testified that Claimant never complained about the modified duty that she was given. (R. p. 163, ll. 12-17). She stated that she received the release note from Doctor's Care noting Claimant felt comfortable performing her regular duties and stated that this note was consistent with Claimant's requests to her to be put back to full duty. (R. p. 163, l. 23 – R. p. 164, l. 14).

Ms. Burr next testified that the facility has terminated other employees for submitting false time requests. (R. p. 164, ll. 15-18). She estimated that it has happened about three to five times in the nine years that she has worked for Employer. (R. p. 164, ll. 19-21). Ms. Burr stated that falsification of any document is grounds for immediate termination per corporate policy, not just the policy of the facility. (R. p. 165, ll. 8-12). She explained that inconsistencies on the time sheet compared to other facility records create issues for the facility with DHEC and Medicare when the facility records are reviewed. (R. p. 165, ll. 5-7). She stated that all facility records must be accurate and consistent with one another. The Commissioner also questioned Ms. Burr

as to the nature of the falsification of records of the other employees who were fired for falsification of documents. Ms. Burr stated that several were terminated for falsifying time for entire shifts, but others were terminated for falsification of other records that were not related to time and pay. (R. p. 174, ll. 1-18). She also recalled that none of the other persons fired for record falsification had ongoing workers' compensation claims. (*Id.*)

The medical records reflect that Claimant initially sought treatment with Doctor's Care on March 11, 2011, on the date of her accident. Claimant reported that she slipped on some stairs and injured her right forearm, right hand, and her thoracic spine. Claimant presented with bruising and swelling in the right arm and hand, and bilateral paraspinal muscle pain in her mid back. (R. p. 342). Claimant was given restrictions of no lifting more than 10 pounds, no use of her right arm, limited use of her back, no standing for greater than 30 minutes per hour, and no repetitive bending/stooping/pushing/twisting. (R. p. 343).

Claimant next followed-up with Doctor's Care on March 14, 2011. Claimant reported feeling very improved with no pain in her right arm. The right arm contusion was noted to be healing with only mild ecchymosis, and she was reported to have only mild tenderness to palpation of the left paraspinal muscles. (R. p. 345). Her work restrictions were reduced to allow standing without restriction, pushing and twisting without restriction, and she was allowed full use of the right arm. (R. p. 346).

Claimant was seen again at Doctor's Care on March 18, 2011, reporting new complaints of right lateral neck and trapezius pulling sensation. (R. p. 348). It was noted that she otherwise denied complaints, that her mid-back felt 85% improved, and that there was no discomfort in the right upper extremity. On exam, Claimant was found to have mild tenderness in the right lateral cervical spine, but with full neck range of motion. It was noted that Claimant had no thoracic spine pain and no shoulder pain. (*Id.*). The work note provided on this visit noted Claimant's

mild cervical pain, but stated that she felt comfortable performing full work duties, thus she was given no restrictions. (R. p. 349).

Claimant next returned to Doctor's Care on March 24, 2011, three days after her termination, and was complaining of thirteen days of right shoulder pain radiating into her neck and back. (R. p. 350). On exam Claimant was noted to have a palpable muscle spasm in the right trapezius. Claimant's diagnosis was amended from a mid back strain and right arm contusion to that of muscle spasm, spondylolisthesis, and neck pain. She was referred for physical therapy and her work restrictions were amended to include limited use of her neck. These symptoms persisted on Claimant's follow-up visit on April 1st, and she complained of difficulty finding a comfortable sleeping position due to neck pain. (R. p. 355). She also was again found to have tenderness in her cervical spine and palpable muscle spasm.

Claimant was sent for a cervical spine MRI on April 4, 2011, which revealed evidence of chronic degenerative changes and a left disc protrusion at C3-4 and some spurring from C3 to C6. (R. p. 363). Claimant went back to Doctor's Care for review of the MRI and was noted to have bilateral tenderness to palpation with muscle spasm bilaterally in her trapezius distribution. She was prescribed a stronger pain medication and a steroid taper. (R. P. 358).

Claimant went for a claimant's IME with Dr. Timothy Zgleszewski. (R. p. 365). She reported to Dr. Zgleszewski that after the fall she had immediate pain in her mid-back, neck, and right wrist. (*Id.*). She further reported that she developed a stabbing sensation in her low back a few days later and reported continued problems with wrist pain, a scar with excess skin growth, and neck pain; despite the records from Doctor's Care that do not corroborate Claimant's statements to Dr. Zgleszewski. Dr. Zgleszewski stated that Claimant has probable facet joint dysfunction at all levels of her back and recommended a course of pain management-related treatment modalities. (R. p. 367).

Claimant's previous medical records from her family doctor were also submitted into evidence. Claimant presented to her family doctor on December 20, 2006 with complaints of right "neck pain" and noted that she had previously undergone massage therapy that was temporarily helpful, indicating that this was an ongoing problem for Claimant. (R. p. 271). Claimant was found to have tenderness in her neck and over the right trapezius muscles, (*Id.*), substantially similar to that which was noted in the Doctor's Care reports after March 24, 2011. These complaints recurred on April 7, 2008, when Claimant presented to her family doctor with complaints of neck and back pain with pain radiating to her right shoulder and pain with forward flexion. (R. p. 334). Claimant was noted to again have a palpable muscle spasm in her right trapezius and this was injected at the time. (*Id.*). Claimant's most recent documented recurrence of neck pain was on April 16, 2010. (R. p. 327). She presented to her family doctor on this occasion with complaints of right shoulder pain into the back of her neck that she described as constant and often a burning sensation. She again had a palpable right trapezius muscle spasm. (*Id.*).

Employer's personnel records regarding the circumstances of Claimant's workers' compensation claim and the false records that led to her termination were also included in the evidence of the case. (*See generally*, R. p. 373 – R. p. 618). Those records correspond with those discussed in the testimony of the witnesses.

ARGUMENTS

I. The Appellate Panel erred in finding that Claimant is entitled to temporary total disability benefits from March 21, 2011, to the present and continuing.

a. Claimant was not entitled to temporary total disability benefits as she had been released from any restrictions prior to her termination.

At the time of Claimant's termination, she had been released from any restrictions by her treating physician and had returned to full duty. As noted above, on March 18th, Claimant was seen at Doctor's Care for a follow-up appointment. The Return to Work form filled out following that visit and returned to Employer by Claimant indicated that could "perform full duty activities as of 3/18/11 without accommodations." (R. p. 349). Claimant returned to work on March 19 and 20; performing her full duties without restrictions. Claimant was then terminated on March 21, 2011. Consequently, it was error to find Claimant to be entitled to temporary total disability from Employer.

b. Claimant refused suitable employment in dereliction of S.C. Code Ann. § 42-9-190. Accordingly, the Appellate Panel's award of temporary total disability benefits was in error.

The substantial evidence in this case shows that Claimant was terminated for providing false information on her time correction form. Claimant's own testimony shows that she knew that she was supposed to clock out any time she left the facility for any reason. The undisputed evidence before the Appellate Panel shows that Claimant's time correction form did not reflect that she left the facility for her doctor's appointment on March 18, 2011. Ms. Burr testified that, pursuant to company policy, employees were not allowed to be paid for time missed from work in order to attend doctor appointments. Claimant's employee file shows that she was provided notice of this policy and that she signed this notice acknowledging that she had received and read the policy. Accordingly, the substantial evidence shows that Claimant was terminated for cause,

which constitutes an unjustified refusal of suitable employment. S.C. Code Ann. § 42-9-190 mandates that Claimant be barred from receiving temporary total disability benefits.

The Appellate Panel, in affirming and adopting the Decision and Order of the Single Commissioner, erroneously disregarded the explicit policy of Employer in finding that Claimant is entitled to temporary total disability benefits. The decision of the Appellate Panel is founded on its finding that it was implausible that "Claimant would intentionally put 9 years of service on the line for the one hour that she was at the doctor." The Appellate Panel further found that "it was obvious she was not trying to falsify records, deceive the Employer, or hide anything else." It was error on the part of the Appellate Panel to hold as it did based on these findings. Whether or not Claimant intended to mislead Employer for monetary gain is secondary to the fact that she stated that she knew that she was required to clock in and clock out any time she left the facility and was not to receive payment for time not at work. Claimant acknowledged as much when she testified that that workers are to clock out when going to retrieve something from their cars and return immediately. Despite her stated knowledge of company rules, Claimant nevertheless filled out and submitted a form wherein she represented to Employer that she had been at work from 7:30 a.m. to 10:30 a.m. when, in fact, she was not there for that entire time. Claimant's actions were in violation of company policy whether she intended to deceive or not. These actions constitute good cause for Claimant's termination.

Employer's time-clock policy is one of many designed to ensure that company records are accurate. This policy is a necessary requirement in order to deal with the heavy regulations of nursing facility administration. It is imperative for Employer to have a wholly accurate record of what personnel were onsite at any given moment of every day. Strict records must be kept to ascertain details such as resident-to-staff ratios and what personnel is available and providing care to residents at any given time. Proper staffing is imperative in this industry and, therefore,

there is a strong emphasis on attendance and record-keeping procedures. The Appellate Panel disregarded these obligations by focusing on whether or not Claimant *intended* to get paid or *otherwise deceive* Employer. Claimant's intentions are irrelevant as to her failure to properly and accurately complete her time correction form to show the time during which she was actually on site at the facility that led to her termination.

The findings of the Appellate Panel that Claimant would have clocked out, and that she was justified by not properly noting her time sheet, and thus granting her temporary total disability benefits are an undue burden on Employer in the management of its facility. Claimant was terminated based on a company policy that sites falsification of any records as grounds for immediate termination: a policy that the testimony shows has been enforced regularly in the past. The Commission's finding creates a situation where Employer has to treat workers' compensation claimants as an exception to the general rules to avoid being held responsible for temporary total disability benefits for terminating an employee based on its standard policy.

c. Claimant failed to prove that she is disabled.

Assuming *arguendo* that Claimant was under restrictions at the time of her termination, which is directly refuted by the evidence of record, Claimant, nevertheless, failed to prove that she is disabled within the meaning of the Act. "Disability" in the workers' comp context is defined as in inability to earn the same wages as the injured employee earned pre-injury. S.C. Code Ann. § 42-1-120. As the evidence reflects, Claimant has achieved a level of education that makes it possible for her to earn a living without relying on her physical abilities. While there may have been certain physical aspects of Claimant's job as an RN in a nursing care facility, she certainly has a skill set that is transferrable to positions that do not involve taking care of invalids. Claimant expressed that she read advertisements for available positions in the newspapers and on the internet, but she never contacted the potential employers to see if she

could perform the jobs within her restrictions. There are work opportunities for nurses beyond that of resident care facilities and hospitals. Nurses are often employed in doctor's offices assisting in the care of able-bodied patients, as well as in various administration and clerical roles where their medical record keeping knowledge is needed. Claimant may have required specific accommodation to avoid working outside of her restrictions in a resident care facility, but in-patient caretaking is not the sole job opportunity for someone with Claimant's skills and she gave no indication that she had explored these alternative options or that she was incapable of performing other lighter duty positions in which nurses are employed. Simply put, Claimant did not set forth any evidence of "disability."

Based on the foregoing, the findings of the Appellate Panel that Claimant is entitled to temporary total disability benefits should be reversed.

II. The Appellate Panel made findings of fact that were internally inconsistent, contradictory and not supported by the substantial evidence in the record.

The Appellate Panel's decision was based on numerous findings of fact that were not supported by substantial evidence and, therefore, should be reversed.

a. The Hand Scanner

In its decision, the Appellate Panel found, in Finding of Fact No. 5, that "On March 11, 2011 and on numerous previous occasions the hand-scanning device did not work for the Claimant." In Finding of Fact No. 6, the Appellate Panel found that "on March 11, 2011 the Claimant was paid her normal hours although she did not clock out in order to go to Doctor's Care, *even though the hand-scanner was working that day.*" (emphasis added). The testimony of Claimant was that she clocked-in on the morning of March 11, 2011, but that she did not clock out that day because she was sent to Doctor's Care. There is no evidence in the record upon which the Appellate Panel could find that the device was not working on March 11, 2011.

Furthermore, the Appellate Panel found that Claimant "had always previously been paid when the scanner was broken and the claimant was required to clock in and out using the manual form." There is insufficient evidence in the record establishing a period or pattern to support a finding that Claimant was "always" paid for missed time for medical visits. Moreover, this finding misses the point that the Employer's policies required an employee to clock in and out for medical visits and the undisputed evidence shows that Claimant did not do this, whether through the hand-scanner or the manual form.

b. Work Restrictions

The Appellate Panel erroneously found that Claimant "continued to work even though working outside of her work restrictions" from March 11 to March 18. This finding is not supported by reliable, probative and substantial evidence.

Claimant's testimony regarding her duties while under medical restrictions was extremely vague. She primarily described what her regular job duties were, and then asserted that she performed her normal job. Based on Claimant's March 11, 2011 Return to Work Form (R. p. 343), Claimant restrictions included: no lifting more than 10 lbs., ground level work only, no repetitive bending, stooping, squatting, pushing, jerking, twisting, or bounding; no continuous standing for more than 30 minutes per hour; minimal walking or climbing; limited use of back; no overhead lifting; no high repetitive hand activities for extended periods of time; and no use of right arm. Claimant testified that she was required to "walk all around the facility in and out of resident's rooms, doing a lot of paperwork, writing – I had to pull charts from overhead to get certain personal information to put on those forms. Sometimes I pushed the residents . . . I had to push them into their rooms in order to interview them." Despite the fact that none of these described activities are outside of her work restrictions, Claimant responded "Yes" to being asked if she felt "that the new job that [her] employer had [her] performing violated those work

restrictions in some way?" Claimant offered no further testimony regarding how she "felt" her new duties were violating her work restrictions. Claimant's restrictions from Doctor's Care did not prevent her from walking or standing, only advised that she not walk or stand for more than 30 minutes per hour. This restriction was removed as of her follow-up visit on March 14, 2011. (R. p. 346). Claimant did not state with any specificity how far or how much she was required in walk to stand, other than "all around." Moreover, this restriction was removed following Claimant's March 14 doctor visit.

Similarly, Claimant's testimony regarding pushing residents in wheelchairs does not support a finding of working outside of her restrictions. Again, the restriction on pushing only applied between March 11 to March 14 and Claimant did not testify as to any specifics as to length, duration or timing of these activities. Claimant also testified that while nurses had to engage in these activities, it was something nurses would do when CNAs were not available. Further testimony offered by Ms. Burr showed that employee's with restrictions are charged with self-monitoring and they should ask for help or come to Ms. Burr regarding any task the employee should avoid.

Finally, Claimant's assertion that she was working outside of her restrictions is undercut by the medical records indicating that Claimant asked to be released from restrictions so that she could perform her regular work. All available evidence, aside from Claimant's self-serving and vague statements that her restrictions were not being met, indicates that Claimant's job was indeed modified to meet her given work restrictions. The evidence also indicates that Claimant requested to be put back to full duty so that she could perform her regular work. Based on the forgoing, the finding of the Appellate Panel is unsupported by substantial evidence in the record and should be reversed.

c. Pay

The Appellate Panel found that "It was the Claimants [sic] clear understanding based upon the acts and information given by the Employer that led the Claimant to believe she was to be paid for time missed from work for her medical appointments." This finding is unsupported by reliable, probative, and substantial evidence.

As Claimant testified, she was given and signed a written policy by Employer expressly stating that employees were not to be paid for time off from work due to doctor's appointments. Claimant's only evidence in contravention of this express written and acknowledged policy is Claimant's testimony that it was her "understanding" that she had been paid her normal hours on March 11, 2011; the day she fell. This vague and unsubstantiated "understanding" does not support the Appellate Panel's finding that "the acts and information given by the Employer" led to Claimant's belief that she would be paid for time off work for doctor's appointments. This is especially true given that Ms. Burr's testimony that injured workers are made aware at the time of injury that they will not be compensated for missed time related to doctors' visits.

d. Claimant's Credibility

In its order, the Appellate Panel found Claimant to be a credible witness and, "but for the malfunctioning hand-scanner the Claimant would have clocked out, thereby not having to use the missed time form that the Employer used as an excuse for terminating her." This finding is directly contradictory to the testimony of Claimant that she did not believe she had to clock out for her doctor's appointment and that she was to be paid for that time. The Appellate Panel's finding is based entirely on speculation and not supported by any reliable, probative and substantial evidence in the record.

Similarly, the Appellate Panel found that "In the past when the hand scanner was working, the Claimant would clock into work, out for lunch, and back to work. If the hand-

scanner had been working on March 18, 2011 the Claimant would not have been terminated." The Appellate Panel's findings disregard the March 18th time form written by Claimant falsely asserting she was at work from 7 am. To 10:30 am. As noted above, such a finding is also contradictory to the other findings and Claimant's testimony that she believed she would be paid for time off for doctor's appointments. Moreover, Claimant's practice in clocking in and out for lunch is not in any way probative of what Claimant did for doctor's appointments, workers' compensation procedures, or other instances closely related to the circumstances at issue in this case. The Appellate Panel's finding is based entirely on speculation and not supported by any reliable, probative and substantial evidence in the record.

III. Conclusion

For all the above reasons, the Appellate Panel's determination that Claimant should not be barred from receiving temporary total disability pursuant to S.C. Code Ann. § 42-9-190 is erroneous. Claimant did not satisfy her burden of proof by a preponderance of the evidence that she is entitled to temporary total disability benefits from March 24, 2011 to the present and continuing. The Appellate Panel's conclusions are based on findings that are contradicted by the evidence in the record, internally inconsistent, and are not based on reliable, probative and substantial evidence. The reliable, probative, and substantial evidence in the record clearly shows that Claimant was provided with suitable modified duty to meet her restrictions, had been released to work without restrictions and was subsequently terminated for violation of company policy. Accordingly, Claimant's petition for temporary total disability benefits from March 24, 2001 and ongoing should be denied.

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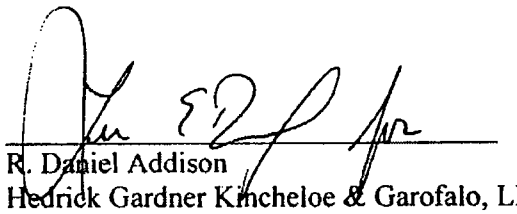

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Andrea C. Roche, T. Scott Beck, Avery B. Wilkerson, Jr.
Workers' Compensation Commissioners

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Tracking No. 2012-212326

WCC File No: 1103442

Gayla Ramey, Employee..... Appellant/Respondent

v.

Unihealth Post Acute Care Tanglewood, Employer, and
American Zurich Insurance Co., Carrier..... Respondents/Appellants

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CERTIFICATE OF COMPLIANCE

The undersigned certified that Appellant's Final Brief complies with Rule 211(b).

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February 4, 2013

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PROOF OF SERVICE

This is to certify that a copy of the foregoing **Appellant's Final Brief** has been served upon the flowing by placing the same in the United States mail, first-class postage pre-paid, addressed as shown below on the 4th day of February, 2013.

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SOUTH CAROLINA
Workers' Compensation Commission

WCC File No. 710442

Gayla Ramey, Employee, Appellant/Respondent,

v.

Lakeside Post Acute Care, Tanglewood, Employer, and American Zurich Insurance Company, Carrier, Respondents/Appellants.

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STATEMENT OF ISSUES ON APPEAL

Claimant's Appeal:

1. Did the Workers' Compensation Commission err as a matter of law in basing the Average Weekly Wage on the previous 4 quarters when basing it on the previous 52 weeks was consistent with the statute and would have been more fair to the parties?

Employer and Carrier's Appeal:

2. Whether substantial evidence supports the Commission's factual findings that Ramey was on light duty restrictions from March 24, 2011 and that the Employer unilaterally withdrew its offer of employment suitable to her capacity; thus requiring the Employer to pay temporary total disability compensation benefits during Ramey's period of disability?

STATEMENT OF THE CASE

This appeal arises out of a workers' compensation claim filed by the Appellant/Respondent, Gayla Ramey. Ramey was employed for nine years as a registered nurse for the Employer Unihealth Post Acute Care. Employer was insured by American Zurich Insurance Company.

On March 11, 2011, she suffered an injury by accident of when she fell on a flight of steps. Ramey injured her back and right arm. The Employer and Carrier accepted her claim and provided medical benefits.

On March 21, 2011, Employer discharged Ramey allegedly for falsifying records to get paid for one hour on March 18, 2011, while she was at the doctor that day treating for her injuries. Thereafter, the Employer refused to pay temporary total disability compensation despite Ramey being under work restrictions and not at maximum medical improvement..

Ramey timely filed a Form 50 (Request for Hearing) seeking medical treatment and temporary total disability compensation from the date of her termination and continuing. [R. p. 30]. Employer timely filed a Form 51 denying the claim for temporary compensation on the grounds that Ramey had been fired for cause. [R. p. 33].

A hearing was held before Commissioner Bryan G. Lyndon on August 10, 2011. Commissioner Lyndon issued a Decision and Order on September 28, 2011. [R. pp. 3-16]. In that Order, the Commissioner ordered the Employer to pay "temporary total disability compensation from March 24, 2011 to the present and continuing." [R. p. 14]. He also set the compensation rate at $671.58 based on an average weekly wage of $1,007.32 as calculated on the Form 20 prepared by the Employer. [R. p. 10, Finding of Fact 1].

Both parties timely appealed from this Order. Ramey appealed the rulings regarding the

compensation rate. Employer appealed the requirement to pay temporary total disability compensation from March 24, 2011.

The Appellate Panel heard oral arguments on March 20, 2012. By Decision and Order dated May 23, 2012, the Appellate Panel affirmed the Decision and Order of the Single Commissioner. [R. pp. 17-28].

These cross-appeals followed.

STATEMENT OF THE FACTS

Gayla Ramey was employed for nine years as a registered nurse for the Employer Unihealth Post Acute Care. Her job duties included numerous physical tasks including turning patients, helping patients move, and helping patients get in and out of wheelchairs.

On March 11, 2011, Ramey clocked in with a hand scanner. Shortly thereafter, she fell, was injured, and was immediately sent to Doctor's Care for treatment. She did not clock out when she went to the doctor and was paid for her normal hours – including the time at the doctor's office.

Doctor's Care put Ramey on work restrictions of no more than 30 minutes per hour on her feet; limited use of the back; no use of the right arm; 10-pound lifting restriction; and no repetitive bending, twisting, stooping, squatting or pushing. [R. pp. 342-343]. The Employer refused to respect these restrictions and kept her working full duty. Two other employees, Tammy Watkins and Lisa Jacobs, were also required to work full duty despite being under medical restrictions from work-related injuries.

On March 18, 2011, Ramey returned to Doctor's Care. She asked the doctor to take her off work restrictions because she needed to help with understaffing on her floor and she was afraid she would be fired if she remained under medical restrictions.

As the hand scanner was not working that day, Ramey was required to submit a written "request for missed time" form. Both of her immediate supervisors, Carrie Ray and Tonya Shephard, reviewed and approved the form as submitted. Both supervisors knew Ramey had left work for her doctor's appointment that morning when they approved the form. Ramey submitted time from 7:00 a.m. to 10:30 a.m. – which included the roughly one hour she spent going to the doctor.

On March 21, 2011, Employer discharged Ramey allegedly for falsifying records to get paid for the one hour she was at the doctor on March 18th.

Ramey returned to Doctor's Care on March 24, 2011. [R. p. 350]. She was placed back on work restrictions. [R. p. 351]. Ramey returned several more times to Doctor's Care – she was continued on work restrictions at each visit. [R. pp. 351-360]. Her last visit was on April 8, 2011 when she was referred to an orthopaedic surgeon. [R. p. 358]. Defendants refused to provide medical care from that point forward until the day of the hearing. [R. p. 100, lines 2-6].

Ramey was seen by Dr. Timothy Zgleszewski on July 19, 2011. Dr. Zgleszewski opined she was not at MMI, required additional treatment for her injuries, and "would be at risk for further injury if she returns to work before the additional treatment is rendered." [R. pp. 365-369].

A hearing was held before Commissioner G. Bryan Lyndon on August 10, 2011. In the pre-trial conference, Employer conceded it was required to provide treatment through an orthopaedic surgeon. The hearing went forward on two issues: (1) whether Employer was required to pay temporary total disability compensation; and (2) the average weekly wage and compensation rate.

At the hearing, Employer denied Ramey should receive temporary total disability benefits because she was terminated for cause. [R. p. 102, lines 8-12]. Commissioner Lyndon ordered the Employer to pay "temporary total disability compensation from March 24, 2011 to the present and continuing." [R. p. 14].

The Commissioner also set the compensation rate at $671.58 based on an average weekly wage of $1,007.32 as calculated on the Form 20 prepared by the Employer. Ramey had argued for a compensation rate of $704.32 based on an average weekly wage of $1099.17. The figure was based on her actual earnings over the 52 weeks immediately prior to her accident.

STANDARD OF REVIEW

In reviewing Workers' Compensation Commission's decision, an appellate court must affirm the Commission's factual findings if they are supported by substantial evidence and not controlled by legal error. Tiller v. National Health Care Center, 334 S.C. 333, 513 S.E.2d 843 (1999). "An appellate court may not substitute its judgment for that of an agency as to the weight of the evidence on questions of fact unless the agency's findings are clearly erroneous in view of the reliable, probative, and substantial evidence on the record." Tiller, 334 S.C. at 339, 513 S.E.2d at 845.

The findings of the Commission are presumed correct and will be set aside only if unsupported by substantial evidence. Rodney v. Michelin Tire Corp., 320 S.C. 515, 466 S.E.2d 357 (1996). Substantial evidence is not a mere scintilla of evidence, nor the evidence viewed blindly from one side of the case, but is evidence which, considering the record as a whole, would allow reasonable minds to reach the conclusion the administrative agency reached in order to justify its action. Miller v. State Roofing Co., 312 S.C. 452, 441 S.E.2d 323 (1994). Where there is a conflict in the evidence, either by different witnesses or in testimony of the same witness, findings of fact of the Commission are conclusive. Tiller v. National Health Care Center, 334 S.C. 333, 513 S.E.2d 843 (1999).

ARGUMENT

1. Gayla Ramey is entitled to ongoing temporary total disability compensation because she is disabled due to her injury and the Employer has not provided employment suitable to her capacity since March 21, 2011.

The Appellate Panel properly found Ramey was entitled to temporary total disability compensation from March 24, 2011. As a matter of law, an Employer must either provide employment suitable to an injured worker's capacity or pay temporary total disability compensation. As Ramey had not reached MMI and no suitable employment was offered, the Appellate Panel's award of temporary total disability compensation must be affirmed.

A. As Ramey was partially incapacitated at the time of her termination, she was entitled to receive temporary total disability compensation [in response to Employer's argument at page 17].

Employer argues that Ramey is not entitled to receive temporary compensation because "at the time of Claimant's termination, she had been released from any restrictions by her treating physician and had returned to full duty." [Brief of Respondents/Appellants at page 17]. As a procedural matter, this conclusory argument has been abandoned due to the failure to cite any legal authority. See Rule 208(b)(1)(D), SCACR (requiring citation to authority in the argument section of an appellant's brief); First Sav. Bank v. McLean, 314 S.C. 361, 363, 444 S.E.2d 513, 514 (1994) (noting when a party fails to cite authority or when the argument is simply a conclusory statement, the party is deemed to have abandoned the issue on appeal).

Even if the Court finds the issue preserved, the argument fails. Although there is a release to full duty from Doctor's Care on March 18, 2011, there is also testimony that the only reason for the release was because Ramey specifically asked to try full duty from fear she would lose her job

if she did not get back to full duty. Even more importantly, Ramey was placed back on medical restrictions on the very next doctor's visit on March 24, 2011. [R. p. 351]. This is the date the Commission used as the starting point for temporary compensation to begin. Ramey continued on work restrictions from then on and has never been released to work without restriction. See Cranford v. Hutchinson Construction, 731 S.E.2d 303, 399 S.C. 65 (Ct. App. 2012)(employer "required to pay [claimant] temporary disability benefits from the day after his termination . . . until he achieved MMI and was authorized to return to work without restriction").

Therefore, this Court should affirm the Commission's award of temporary total disability compensation payable from March 24, 2012.

B. An Employer cannot evade liability for temporary total disability benefits by terminating an injured employee [in response to Employer's argument at pages 17-19].

Employer argues "the substantial evidence shows that Claimant was terminated for cause, which constitutes an unjustified refusal of suitable employment." [Brief of Respondents/Appellants at page 17]. This argument has no merit because, as a matter of law, an employer's purported reason for terminating an employee is not relevant to the legal obligation to pay temporary compensation. Such a rule would be completely contrary to established South Carolina law; would violate public policy; and would impermissibly turn the Commission into a forum to litigate employment related issues. See Smith v. South Carolina Dept. of Mental Health, 329 S.C. 485, 494 S.E.2d 630 (Ct.App. 1997)(reason employer fired claimant are not "strictly relevant to the matter before the commissioner [and] are matters that must be resolved in state or federal court, not before the Workers' Compensation Commission."). Moreover, such a rule would be particularly draconian in this case where the termination arose out of an innocent misunderstanding over whether the company paid for

time spent going to the doctor.

Even if it were relevant, the Commission found as a fact that "It was the Claimant's clear understanding based upon the acts and information given by the Employer that led the Claimant to believe she was to be paid for time missed from work for her medical appointments." [R. p. 12, Finding of Fact 8]. The Commission further found "it was obvious she was not trying to falsify records, deceive the Employer, or hide anything else." [R. pp. 12-13, Finding of Fact 14]. As these findings are based on the testimony of both Gayla Ramey and the Employer's HR Director, Linda Burr, they are supported by substantial evidence. As there is no factual finding that Ramey committed any misconduct that would support a firing for cause, Employer's argument fails for a lack of proof.

Even if there were evidence to support the Employer's argument, it is legally incorrect and must be rejected by this Court. As a matter of law, when the injured worker is under work restrictions, the employer must either offer suitable employment within the injured worker's capacity or pay temporary total disability compensation. See S.C. Code Ann. § 42-9-190 (2005); S.C. Code Ann. § 42-9-200 (2007)("if the injury results in disability of more than fourteen days, compensation shall be allowed from the date of disability"); S.C. Code Ann. § 42-9-260(A) (Supp. 2006); 25A S.C Code Ann. Reg. 67-502 (2007)(defining "disability", "return to work without restriction", and "temporary partial incapacity"); Last v. MSI Const. Co., Inc., 305 S.C. 349, 409 S.E.2d 334 (1991)(fact that incarcerated claimant remained unemployable for reasons other than his injury was not dispositive of his right to temporary compensation; rather, the issue was whether the injury had resulted in some loss of his earning capacity). See also Grayson v. Carter Rhoad Furniture, 317 S.C. 306, 454 S.E.2d 320 (1996)(temporary compensation improperly suspended because claimant

not at MMI and still under restrictions by the doctor, thus no evidence period of temporary total disability ever ended); Hines v. Hendricks Canning Co., 263 S.C. 399, 211 S.E.2d 220 (1975)(allowing an employee temporary total benefits and rejecting the carrier's argument that the claimant's loss of earning capacity was caused by his full-time attendance at school rather than his work-related injury). Cf. Orr v. Elastomeric Products, 323 S.C. 342, 474 S.E.2d 448 (Ct. App. 1996)(claimant's inability to work was still due to her injury and not to her pregnancy and that the prolongation, caused by the pregnancy, of the period of temporary disability did not alter that overriding fact).

The Commission lacks statutory authority to make findings on why an employee was terminated – or to bar compensation on this ground. See Smith v. South Carolina Department of Mental Health, 329 S.C. 485, 494 S.E.2d 630 (Ct. App. 1997)("we do not believe [issues of why claimant was terminated] were strictly relevant to the matter before the commissioner--whether [employer] was entitled to discontinue the disability payments being made to [claimant]."). The sole inquiry is whether employment was offered suitable to the employee's capacity and whether the employee accepted it. Here, there is no question Ramey accepted the work that was offered. The Employer *unilaterally* withdrew the offer of suitable employment. As such, it *must* pay temporary compensation.

The one administrative agency with authority to bar statutory benefits for termination for cause is the Department of Employment and Workforce (formerly the Employment Security Commission). See S.C. Code Ann. § 41-35-120 (2010)(" worker is ineligible for benefits for: Discharge for cause connected with the employment."). It makes logical sense to bar unemployment compensation to workers fired for misconduct since the very philosophy underlying unemployment

compensation is to protect workers who lose their jobs through no fault of their own. Employees who voluntarily quit are ineligible for unemployment compensation, as are those who are terminated for cause.

As the Workers' Compensation Commission has no similar statute, the Commission lacks authority to bar temporary compensation to a disabled employee fired from a light duty position for cause. The Commission simply cannot create barriers to payment of compensation out of whole cloth – particularly when those barriers not only have no statutory support, but actually contradict the statute. Moreover, the policy considerations underlying workers' compensation are radically different than those underlying unemployment compensation. Any flexibility the Commission has must be "exercise[d] . . . in making compensation awards to ensure the best interests of the workers are protected to the extent the award is not otherwise prohibited by the Workers' Compensation Act." James v. Anne's Inc., 390 S.C. 188, 701 S.E.2d 730 (2010).

Here, the Employer unilaterally withdrew its offer of light duty work to Ramey – essentially failing to mitigate its damages. At the time of her involuntary termination Ramey was under work restrictions due to her injury. Even if there is a dispute over whether she was under restrictions on the day she was fired, it is undisputed she was under restrictions on March 24, 2011 – which is the date the Commission ordered temporary compensation to commence. These restrictions disqualified her from working in her occupation. As she was considered to be disabled under the Act, Ramey's loss of earnings capacity is a direct result of the limitations resulting from her work injury. See S.C. Code Ann. § 42-1-120 (2007) ("The term 'disability' means incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment."). Therefore, the Decision and Order of the Commission should be affirmed and this

Court should hold Ramey is entitled to receive temporary total disability compensation as a matter of law.

C. Ramey is entitled to receive temporary total disability compensation because the Employer failed to provide employment suitable to her capacity [in response to Employer's argument at pages 19-20].

Employer raises the creative argument that an injured worker whose employer is unwilling or unable to offer employment suitable to her capacity must be *totally disabled from all employment* as a condition of receiving temporary total disability compensation. This has never been the law in South Carolina; indeed, it is patently contrary to our law.

Employer states: "'Disability' in the workers' comp context is defined as an inability to earn the same wages as the injured employee earned pre-injury." [Appellants' Brief of Respondents/Appellants at 19]. Although Employer references § 42-1-120, this is not the definition contained in the statute. The statute actually reads: "The term 'disability' means incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment." S.C. Code Ann. § 42-1-120 (2007). The Commission found as a fact that Ramey "is temporarily totally disabled." [R. p. 13, Finding of Fact 15]. This finding satisfies the statute as the Commission also found Ramey's work restrictions disqualified her from working all the duties of her job. [Order, Finding of Fact 9].

This Court definitively dispensed with a similar argument by an employer in Cranford v. Hutchinson Construction, 731 S.E.2d 303, 399 S.C. 65 (Ct. App. 2012). In Cranford, the Commission held the employee failed to prove his entitlement to temporary compensation after being terminated by his employer 17 days after returning to light duty work. Contrary to the Commission's findings, the evidence showed Cranford had not been returned to work without

restriction and had not reached maximum medical improvement. This Court held the employer was "required to pay Cranford temporary disability benefits from the day after his termination . . . until he achieved MMI and was authorized to return to work without restriction." Id. Cranford had briefly returned to work for another employer, albeit at a lower wage. Neither the fact he found other work nor the fact he was laid off by the other employer after a short time had an bearing on his basic right to receive temporary compensation.

There is no duty on the part of the injured worker to seek alternative employment during his period of disability. Indeed, to do so would frustrate one of the key purposes of the Act: to return injured workers back to work with the same employer. See S.C. Code § 42-9-160 and 42-9-170 (2005)(relieving employer from paying double compensation to employee drawing compensation for previous injury in same employment); State Workers' Compensation Fund v. South Carolina Second Injury Fund, 313 S.C. 536, 443 S.E.2d 546 (1994)("The primary purpose of subsequent injury fund legislation is to encourage employers to hire handicapped persons, or to retain employees who become partially disabled in the course and scope of their employment."). As it is undisputed that Ramey was still partially disabled and had not reached MMI, she is entitled to receive temporary compensation as a matter of law.

The only remaining question before this Court is whether Ramey must prove she was unable to obtain other employment before she can receive temporary total disability compensation. The entire statutory and regulatory scheme makes it clear she need not do so. If an employer is permitted to suspend temporary compensation *only* if an employee is *actually* working, then surely the employer cannot be permitted to withhold temporary compensation because an employee has not secured a new job with a different employer. See Grayson v. Carter Rhoad Furniture, 317 S.C. 306,

454 S.E.2d 320 (1996)(temporary compensation improperly suspended because claimant not at MMI and under restrictions by the doctor, thus no evidence period of temporary total disability ever ended); Hines v. Hendricks Canning Co., 263 S.C. 399, 211 S.E.2d 220 (1975)(allowing an employee temporary total benefits and rejecting the carrier's argument that the claimant's loss of earning capacity was caused by his full-time attendance at school rather than his work-related injury). Cf. Orr v. Elastomeric Products, 323 S.C. 342, 474 S.E.2d 448 (Ct. App. 1996)(claimant's inability to work was still due to her injury and not to her pregnancy and that the prolongation, caused by the pregnancy, of the period of temporary disability did not alter that overriding fact).

There is a sound policy basis underlying this rule. The hope is that upon recovery from their injuries, injured workers will be able to return to their previous employment. Workers' compensation claimants are one of the few classes of workers in South Carolina that enjoy some measure of statutory job security. See S.C. Code Ann. § 41-1-80 (1985)(prohibiting discharge or demotion in retaliation for instituting a workers' compensation claim). Requiring injured workers to look for new jobs would greatly lessen the likelihood they would return to work with their original employers. Moreover, a rule excusing employers from paying temporary compensation would create an incentive for employers not to offer light duty to injured workers or even manufacture reasons to fire them outright – as apparently happened in this case.

This Court should reject the Employer's argument and affirm the Appellate Panel.

2. The findings of fact of the Appellate Panel are both internally consistent and supported by substantial evidence [in response to Employer's argument at pages 20-24].

A proper review of the Appellate Panel's material factual findings shows they are both internally consistent and supported by substantial evidence. If there are any inconsistencies, they are

not material and would not change the ultimate result; thus, this Court should affirm the result under a harmless error analysis. See McCollum v. Singer Co., 386 S.E.2d 471, 300 S.C. 103 (Ct.App. 1989)(unless prejudice to the complaining party has resulted therefrom, an error is harmless error and not sufficient for reversal).

A. The Hand Scanner [in response to Employer's argument at pages 20-21].

Employer points out that the Appellate Panel made a finding that on March 11, 2011, "the hand-scanning device did not work;" while making a contrary finding that "the hand-scanner was working that day." [Brief of Respondents/Appellants at page 17]. Neither of these findings bear on the actual result of the trial –which is that Gayla Ramey is entitled to be paid temporary total disability compensation as a matter of law. Whether Ramey committed misconduct leading to termination is irrelevant as a matter of law. Even if it were relevant, the Commission found as a fact that "It was the Claimant's clear understanding based upon the acts and information given by the Employer that led the Claimant to believe she was to be paid for time missed from work for her medical appointments." [R. p. 12, Finding of Fact 8]. Whether or not the hand-scanner was working on March 11, 2011 is not a material fact. Employer suffered no prejudice from the inconsistent findings, therefore, any error is insufficient grounds for this Court to reverse the decision below. McCollum v. Singer Co., 386 S.E.2d 471, 300 S.C. 103 (Ct.App. 1989).

B. Work Restrictions [in response to Employer's argument at pages 21-22].

Employer argues at length that the Appellate Panel's finding that Ramey "'continued to work even though outside of her work restrictions' from March 11 to March 18" is unsupported by substantial evidence. [Brief of Respondents/Appellants at page 17].

To begin with, there is ample testimony from both witnesses that Ramey worked outside her

restrictions during this time period. Ultimately though, it doesn't matter. The Commission ordered the Employer to pay temporary total disability compensation from March 24, 2011 – a period during which it is undisputed that Ramey was under work restrictions and the Employer offered no employment suitable to her capacity. As such, even if the finding was erroneous, it is harmless error. McCollum v. Singer Co., 386 S.E.2d 471, 300 S.C. 103 (Ct.App. 1989).

C. Pay [in response to Employer's argument at page 23].

There is no merit to Employer's argument that there is no substantial evidence to support the finding that Ramey believed she would be paid for time spent attending doctor's appointment related to her injury. The Employer paid Ramey for the time she left work to attend the first appointment at Doctor's Care after her accident on March 11, 2011. [R. p. 108, lines 6-14]. From this testimony, it was reasonable for the Commission to infer that she believed she would continue to be paid for other doctor's visits.

This finding is supported by substantial evidence and must be affirmed. Moreover, there is no prejudice to the Employer and no grounds for reversal even if the finding had been in error. McCollum v. Singer Co., 386 S.E.2d 471, 300 S.C. 103 (Ct.App. 1989)

D. Claimant's Credibility [in response to Employer's argument at pages 23-24].

As a general rule, the Commission's credibility findings are not subject to appellate review. The exception would be if the findings are so arbitrary or capricious as to constitute an error of law. Houston v. Deloach & Deloach, 378 S.C. 543, 663 S.E.2d 85 (Ct. App. 2008)("The appellate court is prohibited from overturning findings of fact of the Appellate Panel unless there is no reasonable probability the facts could be as related by the witness upon whose testimony the finding was based."); see, also Stallcup v. Carolina Wood Turning, Co., 7 S.E.2d 550 (N.C. 1940)(Seawell, J.

dissenting)("How far the Industrial Commission may be indulged in refusing to believe credible testimony is still to be worked out, but its arbitrary disregard of positive testimony and the substitution therefor of mere speculation is within the power of review and correction by this Court.").

There are no material inconsistencies in Ramey's testimony. She was never impeached with prior inconsistent statements or actions. Indeed, her testimony was essentially consistent with that of the Employer's witness. Under the deferential standard given to the Commission's credibility findings, there are no grounds to reverse.

CONCLUSION

For the foregoing reasons, the Decision and Order of the Appellate Panel awarding workers' compensation benefits to Gayla Ramey should be affirmed. For the reasons argued in the Appellant's Brief of Appellant/Respondent, the Decision and Order should be reversed and modified as to Ramey's average weekly wage and compensation rate.

Respectfully submitted,

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Columbia, South Carolina
January 31, 2013

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SOUTH CAROLINA
Workers' Compensation Commission

WCC File No. 1103442

Gayla Ramey, Employee ..... Appellant/Respondent,

v.

Unihealth Post Acute Care Tanglewood, Employer, and American Zurich Insurance Company, Carrier, ... Respondents/Appellants.

CERTIFICATE OF COUNSEL

The undersigned certifies that this Final Brief of Respondent complies with Rule 211(b), SCACR.

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RECORD ON APPEAL

VOLUME I

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BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Gayla Ramey, Employee/Claimant Vs. Unihealth Post Acute Care Tanglewood, Employer -and- American Zurich Insurance Company, Carrier/ Defendants.	**DECISION AND ORDER** WCC File Number: 1103442

APPEARANCES: Claimant represented by Mark R. Calhoun.
Defendants represented by Daniel Addison.

HEARING: Held in Columbia, South Carolina on August 10, 2011.

PURPOSE OF HEARING: To determine issues as set forth in Claimant's Motion to Form 50 and any other issues, which may timely come before the Commissioner.

OPINION AND AWARD: Commissioner G. Bryan Lyndon

FILED: **September 28, 2011**

STIPULATIONS

At the call of the case, the parties agreed to the following:

1. The purpose of the hearing was to determine all issues in dispute as set forth in the hearing notice and any other issues, which may timely come before the Commissioner.
2. The Claimant and Defendants are subject to and bound by the provisions of the South Carolina Workers Compensation Act.
3. The notice of the hearing was timely and properly served upon all parties of interest.
4. All parties agreed that venue was proper.
5. The Claimant seeks benefits under the South Carolina Workers Compensation Act based upon an alleged accidental injury that occurred on or about March 11, 2011.

APA SUBMISSIONS

Under the Administrative Procedures Act, the following medical and expert witness reports were submitted into evidence.

Claimant's

APA No. 1	Alice J. Brooks	7/12/2000-12/29/2010	108pgs.
APA No. 2	Doctors Care	3/11/2011-4/8/2011	19 pgs.
APA No. 3	Camden Open MRI	3/31/2011	1 page
APA No. 4	Palmetto Spine & Sports Medicine	07/19/2011	5 pgs.

Defendant's

APA No. 1	Personnel Records of the Employer	71 pgs.
APA No. 2	Deposition of Claimant	
APA No. 3	Deposition of Linda Burr	

STATEMENT OF THE CASE

This is a denied claim. The Claimant seeks a determination of her average weekly wage and compensation rate. The Claimant asserts that she injured her back and right arm after sustaining a fall at work. She feels that she is entitled to further medical care since maximum medical improvement has not been reached and she also feels she is entitled to temporary total disability benefits from March 24, 2011 to the present and continuing. The Defendants contest the injuries were causally related to the accident, that the Claimant is entitled to temporary disability benefits because she was terminated for cause and argue that she is at maximum medical improvement.

EVIDENCE OF THE CASE

The Claimant has worked for the Employer for approximately 9 years previous to the day of accident, March 21, 2011. The Claimant states that the previous 52 weeks to the date of accident yield an average weekly wage of $1099.17. Divided by 52 weeks this would yield the maximum compensation rate for 2011, $704.32. The Employer relies on the previous four quarters that were reported on the Form 20 which gives an average weekly wage of $1007.32, which would result in a compensation rate of $671.58 (APA p. 4-5). Before the Hearing began, the Employer conceded that the Claimant is entitled to more medical treatment and would schedule an appointment with an orthopedic back

specialist of their choosing. The final issue to be resolved is whether the Claimant should receive temporary total disability benefits from March 21, 2011 to the present and continuing until she reaches maximum medical improvement. The Claimant testified that she is 50 years old and lives in a household with 11 family members, mostly children and grandchildren. The Claimant received her R.N. degree in 2008. In fact, her Employer gave the Claimant a scholarship in order to get her R.N. degree (APA p. 12). The Claimant described her job duties as including helping patients with treatment, moving and turning patients in and out of bed, pushing patients in wheelchairs and helping them in and out of wheelchairs and moving the medical cart around the facility. She also does a lot of charting and working with the doctors to provide care to those patients (APA p. 12-13).

The Claimant testified she has never had any medical problems or treatment related to her back or spine. She did suffer from muscle spasms in her right shoulder in approximately 2006 and 2008 which were completely unrelated to her spine. They were muscular issues only (APA p. 13).

The Claimant stated that when she arrives at work she is required to "punch-in" by the use of a hand scanning device. After scanning the Claimants hand, the device records the time that the Claimant arrives at the working premises and later leaves the working premises. On March 11, 2011 the Claimant had scanned in after she arrived at work. After falling on some steps, the Claimant was immediately taken to Doctors Care for treatment. She did not have time to punch out with the hand scanner that day but was still paid her normal hours. Doctors Care placed her on restrictions of: limited use of the back, no use of the right arm, 10 pound lifting restriction, no repetitive bending, twisting,

stooping, squatting or pushing, no more than 30 minutes per hour standing. These restrictions were for injuries to the Claimants back and right arm (APA p. 13-14). The Employer kept the Claimant working in violation of these work restrictions (APA p. 15). The Claimant continued to work, although she was violating her restrictions, because she was scared of being terminated. There were two other employees who also had workers compensation claims who were also kept working. The Claimant understood that one of these two women was about to be terminated (APA p. 16).

The Claimant had a follow up doctor's appointment on March 18, 2011. The Claimant was informed about the Doctors appointment by Human Resources manager Linda Burr. The Claimant arrived at work at 7am the morning of March 18, 2011 so that she could speak to Ms. Burr before she left for her appointment at Doctors Care. Although she was supposed to be at work that morning, Ms. Burr was not there. The hand-scanner was not working the day of the 18th, 2011 (APA p. 16-18). The Claimant attended her appointment with Doctors Care and returned to work approximately at 9:45am. Her supervisor Tonya Shepard told her told her to leave work early at 10:30am because she wanted the Claimant to work the next two days, Saturday and Sunday (APA p. 18). The Claimant testified that it was her understanding that she was to be paid for time missed from work in order to attend regularly scheduled doctors' appointments. In fact this had occurred the day she was injured March 11, 2011 (APA p. 19).

When the Claimant returned to work, she was required to fill out a form to request missed time from work since the hand scanner was broken. After filling out the form she gave it to her two supervisors Carrie Ray and Tonya Shepherd who signed off and approved the form. Each supervisor was aware that the Claimant had left work the

morning of the 18th to attend her doctor's appointment (APA 19-20). It was not unusual for the hand-scanner to not work. Every time previously that the hand-scanner had not worked, the Claimant has always been paid by the Employer. This is done by the procedure of having the Claimant manually fill out a lost time sheet which is approved by her supervisor. If the hand-scanning machine had been working properly on March 18, 2011 the Claimant would have been able to scan herself in and out of the facility for her doctor appointment (APA p. 52-54).

At the Claimants doctors appointment on March 18, 2011 she requested that the physician remove her work restrictions so she can attempt to work full duty (APA p. 47). The Claimant did so due to her fear of being terminated. On March 19 and 20, 2011 the Claimant attempted to work full duty but was unable to do so. When she returned to the doctor on March 24, 2011 and informed them of her inability to work full duty, the doctor reinstated her work restrictions as of March 24, 2011 (APA p 118). On March 21, 2011 the Claimant was called in to meet with Linda Burr. Linda Burr fired the Claimant for the stated reason that the Claimant was not allowed to be paid for time missed from work in order to attend doctor appointments (APA p. 20). The Claimant stated she has attempted to find employment that does not violate her work restrictions since being terminated has been unsuccessful in doing so (APA p. 21-22). She desires the medical treatment recommended by Dr. Zgleszewski and is requesting temporary total disability benefits until she is placed at maximum medical improvement.

The Employer argues that it had Ms. Ramey sign a piece of paper stating she agreed to not be paid for missed time from work for doctors appointments. The Claimant admits signing this piece of paper but denies she was ever given the opportunity to read

it, only told to sign it. The Employer also maintains that the Claimant has had right shoulder and neck problems for a number of years. The Claimant testified that she had been treated for muscle spasms in her right shoulder in 2006 and 2008 but had never been treated for issues in her cervical spine or back (APA p. 43-44).

Human Resources director Linda Burr testified that the Claimant was terminated for falsifying records. She explained that when the Claimant turned in her missed time form (due to the hand-scanner not working) that the Claimant was falsifying records by requesting to be paid for time on the morning of the 18th that the Claimant was actually at a doctors appointment. Although Ms. Burr, and both of the Claimants supervisors knew the Claimant had a doctors appointment that morning, Ms. Burr believes the Claimant was falsifying a time sheet by requesting to be paid for that period that the Claimant was at her doctors appointment (APA p. 65). Ms. Burr also testified that in the 9 years she has worked with the Claimant she has never heard the Claimant complain about pain in her back or neck (APA p. 73). Ms. Burr stated that the Claimant is not to be paid for any time that she misses work due to receiving medical treatment on a workers compensation claim (APA p. 74).

The medical records from Doctors Care indicate that the Claimant injured her back and right arm on March 11, 2011. The Claimant was placed on the previously mentioned substantial restrictions on that day. These restrictions remained in effect until March 18, 2011 the day the Claimant testified that she requested to try full duty. The Claimants next doctor appointment after the 18th was March 24th , 2011. On that date the Claimants work restrictions were reinstated. The Claimant was examined by Dr. Zgleszewski on July 19, 2011 who also held the Claimant out of work (APA p. 130-134).

Dr. Z recommends a thorough course of medical treatment for the Claimants back including an MRI. The medical records from Doctors Care also indicate that the Claimant is being referred to see an orthopedic doctor for her neck pain (APA p. 126).

A record of all pertinent information was made at the preceding's in this matter. This Commissioner has made a careful review of all the evidence presented and has been able to observe personally the demeanor of the witnesses in this case. Based upon the above stated evidence. The following is accordingly made:

FINDINGS OF FACT

Based upon the stipulations of both parties and the testimony and evidence produced at this hearing, the undersigned Commissioner makes the following Findings Of Fact:

1. All parties are bound by and subject to the terms and provisions of the South Carolina Workers' Compensation Act, as amended. This finding is based upon stipulation by the parties. The Claimants compensation rate is $671.58. This finding is based upon the average weekly wage of $1007.32 on the Employers Form 20 which covers the last four quarters of the Claimants employment.
2. The Claimant sustained a compensable injury to her back and right arm in an admitted work related accident on March 11, 2011. This finding is based on the Claimants testimony and medical reports.
3. The Claimant is a 9 year employee of the Employer. She was given a scholarship by the Employer in order to receive her R.N. degree. The Claimant has never

previously been accused by the Employer of falsifying time sheets or other records.

4. The Claimant has had no previous problems with her spine. She did explain that she had received treatment for muscular issues in her right shoulder and trapezius muscles which have been resolved.

5. Work time reporting procedures required employees to use a hand-scanning device to clock in and out of work. On March 11, 2011 and on numerous previous occasions the hand-scanning device did not work for the Claimant.

6. The Claimant had a regularly scheduled doctors appointment the morning of March 18, 2011. The Human Resources Director Linda Burr and the Claimants two supervisors (Ms. Ray and Ms. Shepherd) knew about the Claimants appointment. This was confirmed by Linda Burr who testified at the hearing and the missed time form which was signed off by the two supervisors. Since the Claimant knew the scanner was not working the morning of March 18, 2011 she did not clock in and out. As a result the Claimant was paid for the hours she went to the doctor. She had always previously been paid when the scanner was broken and the Claimant was required to clock in and out using the manual form. In fact, on March 11, 2011 the Claimant was paid her normal hours although she did not clock out in order to go to Doctors Care, even though the hand-scanner was working that day.

7. The Claimant was on light duty restrictions from March 11th to March 18th, 2011 and continued to work. She continued to work even though working outside of her work restrictions.

8. The Employer discharged the Claimant for falsifying records for getting paid for the one hour she was at the doctor on March 18, 2011. It was the Claimants clear understanding based upon the acts and information given by the Employer that led the Claimant to believe she was to be paid for time missed from work for her medical appointments.
9. Linda Burr, the Claimants Human Resources Director testified that the Claimant wanted to do more work in order to help out while she was on her restrictions but was not allowed to do so because of her restrictions.
10. On March 18, 2011 the Claimant requested that Doctors Care allow her to go back to regular duty.
11. Linda Burr testified that she knew the Claimant was going to Doctors Care on March 18, 2011 as did other people or supervisors in management.
12. I find the Claimant was a credible witness. I further find that but for the malfunctioning hand-scanner the Claimant would have clocked out, thereby not having to use the missed time form that the Employer used as an excuse for terminating her.
13. In the past when the hand scanner was working, the Claimant would clock into work, out for lunch, and back to work. If the hand-scanner had been working on March 18, 2011 the Claimant would not have been terminated.
14. I do not find it plausible that the Claimant would intentionally put 9 years of service on the line for the one hour that she was at the doctor. She was out of the office for a doctors appointment. This appointment was for an admitted work related injury and the Employer knew the Claimant was at the doctors

appointment. The Claimant also gave the Employer the time she was at the Doctors appointment so it was obvious she was not trying to falsify records, deceive the Employer, or hide anything else.

15. The Claimant is temporarily totally disabled and is entitled to benefits for March 24, 2011 to the present and continuing.

16. The Claimant is to be treated by an orthopedic doctor chosen by the Employer.

CONCLUSIONS OF LAW

Accordingly, as provided in the South Carolina Code of Laws 1976, as amended, §42-17-140, it is the determination of this Commissioner that:

1. Under §42-1-160, the Claimant sustained a compensable injury to her back and right arm by accident arising out of and in the course of her employment.
2. Under §42-1-40 the Claimant's average weekly wage is $1007.32, with a corresponding compensation rate of $671.58.
3. Under §42-15-60 the Defendants are responsible for all causally-related medical treatment allowed under the Act.
4. Under §42-9-10 the Claimant is entitled to continued temporary total disability benefits from March 24, 2011 to the present and continuing.
5. The burden of proof applicable to a claim for workers compensation benefits is the preponderance of the evidence. The Claimant must establish by preponderance of the evidence the facts that will entitle her to an award. Walsh v. U.S. Rubber Company, 120 S.E. 2d 685 (1961); Herndon v. Morgan

Mills Inc., 143 S.E. 2d 376 (1965). The Claimant has met her burden of proof in establishing her claims by a preponderance of the evidence.

6. Under §42-1-130 the Claimant was a covered employee at the time of her accident on March 11, 2011.
7. Under §42-15-20, proper notice was given to the Employer of the Claimants March 11, 2011 injuries to her right arm and back.
8. Under §42-15-20, proper notice was given to the Employer of the Claimants March 11, 2011 accident.
9. Under §42-9-10, the Claimant is entitled to receive compensation from the Defendants for her period of temporary total disability resulting from her March 11, 2011 accident from March 24, 2011 until the present and continuing.

ORDER

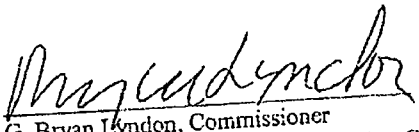
IT IS, THEREFORE, ORDERED that the Findings of Fact and Conclusions of Law are incorporated herein as if set forth verbatim, and that the Defendant shall provide the following benefits:

1. ORDERED, ADJUDGED AND DECREED that the Claimant is entitled to receive temporary total disability compensation from March 24, 2011 to the present and continuing;
2. ORDERED, ADJUDGED AND DECREED that the Defendant shall be responsible for any and all causally related medical treatment provided to the Claimant related to her compensable injury on March 11, 2011 including all medication expenses and mileage and it is further,

3. ORDERED, ADJUDGED AND DECREED that the Claimant sustained a compensable injury by accident on March 11, 2011 to her back and right upper extremity.

IT IS SO ORDERED.

No hearings costs assessed in this matter.

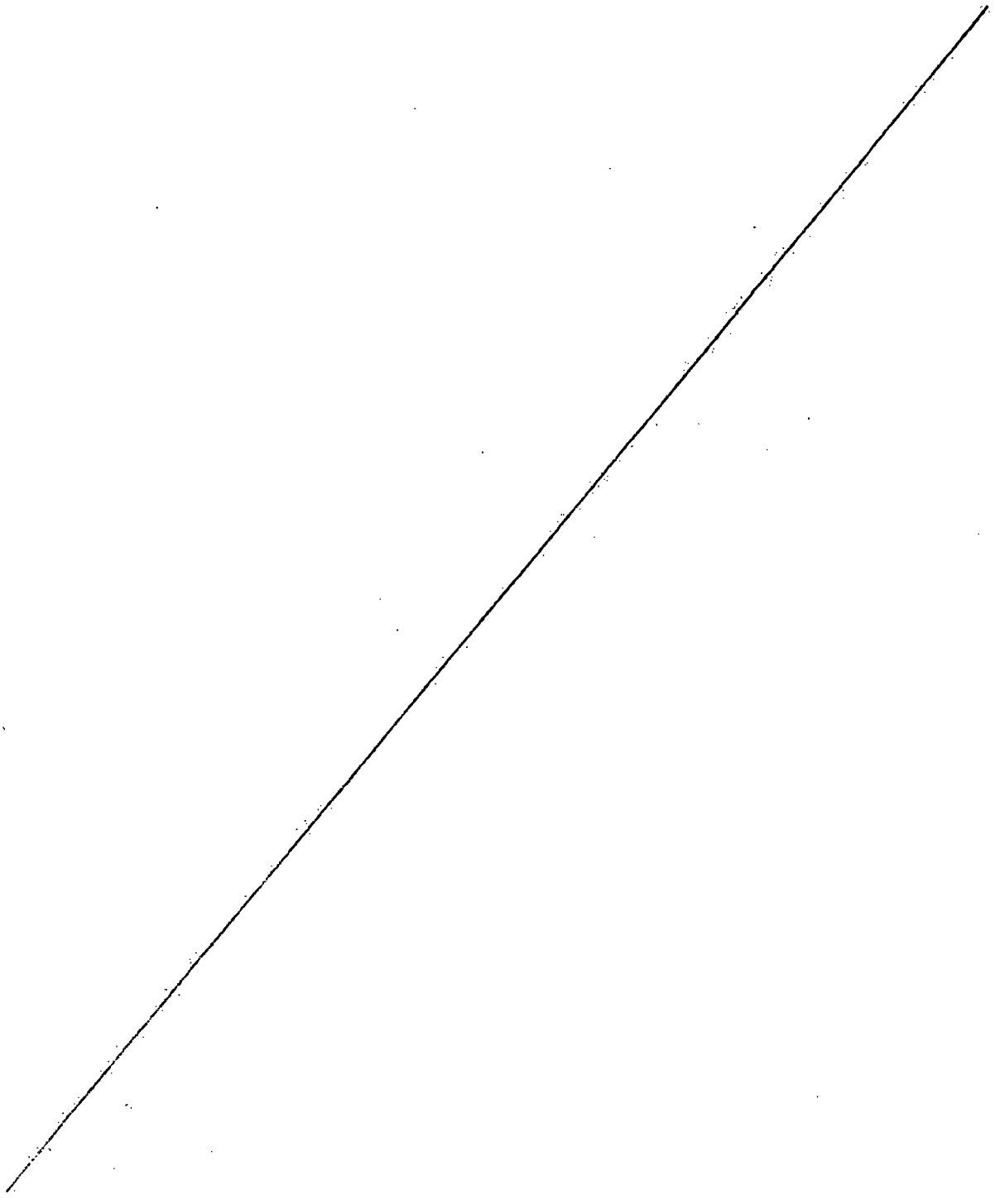


G. Bryan Lyndon, Commissioner
South Carolina Workers' Compensation Commission

CERTIFICATE OF SERVICE

This is to certify the undersigned has this date served this order in the above entitled action upon all parties to this cause by sending an electronic copy hereof by electronic mail addressed to the attorney or attorneys for said parties or by depositing a copy hereof, postage paid, in the United States certified mail addressed to any unrepresented party.
September 28, 2011

By: Tamara Morris, Administrative Assistant to Commissioner Lyndon



APPELLATE PANEL

DECISION AND ORDER

OF THE

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO.: 1103442

GAYLA RAMEY, CLAIMANT
V.
UNIHEALTH POST ACUTE CARE TANGLEWOOD, EMPLOYER
AND
AMERICAN ZURICH INSURANCE CO., CARRIER

Appellate Panel Review held in Columbia, South Carolina, on March 20, 2012, per notices timely and properly served upon all parties of Interest.

Appellate Panel Decision and Order filed: 5/23/12

APPEARANCES: Appellants-Defendants represented by Hedrick Gardner Kinchelne & Garofalo LLP with R. Daniel Addison appearing.

Appellant-Claimant represented by Calhoun Law Firm with Mark R. Calhoun appearing.

STATEMENT OF THE CASE

The parties were heard by Commissioner G. Bryan Lyndon on August 10, 2011 in Columbia, South Carolina. Under date of September 28, 2011 the Hearing Commissioner issued the following Findings of Fact, Conclusions of Law and Order:

FINDINGS OF FACT

Based upon the stipulations of the parties, the evidence submitted pursuant to the Administrative Procedures Act, and the testimony and exhibits presented at the hearing, I hereby make the following Findings of Fact:

1. All parties are bound by and subject to the terms and provisions of the South Carolina Workers' Compensation Act, as amended. This finding is based upon stipulation by the parties. The Claimants compensation rate is $671.58. This finding is based upon the average weekly wage of $1007.32 on the Employers Form 20 which covers the last four quarters of the Claimants employment.
2. The Claimant sustained a compensable injury to her back and right arm in an admitted work related accident on March 11, 2011. This finding is based on the Claimants testimony and medical reports.
3. The Claimant is a 9 year employee of the Employer. She was given a scholarship by the Employer in order to receive her R.N. degree. The Claimant has never previously been accused by the Employer of falsifying time sheets or other records.
4. The Claimant has had no previous problems with her spine. She did explain that she had received treatment for muscular issues in her right shoulder and trapezius muscles which have been resolved.

5. Work time reporting procedures required employees to use a hand-scanning device to clock in and out of work. On March 11, 2011 and on numerous previous occasions the hand-scanning device did not work for the Claimant.

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10. On March 18, 2011 the Claimant requested that Doctors Care allow her to go back to regular duty.

11. Linda Burr testified that she knew the Claimant was going to Doctors Care on March 18, 2011 as did other people or supervisors in management.

12. I find the Claimant was a credible witness. I further find that but for the malfunctioning hand-scanner the Claimant would have clocked out, thereby not having to use the missed time form that the Employer used as an excuse for terminating her.

13. In the past when the hand scanner was working, the Claimant would clock into work, out for lunch, and back to work. If the hand-scanner had been working on March 18, 2011 the Claimant would not have been terminated.

14. I do not find it plausible that the Claimant would intentionally put 9 years of service on the line for the one hour that she was at the doctor. She was out of the office for a doctors appointment. This appointment was for an admitted work related injury and the Employer knew the Claimant was at the doctors appointment. The Claimant also gave the Employer the time she was at the Doctors appointment so it was obvious she was not trying to falsify records, deceive the Employer, or hide anything else.

15. The Claimant is temporarily totally disabled and is entitled to benefits for March 24, 2011 to the present and continuing.

16. The Claimant is to be treated by an orthopedic doctor chosen by the Employer.

CONCLUSIONS OF LAW

Pursuant to S.C. Code Ann. §42-17-40 and based upon the above Findings of Fact, I make the following Conclusions of Law:

17. Under §42-1-160, the Claimant sustained a compensable injury to her back and right arm by accident arising out of and in the course of her employment.

18. Under §42-1-40 the Claimant's average weekly wage is $1007.32, with a corresponding compensation rate of $671.58.

19. Under §42-15-60 the Defendants are responsible for all causally-related medical treatment allowed under the Act.

20. Under §42-9-10 the Claimant is entitled to continued temporary total disability benefits from March 24, 2011 to the present and continuing.

21. The burden of proof applicable to a claim for workers compensation benefits is the preponderance of the evidence. The Claimant must establish by preponderance of the evidence the facts that will entitle her to an award. Walsh v. U.S. Rubber Company, 120 S.E. 2d 685 (1961); Herndon v. Morgan Mills Inc., 143 S.E. 2d 376 (1965). The Claimant has met her burden of proof in establishing her claims by a preponderance of the evidence.

22. Under §42-1-130 the Claimant was a covered employee at the time of her accident on March 11, 2011.

23. Under §42-15-20, proper notice was given to the Employer of the Claimants March 11, 2011 injuries to her right arm and back.

24. Under §42-15-20, proper notice was given to the Employer of the Claimants March 11, 2011 accident.

25. Under §42-9-10, the Claimant is entitled to receive compensation from the Defendants for her period of temporary total disability resulting from her March 11, 2011 accident from March 24, 2011 until the present and continuing.

ORDER

IT IS, THEREFORE, ORDERED that the Findings of Fact and Conclusions of Law are incorporated herein as if set forth verbatim, and that the Defendant shall provide the following benefits:

1. ORDERED, ADJUDGED AND DECREED that the Claimant is entitled to receive temporary total disability compensation from March 24, 2011 to the present and continuing;

2. ORDERED, ADJUDGED AND DECREED that the Defendant shall be responsible for any and all causally related medical treatment provided to the Claimant related to her compensable injury on March 11, 2011 including all medication expenses and mileage and it is further.

3. ORDERED, ADJUDGED AND DECREED that the Claimant sustained a compensable injury by accident on March 11, 2011 to her back and right upper extremity.

Within the statutory period, counsel for the Claimant and Defendants filed Application for Review in the case setting forth the grounds of appeal, copies of which were furnished to all interested parties prior to oral arguments presented before the Appellate Panel on March 20, 2012.

All proffered testimony has been taken. Such, together with all documentary evidence has been delivered by argument to the individual members of the Panel and has since been under study and consideration.

By appeal, Appellant-Defendants respectfully submitted:

1. The Single Commissioner erred in Finding of Fact No. 5 by finding that on March 11, 2011 and numerous previous occasions the hand-scanning device did not work for the Claimant. This contradicts Findings of Fact No. 6 wherein the Single Commissioner notes that the hand scanner was working on March 11, 2011, thus this finding appears to be in error and confuses the issues in the claim.

2. The Single Commissioner erred in Finding of Fact No. 6 by finding as follows: "Since the claimant knew the scanner was not working on the morning of March 18, 2011 she did not clock in and out. As a result the claimant was paid for the hours she went to the doctor. She had always previously been paid when the scanner was broken and the claimant was required to clock in and out using the manual form. In fact, on March 11, 2011 the claimant was paid her normal hours although she did not clock out in order to go to Doctors Care, even though the hand-scanner was working that day." This finding is not supported by the reliable, probative, and substantial evidence in the record. The Claimants injury occurred on March 11, 2011, there is insufficient period or pattern to support a finding that the Claimant was "always" paid for missed time for medical visits and further ignores the fact that the claimant was still required to clock in and out for medical visits, be it by scanner or manual form, and failed to do so on March 18, 2011.

3. The Single Commissioner erred in Finding of Fact No. 7 by finding that the claimant was working outside her work restrictions. This finding in in disregard of the evidence that appropriate light duty work had been provided for the claimant.

4. The Single Commissioner erred in Finding of Fact No. 8 by finding that it was the claimants "clear understanding" based upon the acts and information given to her by the employer that led the claimant to believe she was to be paid for time missed from work for her medical appointments. This finding is not supported by the reliable, probative, and substantial evidence in the record.

5. The Single Commissioner erred in Finding of Fact No. 12 by finding the claimant to be a credible witness and that but for the malfunctioning hand-scanner the claimant

would have clocked out, thereby not having to use the missed time form that the employer used as an excuse for terminating [the claimant]. The finding that the claimant would have clocked out had the scanner been working contradicts the previous finding that the claimant believed that she did not have to clock out. With such conflicting information given by the claimant, she cannot be found credible in her testimony in this regard.

6. The Single Commissioner erred in Finding of Fact No. 13 by finding that in the past when the hand scanner was working, the claimant would clock into work, out for lunch, and back to work. If the hand scanner had been working on March 18, 2011 the claimant would not have been terminated. This finding is contrary to other findings that the claimant thought she was to be paid for the time missed for medical appointments. Further, this finding is based on speculation due to the claimants lunchtime practices that have nothing to do with medical appointments, workers' compensation procedures, or other instances more closely related to the circumstances at issue.
7. The Single Commissioner erred in Finding of Fact No. 14 by finding that the "it was obvious [the claimant] was not trying to falsify records, deceived the employer, or hide anything else" because the employer knew the claimant was at the doctor for an appointment for an admitted work related injury. This finding is not supported by the reliable, probative, and substantial evidence in the record.
8. The Single Commissioner erred in Finding of Fact No. 15 by finding that the claimant is temporarily totally disabled and is entitled to benefits for March 24, 2011 to the present and continuing. This finding is not supported by the reliable, probative, and

substantial evidence in the record. The claimant was terminated for cause while she was working full duty, thus the claimant should not be entitled to TTD.

9. The Single Commissioner erred in Conclusion of Law No. 4 by concluding that the claimant is entitled to temporary total disability benefits from March 24, 2011 to the present and continuing. This conclusion is not supported by the reliable, probative, and substantial evidence in the record.

10. The Single Commissioner erred in Conclusion of Law No. 5 by concluding that the claimant has met her burden of proof in establishing her claims by a preponderance of the evidence. This conclusion is not supported by the reliable, probative, and substantial evidence in the record.

11. The Single Commissioner erred in Conclusion of Law No. 9 by concluding that under 42-9-10 the claimant is entitled to receive compensation from the defendants for her period of temporary total disability resulting from her March 11, 2011 accident from March 24, 2011 until the present and continuing. This conclusion is not supported by the reliable, probative, and substantial evidence in the record.

12. The Single Commissioner erred in ordering that the claimant is entitled to receive temporary total disability compensation from March 24, 2011 to the present and continuing. This award is not supported by the reliable, probative, and substantial evidence in the record.

13. The Single Commissioner erred in failing to find that the claimant had been terminated for cause and therefore is not entitled to temporary total disability benefits.

By appeal, Appellant-Claimant respectfully submitted:

1. Did the Commissioner err in finding as fact that the Claimants compensation rate is $671.58 with an average weekly wage of $1,007.32, error being that such finding is against the preponderance of evidence on the record, is grounded in speculation, and is based upon erroneous legal conclusions?
2. Did the compensation Commissioner err in finding as a matter of law that the Claimants compensation rate is $671.58 with an average weekly wage of $1,007.32, error being that such finding is against the preponderance of evidence on the record, is grounded in speculation, and is based upon erroneous legal conclusions?

In an Appellate Review, the Commission has the power to weigh the evidence as presented at the initial hearing and, after careful review in the instant case, the Commission by unanimous vote, has determined that the Hearing Commissioners Findings of Fact and Rulings of Law should be Affirmed in Full. The Panel affirms the decision of the Single Commissioner.

ORDER

The Order of the Single Commissioner filed in the above titled matter on September 28, 2011, is hereby affirmed by the panel and the same shall constitute the Decision and Order of the Appellate Panel.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Commissioner Andrea C. Roche

Commissioner T. Scott Beck

Commissioner Avery B. Wilkerson Jr.

Date: 5/23/2012

CERTIFICATE OF SERVICE

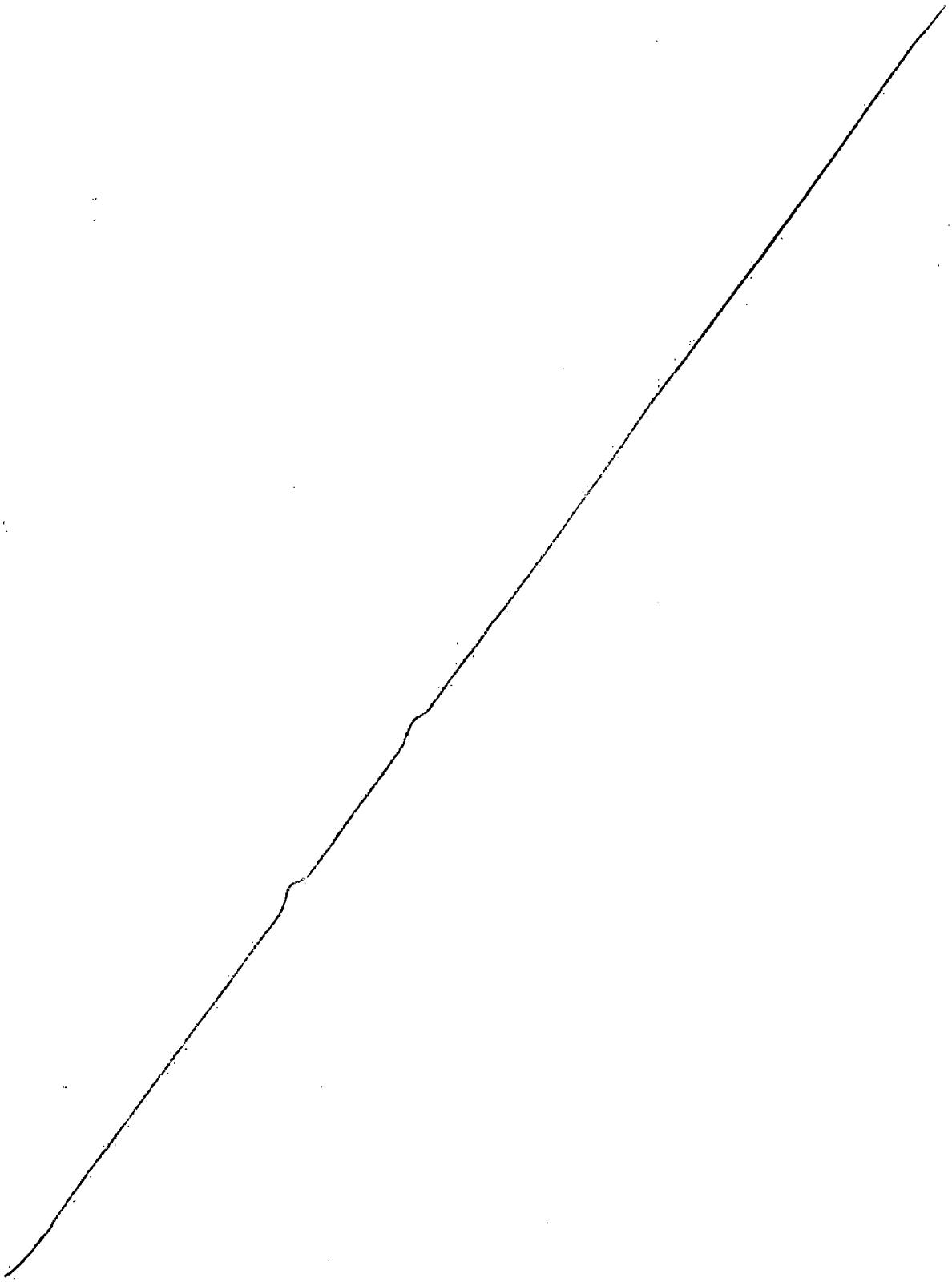
This is to certify that the undersigned has this date served this order in the above entitled action upon all parties in this cause by depositing a copy hereof, postage paid, in the United State mail addressed to the attorney or attorneys for said parties

This 23 day of May 2012

By [illegible]

Administrative Assistant to the Commissioner

Mark K McCrary
R Daniel Aldridge



South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723
www.wcc.sc.gov

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: Gayla Ramey SSN: - -
Address: [redacted]
City: [redacted] State: [redacted] Zip: [redacted]
Home Phone: ( ) - Work Phone: ( ) -

Employer's Name: Unity Healthpost Acute Care Tanglewood
Address: 213 Tanglewood Court
City: Ridgeway State: SC Zip: 29130
Insurance Carrier: American Zurich Ins. Co.)
Preparer's Name: Mark R. Calhoun Law Firm: Calhoun Law Firm Preparer's Phone #: 803 957-8401

Complete each information blank. To request a hearing, check Box 13b, indicate the kinds of benefits claimed by checking the box(es) at Lines 6, 7, 8, and 9, and file this form in duplicate.

A claim for workers' compensation benefits is made based on the following grounds: Date of Injury or Illness: 3-11-11

☒ Injury ☐ Illness ☐ Repetitive Trauma Back, Rt. Arm (Part(s) of Body Injured) on 3-11-11 (Month/Day/Year) in Fairfield county, state of South Carolina.

1a. The claimant sustained an injury to _____
1b. Body part(s) affected are: Back, Rt. Arm
Briefly describe how the accident occurred. Claimant fell down Stairs.

2. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.

3. The relationship of employer and employee existed at the time of injury.

4. At the time of the injury the claimant was performing services arising out of and in the course of employment.

5. Notice of the accidental injury was given to the Employer on 3-11-11 (Month/Day/Year) in the following manner:
Verbally

☒ 6. Due to injury, the claimant is in need of (check one):
☐ (a) medical examination and treatment for: ____
☒ (b) additional medical examination and treatment for: Pain and Discomfort.

☒ 7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:
3-11-11 through an undetermined period of time.

☒ 8. Due to the injury, the Claimant has permanent disability of the following nature and extent (check one):
☒ (1) General Disability: ☒ Total ☐ Partial ☒ (2) Specific Disability: ☒ Total ☒ Partial
☒ (3) Wage Loss

☐ 9. Due to the injury, the Claimant has a serious bodily disfigurement consisting of:

10a. At the time of the injury, the Claimant was paid weekly wages of $ 1100.00 and demands accounting of days worked and wages earned as provided by law.

10b. Give names and addresses of all employers for whom the Claimant has worked since the date of the accident:
Unity Healthpost Acute Care

11a. Further grounds or unusual aspects of claim:
Claimant requests all benefits under the Act.

11b. List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident:
Doctors Care.

11c. To the best of your knowledge, did you have any prior permanent disability? no
If yes, describe: ____

12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.

☐ 13a. **I am filing a claim. I am not requesting a hearing at this time.**

☒ 13b. **I am requesting a hearing. A $25 fee is required.**

14. Estimated time needed for hearing: One hour

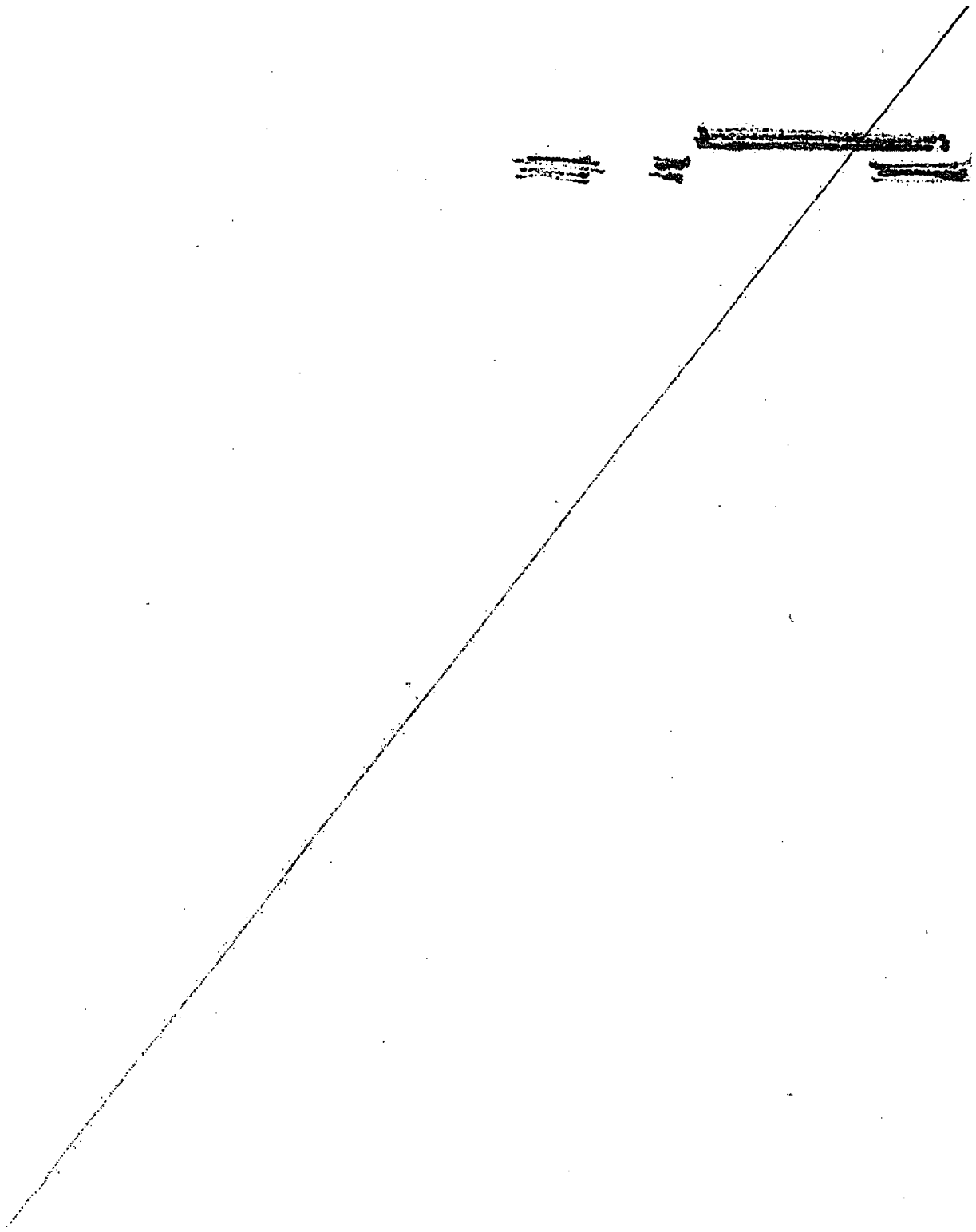
I verify the contents of this form are accurate and true to the best of my knowledge.

Mark Calhoun — Preparer's Signature
Attorney — Title
mrcalhounlaw@earthlink.net — Email
12-5-11 — Date

Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Claims Department.

WCC Form # 50
Revised 9/07

Employee's Notice of Claim and/or Request for Hearing



South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723
www.wcc.sc.gov

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: Gayla Ramey SSN: ___-___-____
Address: [redacted]
City: [redacted] State: [redacted]
Home Phone: ( ) - Work Phone: ( ) -

Employer's Name: Unity Healthpost Acute Care Tanglewood
Address: 213 Tanglewood Court
City: Ridgeway State: SC Zip: 29130
Insurance Carrier: American Zurich Ins. Co.)

Preparer's Name: Mark R. Calhoun Law Firm: Calhoun Law Firm Preparer's Phone #: 803 957-8401

Complete each information blank. To request a hearing, check Box 13b, indicate the kinds of benefits claimed by checking the box(es) at Lines 6, 7, 8, and 9, and file this form in duplicate.

A claim for workers' compensation benefits is made based on the following grounds: **Date of Injury or Illness:** 3-11-11

☒ Injury ☐ Illness ☐ Repetitive Trauma

1a. The claimant sustained an injury to Back, Rt. Arm (Part(s) of Body Injured) on 3-11-11 (Month/Day/Year) in Fairfield county, state of South Carolina.

1b. Body part(s) affected are: Back, Rt. Arm

Briefly describe how the accident occurred. Claimant Fell down Stairs.

2. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.

3. The relationship of employer and employee existed at the time of injury.

4. At the time of the injury the claimant was performing services arising out of and in the course of employment.

5. Notice of the accidental injury was given to the Employer on 3-11-11 (Month/Day/Year) in the following manner:
Verbally

☒ 6. Due to injury, the claimant is in need of (check one):
☐ (a) medical examination and treatment for: ____
☒ (b) additional medical examination and treatment for: Pain and Discomfort.

☒ 7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:
3-11-11 through an undetermined period of time.

☒ 8. Due to the injury, the Claimant has permanent disability of the following nature and extent (check one):
☒ (1) General Disability: ☒ Total ☐ Partial
☐ (2) Specific Disability: ☒ Total ☐ Partial
☒ (3) Wage Loss

☐ 9. Due to the injury, the Claimant has a serious bodily disfigurement consisting of:
____

10a. At the time of the injury, the Claimant was paid weekly wages of $ 1100.00 and demands accounting of days worked and wages earned as provided by law.

10b. Give names and addresses of all employers for whom the Claimant has worked since the date of the accident:
Unity Healthpost Acute Care

11a. Further grounds or unusual aspects of claim:
Claimant requests all benefits under the Act.

11b. List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident:
Doctors Care

11c. To the best of your knowledge, did you have any prior permanent disability? no
If yes, describe: ____

12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.

☐ 13a. **I am filing a claim. I am not requesting a hearing at this time.**

☒ 13b. **I am requesting a hearing. A $25 fee is required.**

14. Estimated time needed for hearing: One hour

I verify the contents of this form are accurate and true to the best of my knowledge.

Mark Calhoun — Preparer's Signature
Attorney — Title
mrcalhounlaw@earthlink.net — Email
12-5-11 — Date

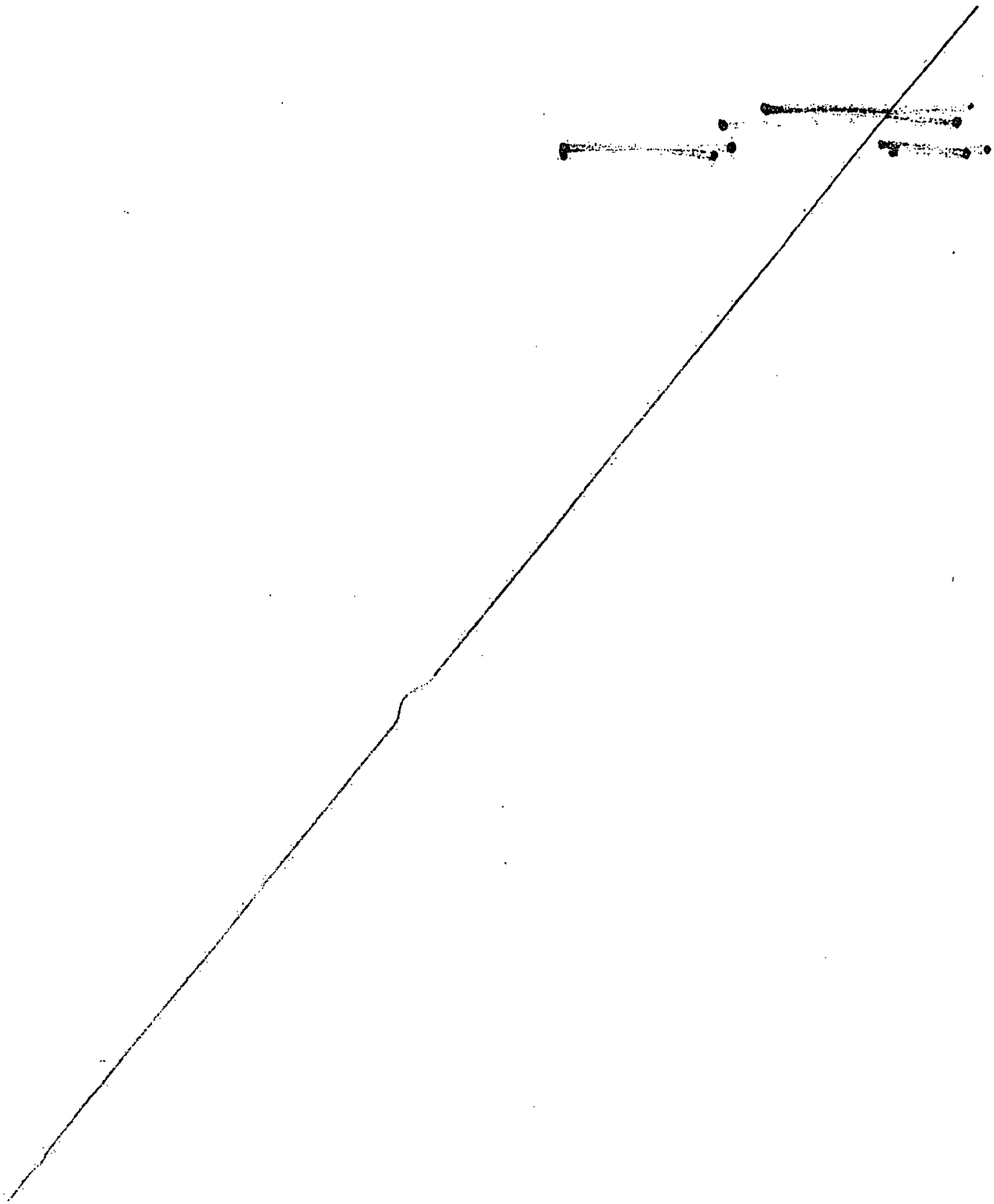
Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Claims Department.

WCC Form # 50
Revised 9/07

50

Employee's Notice of Claim and/or Request for Hearing

APP - 099



South Carolina Workers' Compensation .mission
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Columbia, South Carolina 29202-1715
(803) 737-5700
www.wcc.sc.gov

WCC . No.: 1103618
Carrier File #: 6817 498 209762 3
Carrier Code #:
Employer FEIN #:

Claimant's Name:	Gayla Ramey [redacted]	Employer's Name:	Unihealth Post Acute Care Tanglewood
Address:	[redacted]	Address:	213 Tanglewood Court
City:	[redacted] State: [redacted] Zip: [redacted]	City:	Ridgeway State SC ZIP 29130
Home Phone:	[redacted] Work Phone	Insurance Carrier:	American Zurich Ins. Co.
Date of Injury:	March 11, 2011		
Preparer's Name:	R. Daniel Addison	Law Firm: Hedrick, Gardner, Kincheloe & Garofalo, L.L.P.	Preparer's Phone #: (803) 727-1200

Date of Injury or Illness: **March 11, 2011**

Complete each information blank. Specify clearly when contentions are admitted in part and denied in part. The employer/carrier in answer to the claim, respectfully shows:

1. It is admitted the employee sustained an injury or illness on or about the date set forth in the Form 50. The reasons for denial are:
Defendants admit claimant sustained a minor injury to her right arm and upper back.

2. It is admitted both the employer and employee were subject to the Workers' Compensation Act at the time in question. The reasons for denial are:

3. It is admitted the relationship of employer and employee existed at the time in question. The reasons for denial are:

4. It is admitted at the time in question the employee was performing services arising out of and in the course of employment. The reasons for denial are:

5. It is admitted notice of injury was given the employer. The reasons for denial are:

6. It is denied the employee needs / is entitled to additional medical care as a result of injury or illness. The reasons for denial are:
Defendants have provided the claimant all medical treatment to which she is entitled.

7. It is denied the employee is entitled to temporary total disability for the period(s) of :
The claimant is not entitled to any indemnity benefits. Defendants accommodated the claimant's light duty restrictions. The claimant unjustifiably refused suitable employment in violation of S.C. Code 42-9-190.

8. It is denied the employee is permanently disabled. The reasons for denial are:
No facts to substantiate.

9. It is denied the employee has serious disfigurement.

10. It is contended that an average weekly wage of $ TBD by Form 20 applies, according to attached Form 20 as provided by law.

11. Further contentions, grounds of defense, or unusual aspects are: The defendants are not aware of any affirmative defenses. However, if further discovery reveals the basis for any affirmative defenses, the defendants will amend this answer to assert those defenses.

12. Estimated time needed for hearing: 45 minutes

I certify I have served this document pursuant to R.67-212 by delivering a copy to:

Name: Mark R. Calhoun, Mark R. Calhoun, Attorney At Law

Address: 714 East Main Street,Lexington, SC, 29072

On the 29th day of April, 2011 by ☒ first class mail ☐ personal service ☐ certified mail.

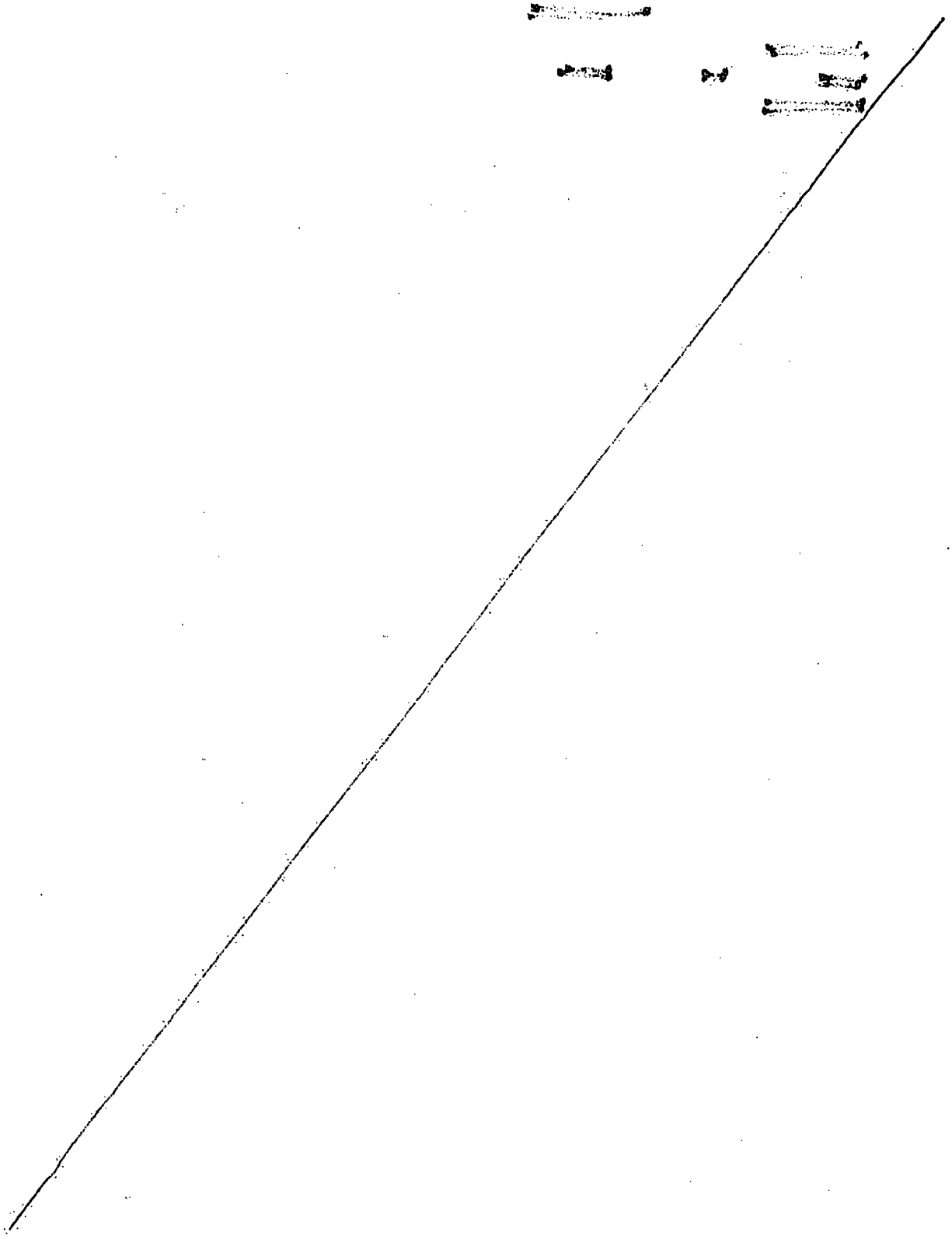
I verify the contents of this Form are accurate and true to the best of my knowledge.

Preparer's Signature: Dewana F Rogers for Dan Addison Attorney
Title

daddison@hedrickgardner.com
Email

April 29, 2011
Date

Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Judicial Department. Pursuant to R.67-606, a Form 20 must be filed with the Claims Department at least 30 days from the date of filing this form.



South Carolina Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5739
www.wcc.sc.gov

PRE-HEARING BRIEF
WCC File No: 1103442

Claimant's Name: Gayla Ramey
Address: [redacted]
City: [redacted] State: SC Zip: [redacted]
Home Phone: Work Phone: ( ) -
Preparer's Name: Mark R. Calhoun

Employer's Name: Unihealth Post -Acute Care Tanglewood
Address: 213 Tanglewood Court
City: Ridgeway State: SC Zip: 29130
Carrier: American Zurich Insurance Co.
Preparer's Phone #: (803) 957-8401

A claim for workers' compensation benefits is made based on the following grounds:

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: to be determined 2. AWW: to be determined **Date of Injury:** 03/11/2011
3. Type of injury and body part(s): Back, Right Arm.
4. Facts in controversy: See Addendum.
5. Legal issues involved:
   a) Is Claimant at MMI? (We say she is not).
   b) Past due TTD.
   c) Whether claimant is entitled to Dodge v. Bruccolli medicals? (We say she is).
   d) Determine Comp. Rate.
   e) Claimant requests that Dr. Timothy Zgleszewski be appointed the Claimants Authorized Treating Physician for future medical treatment.
6. Unusual aspects: None.
7. Witnesses (designate if expert):* Gayla Ramey, Linda Burr and any witnesses listed on behalf of the Employer.
8. Exhibits: 1) Deposition Transcript of Linda Burr scheduled for August 3, 2011.
   2) Claimants Wage Records were subpoenaed on April 6, 2011. At this time the wage records have not been provided by the Employer (Subpoena Enclosed).
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance):
   Medical Records will be submitted pursuant to R.67-612 and the APA.
10. Name, address, and specialty, if any, of the treating physician: Doctors Care, Dr. Michael Killian- 4214 Hardscrabble Road Columbia, SC 29223.
11. Impairment rating(s); body part(s); physician and date of opinion: The Claimant is not at MMI. See enclosed report of Dr. Zgleszewski
12. I am amending my Form 50/51 in the following manner: None

I verify the contents of this form are accurate and true to the best of my knowledge.

Signature:
Email: mrcalhounlaw@earthlink.net
Date of hearing: August 10, 2011 at 11:45 AM
Time needed for hearing: 1: 00 hours

On behalf of ☒ Claimant ☐ Employer

le this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports.
Commissioners reserve the right to admit expert witnesses at hearings.

WCC Form # 58
Rev. 9/07

58

PRE-HEARING BRIEF

ADDENDUM

The Claimant was injured on March 11, 2011 when she fell on steps entering her place of employment. Mrs. Ramey has been employed as a nurse with the Employer for approximately 9 years. Prior to her injury she had never suffered any problems or symptoms related to her lower, mid or upper spine (APA of Family Practice Dr. Alice Brooks p. 1-108). She is married with 4 grown children. 2 of these grown children currently live with Mrs. Ramey and her husband along with her grandchildren. She and her husband support all of these individuals. When the Claimant fell she landed on her right side and right arm. The most immediately painful injury was to her right arm of which she informed her supervisor. She was quickly taken to Doctors Care whom she also informed of her right arm and quickly developing back pain. After Mrs. Ramey's back pain increased, she informed her supervisors of this also.

When the Claimant was seen on the same date of injury at Doctors Care, she was diagnosed with contusions, right arm pain and back pain (APA p.109). She was immediately given work restrictions of no lifting more than 10 pounds, ground work only, no repetitive bending, stooping, squatting, pushing, jerking, twisting or bouncing, no standing more than 30 minutes per hour, limited use of back, no overhead lifting, no repetitive hand activity and no use of the right arm. She was given pain and anti-inflammatory pain medication by Doctors Care. The Claimant was diagnosed with neck pain and spondylolisthesis and an MRI of the cervical spine was ordered. On April 8, 2011 she was referred for evaluation by an orthopedic back specialist (APA p.125-126).

The Claimant was never seen by an orthopedic specialist as referred by Doctors Care because shortly after the referral the Employer fired her. The reason for the termination as explained to the Claimant was that she signed her timesheet indicating she should get paid for the period of time that she was at Doctors Care receiving treatment on her Workers Compensation claim. The Employer explained to Mrs. Ramey that she is not entitled to be paid for the time she is receiving medical treatment on her workers' compensation claim and likewise terminated her under the allegation that she falsified her timesheet. Once Mrs. Ramey was terminated the Employer ended her medical treatment.

Mrs. Ramey was evaluated by an orthopedic spine specialist on July 19, 2011. Dr. Timothy Zgleszewski states to a reasonable degree of medical certainty that the Claimants industrial injuries are causally related to her fall on March 11,

2011. That Mrs. Ramey is not at MMI and recommends a course of treatment in order to lessen her period of disability (APA p.130-134). Dr. Zgleszewski is willing to provide this treatment to the Claimant and the Claimant respectfully submits that the Court appoint Dr. Zgleszewski as the authorized treating physician.

6

South Carolina Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5739
www.wcc.sc.gov

PRE-HEARING BRIEF
WCC File No: 1103442

Claimant's Name: Gayla Ramey

Address: [redacted]

City: [redacted] State: [redacted]

Home Phone: Work Phone: ( )

Preparer's Name: Mark R. Calhoun

Employer's Name: Unihealth Post -Acute Care Tanglewood

Address: 213 Tanglewood Court

City: Ridgeway State: SC Zip: 29130

Carrier: American Zurich Insurance Co.

Preparer's Phone #: (803) 957-8401

A claim for workers' compensation benefits is made based on the following grounds:

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: to be determined 2. AWW: to be determined **Date of Injury:** 03/11/2011

3. Type of injury and body part(s): Back, Right Arm.

4. Facts in controversy: See Addendum.

5. Legal issues involved:
   a) Is Claimant at MMI? (We say she is not).
   b) Past due TTD.
   c) Whether claimant is entitled to Dodge v. Bruccolli medicals? (We say she is).
   d) Determine Comp. Rate.
   e) Claimant requests that Dr. Timothy Zgleszewski be appointed the Claimants Authorized Treating Physician for future medical treatment.

6. Unusual aspects: None.

7. Witnesses (designate if expert):* Gayla Ramey, Linda Burr and any witnesses listed on behalf of the Employer.

8. Exhibits:
   1) Deposition Transcript of Linda Burr scheduled for August 3, 2011.
   2) Claimants Wage Records were subpoenaed on April 6, 2011. At this time the wage records have not been provided by the Employer (Subpoena Enclosed).

9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance):
   Medical Records will be submitted pursuant to R.67-612 and the APA.

10. Name, address, and specialty, if any, of the treating physician: Doctors Care, Dr. Michael Killian- 4214 Hardscrabble Road Columbia, SC 29223.

11. Impairment rating(s); body part(s); physician and date of opinion: The Claimant is not at MMI. See enclosed report of Dr. Zgleszewski

12. I am amending my Form 50/51 in the following manner: None

I verify the contents of this form are accurate and true to the best of my knowledge.

Signature: MRC

Email: mrcalhounlaw@earthlink.net

Date of hearing: August 10, 2011 at 11:45 AM

Time needed for hearing: 1: 00 hours

On behalf of ☒ Claimant ☐ Employer

File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports.
* Commissioners reserve the right to admit expert witnesses at hearings.

WCC Form # 58
Rev. 9/07

58

PRE-HEARING BRIEF

ADDENDUM

The Claimant was injured on March 11, 2011 when she fell on steps entering her place of employment. Mrs. Ramey has been employed as a nurse with the Employer for approximately 9 years. Prior to her injury she had never suffered any problems or symptoms related to her lower, mid or upper spine (APA of Family Practice Dr. Alice Brooks p. 1-108). She is married with 4 grown children. 2 of these grown children currently live with Mrs. Ramey and her husband along with her grandchildren. She and her husband support all of these individuals. When the Claimant fell she landed on her right side and right arm. The most immediately painful injury was to her right arm of which she informed her supervisor. She was quickly taken to Doctors Care whom she also informed of her right arm and quickly developing back pain. After Mrs. Ramey's back pain increased, she informed her supervisors of this also.

When the Claimant was seen on the same date of injury at Doctors Care, she was diagnosed with contusions, right arm pain and back pain (APA p.109). She was immediately given work restrictions of no lifting more than 10 pounds, ground work only, no repetitive bending, stooping, squatting, pushing, jerking, twisting or bouncing, no standing more than 30 minutes per hour, limited use of back, no overhead lifting, no repetitive hand activity and no use of the right arm. She was given pain and anti-inflammatory pain medication by Doctors Care. The Claimant was diagnosed with neck pain and spondylolisthesis and an MRI of the cervical spine was ordered. On April 8, 2011 she was referred for evaluation by an orthopedic back specialist (APA p.125-126).

The Claimant was never seen by an orthopedic specialist as referred by Doctors Care because shortly after the referral the Employer fired her. The reason for the termination as explained to the Claimant was that she signed her timesheet indicating she should get paid for the period of time that she was at Doctors Care receiving treatment on her Workers Compensation claim. The Employer explained to Mrs. Ramey that she is not entitled to be paid for the time she is receiving medical treatment on her workers' compensation claim and likewise terminated her under the allegation that she falsified her timesheet. Once Mrs. Ramey was terminated the Employer ended her medical treatment.

Mrs. Ramey was evaluated by an orthopedic spine specialist on July 19, 2011. Dr. Timothy Zgleszewski states to a reasonable degree of medical certainty that the Claimants industrial injuries are causally related to her fall on March 11,

2011. That Mrs. Ramey is not at MMI and recommends a course of treatment in order to lessen her period of disability (APA p.130-134). Dr. Zgleszewski is willing to provide this treatment to the Claimant and the Claimant respectfully submits that the Court appoint Dr. Zgleszewski as the authorized treating physician.

The deposition of Linda Burr was taken on August 5, 2011. Ms. Burr's testimony clearly demonstrates that firing of the Claimant was a pre-textual termination. Ms. Burr testified that the Claimant reported her injured arm and back the day of the accident (Deposition transcript page 8, lines 12-14). Ms. Burr also testified that she could not remember any prior disciplinary problems for Ms. Gayla Ramey (Deposition transcript page 9, lines 1-15). Ms. Burr also testified the Claimant never complained of any prior back problems before during the 9 years that Ms. Burr worked with Gayla Ramey (Deposition transcript page 12, lines 2-4).

Linda Burr terminated the Claimant. Ms. Burr explained that the reason she terminated the Claimant was that the punch clock was not working the day Gayla Ramey went to authorized medical treatment on March 18, 2011 therefore Mrs. Ramey was required to fill in a time sheet stating what time she worked on that day. Mrs. Ramey filled in her normally scheduled hours which were 7am to 10:30am that morning. Even though Mrs. Ramey informed her Employer that she was at the doctor's office from approximately 8:25am to 9:21am, she was terminated because Ms. Burr claims that employees are not to be paid for loss time spent receiving medical treatment on their workers compensation claims (deposition transcript page 14 lines 1-18; pg 15 lines 1-5; page 15 lines 6-13). This was done even though Mrs. Ramey's written request to correct the punch clock was approved by supervisors Karri Ray and Tonya Shepard (Deposition transcript page 18, lines 6-23).

For the Claimants average weekly wage and compensation rate, the wage records provided on August 2, 2011 state that the Claimant earned a total of $57,156.93 for the 52 weeks preceding the date of injury. This gives a corresponding compensation rate of $1,099.17.

$732.04

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5700
www.wcc.sc.gov

PRE-HEARING BRIEF
WCC File No.: 1103442

Claimant's Name:	Gayla Ramey	Employer's Name:	Unihealth Post Acute Care Tanglewood
Address:	[redacted]	Address:	213 Tanglewood Court
City:	[redacted]	City:	Ridgeway State SC ZIP 29130
Home Phone:	([redacted]) Work Phone	Carrier:	American Zurich Ins. Co.
Preparer's Name:	R. Daniel Addison	Preparer's Phone #:	(803) 727-1200

A claim for workers' compensation benefits is made based on the following grounds:
☒Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: To be determined 2. AWW: $To be determined **Date of Injury:** March 11, 2011
3. Type of injury and body part(s) Minor injury to right arm and upper back.
4. Facts in controversy: What is the extent of the injuries causally related to the accident? Is the claimant at maximum medical improvement for those injuries causally related to the accident? Is the claimant entitled to temporary disability benefits although she was terminated for cause? To what further benefits is the claimant entitled?
5. Legal issues involved Same as above; §42-15-60; §42-9-190.
6. Unusual aspects: None anticipated.
7. Witnesses (designate if expert)* The claimant; anyone named by the claimant; Lynda Burr; William Bellotti.
8. Exhibits: Personnel records of the employer regarding the claimant; deposition of claimant; deposition of Lynda Burr.
9. Medical evidence: (Indicate report pursuant to R.67-612; deposition or appearance pursuant to the APA and R 67-612") None other than those submitted by claimant.
10. Name, address, and specialty, if any, of the treating physician: Doctors Care – Ridgeview - Columbia, SC – general medicine.
11. Impairment rating(s); body part(s); physician and date of opinion: N/A.
12. I am amending my Form 50/51 in the following manner N/A.

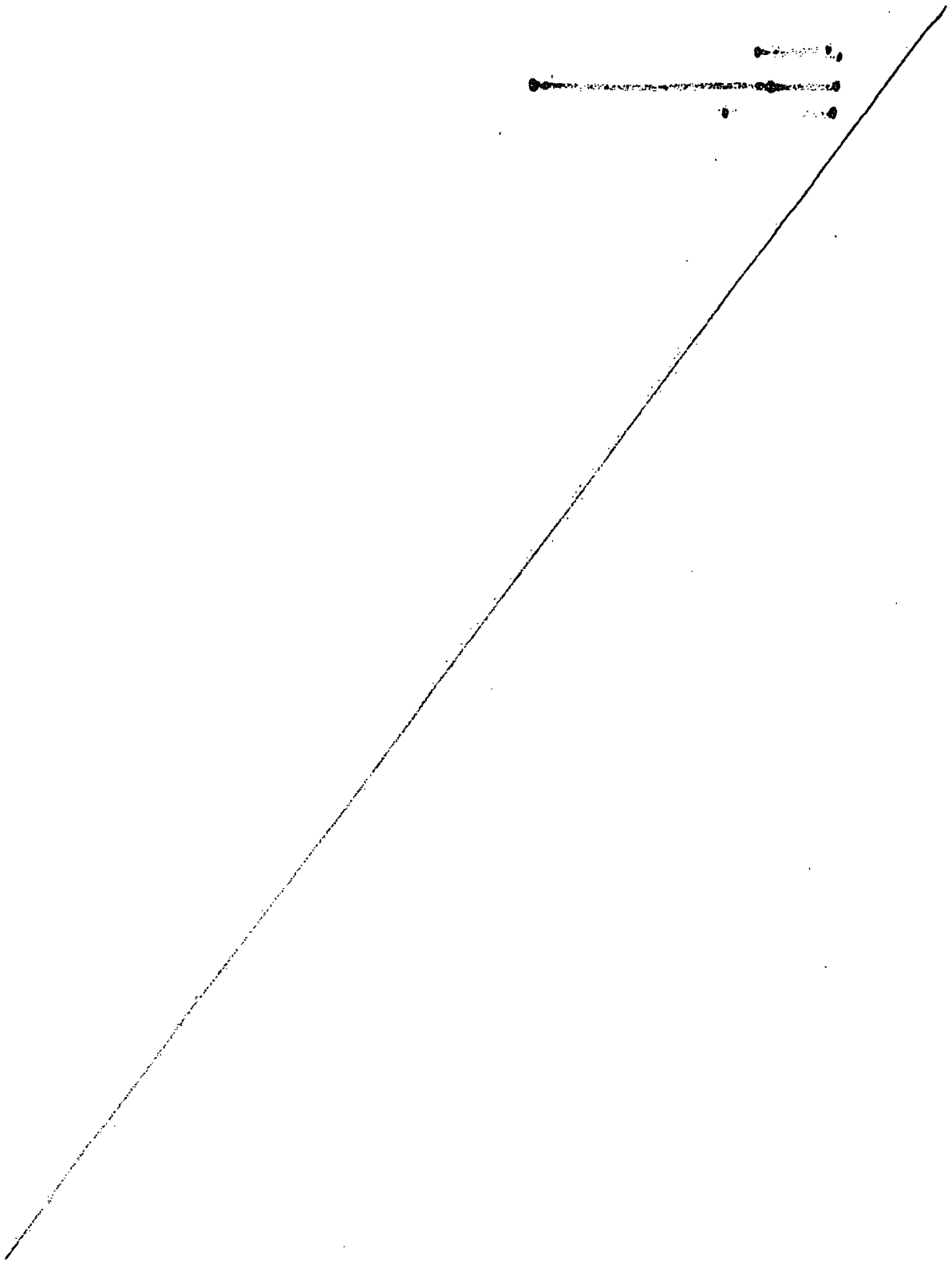
I verify the contents of this Form are accurate and true to the best of my knowledge.

Signature: [signature] Email: daddison@hedrickgardner.com

Date of Hearing August 10, 2011 Time needed for hearing: 1 hour

On behalf of ☐ Claimant ☒Employer

File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports.
* Commissioners reserve the right to admit expert witnesses at hearings.



South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1333 Main Street, Suite 500
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 1103442
Carrier File # 6817 498 209762 3
Carrier Code #
Employer FEIN

Gayla Ramey [redacted] SSN
Claimant's Name

[redacted]
Address City State Zip

[redacted]
Home Phone Work Phone

Unihealth Post Acute Care Tanglewood
Employer's Name

213 Tanglewood Court, Ridgeway, SC 29130
Address City State Zip

American Zurich Ins. Co.
Insurance Carrier

R. Daniel Addison (803) 727-1200
Preparer's Name Phone #

Request for Commission Review by ☐claimant ☒employer (check one) Date of injury: March 11, 2011

The undersigned makes application for review of the findings of the Commissioner in the above captioned case. The request for review is based on the following grounds: (State the grounds of your appeal in the form of questions presented. Each question presented must contain a concise statement of one proposition of law or fact. Refer to evidence by title and exhibit number. Use additional pages, if necessary).

SEE ATTACHED GROUNDS FOR REVIEW.

(Check one) Oral argument ☒ is ☐ is not requested. Appellant's request for oral argument is waived if not indicated on this form.

I certify that ____ I have served this document pursuant to R.67-211 by delivering a copy to Mark R. Calhoun
Name

714 East Main Street, Lexington, SC 29072
Address

on the 12th day of October, 2011 by ☒ first class mail; ☐ personal service; ☐ certified mail.

R. Daniel Addison
Preparer's Signature

Attorney for Employer/Carrier
Title

October 12, 2011
Date

Check this box if you are not represented by an attorney. ☐

If the claimant appeals and is representing himself or herself, the Judicial Department will prepare the additional copies of this form and serve this form on the opposing party. R.67-701 B. Otherwise, file the original and 4 copies of this form with the Judicial Department. The appeal must be postmarked no later than 14 days from the date of service of the Hearing Commissioner's decision. R.67-701 and R.67-205. Attach the filing fee to this form. Attach a Form 32 if you are unable to pay the filing fee. Refer to R.67-701 through R.67-711 for additional information.

GROUNDS FOR REVIEW

1. The Single Comissioner erred in Finding of Fact No. 5 by finding that on *March 11, 2011* and numerous previous occasions the hand-scanning device did not work for the claimant. This contradicts Finding of Fact No. 6 wherein the Single Commissioner notes that the hand scanner was working on March 11, 2011, thus this finding appears to be in error and confuses the issues in the claim.

2. The Single Commissioner erred in Finding of Fact No. 6 by finding as follows: "Since the claimant knew the scanner was not working on the morning of March 18, 2011 she did not clock in and out. As a result the claimant was paid for the hours she went to the doctor. She had always previously been paid when the scanner was broken and the claimant was required to clock in and out using the manual form. In Fact, on March 11, 2011 the claimant was paid her normal hours although she did not clock out in order to go to Doctor's Care, even though the hand scanner was working that day." This finding is not supported by the reliable, probative, and substantial evidence in the record. The claimant's injury occurred on March 11, 2011, there is insufficient period or pattern to support a finding that the claimant was "always" paid for missed time for medical visits and further ignores the fact that the claimant was still required to clock in and out for medical visits, be it by scanner or manual form, and failed to do so on March 18, 2011.

3. The Single Commissioner erred in Finding of Fact No. 7 by finding that the claimant was working outside her work restrictions. This finding is in disregard of the evidence that appropriate light duty work had been provided for the claimant.

4. The Single Commissioner erred in Finding of Fact No. 8 by finding that it was the claimant's "clear understanding" based upon the acts and information given to her by the employer that led the claimant to believe she was to be paid for time missed from work for her medical appointments. This finding is not supported by the reliable, probative, and substantial evidence in the record.

5. The Single Commissioner erred in Finding of Fact No. 12 by finding the claimant to be a credible witness and that but for the malfunctioning hand-scanner the claimant would have clocked out, thereby not having to use the missed time form that the employer used as an excuse for terminating [the claimant]. The finding that the claimant would have clocked out had the scanner been working contradicts the previous finding that the claimant believed that she did not have to clock out. With such conflicting information given by the claimant, she cannot be found credible in her testimony in this regard.

6. The Single Commissioner erred in Finding of Fact No. 13 by finding that in the past when the hand scanner was working, the claimant would clock into work, out for lunch, and back to work. If the hand scanner had been working on March 18, 2011 the claimant would not have been terminated. This finding is contrary to other findings that the claimant thought she was to be paid for the time missed for medical appointments. Further, this finding is based on speculation due to claimant's lunchtime practices that have nothing to do with medical appointments, workers' compensation procedures, or other instances more closely related to the circumstances at issue.

7. The Single Commissioner erred in Finding of Fact No. 14 by finding that the "it was obvious [the claimant] was not trying to falsify records, deceive the employer, or hide anything else" because the employer knew the claimant was at the doctor for an appointment for an admitted work related injury. This finding is not supported by the reliable, probative, and substantial evidence in the record.

8. The Single Commissioner erred in Finding of Fact No. 15 by finding that the claimant is temporarily totally disabled and is entitled to benefits for March 24, 2011 to the present and continuing. This finding is not supported by the reliable, probative, and substantial evidence in the record. The claimant was terminated for cause while she was working full duty, thus the claimant should not be entitled to TTD.

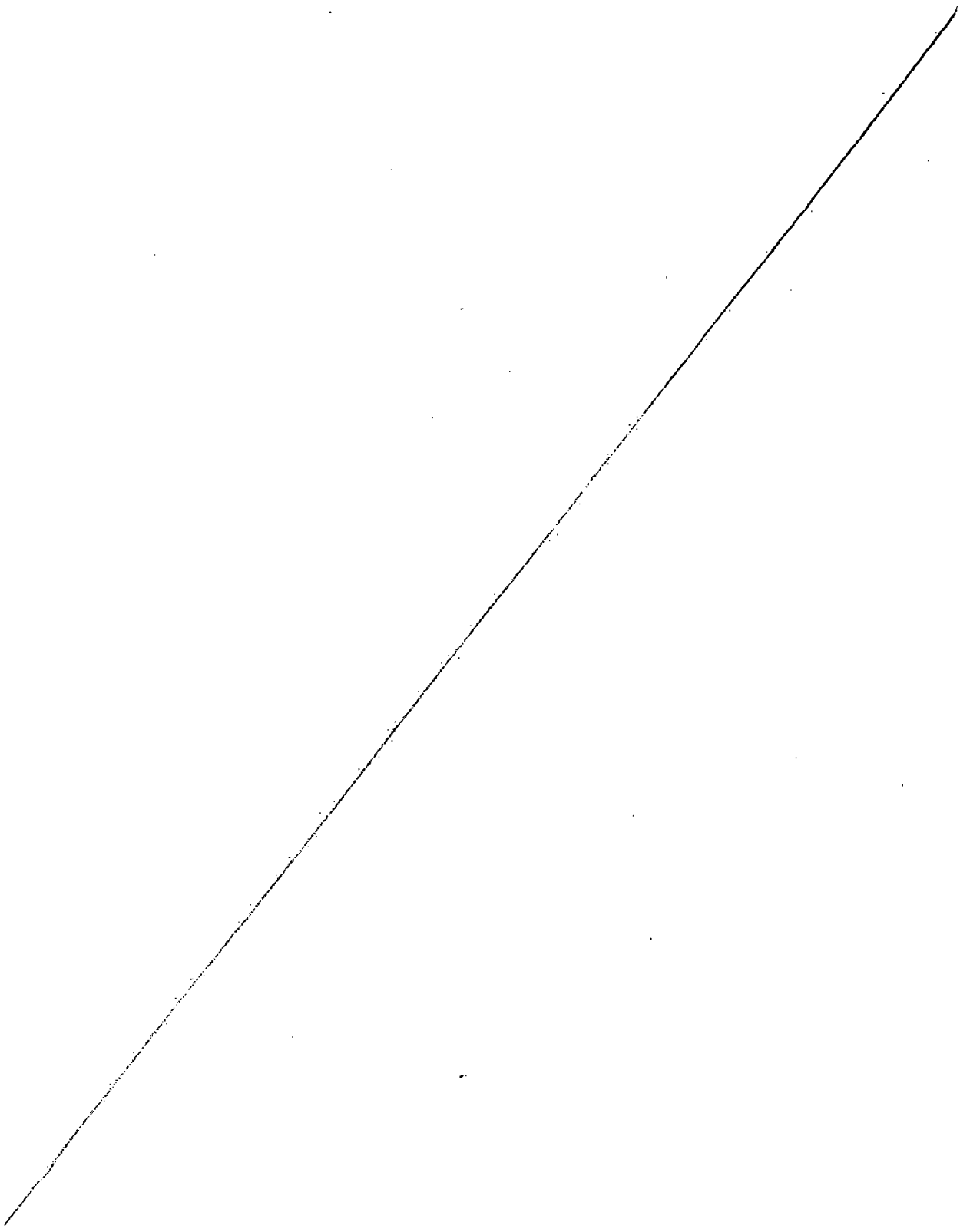
9. The Single Commissioner erred in Conclusion of Law No. 4 by concluding that the claimant is entitled to temporary total disability benefits from March 24, 2011 to the present and continuing. This conclusion is not supported by the reliable, probative, and substantial evidence in the record.

10. The Single Commissioner erred in Conclusion of Law No. 5 by concluding that the claimant has met her burden of proof in establishing her claims by a preponderance of the evidence. This conclusion is not supported by the reliable, probative, and substantial evidence in the record.

11. The Single Commissioner erred in Conclusion of Law No. 9 by concluding that under 42-9-10 the claimant is entitled to received compensation from the defendants for her period of temporary total disability resulting from her March 11, 2011 accident from March 24, 2011 until the present and continuing. This conclusion is not supported by the reliable, probative, and substantial evidence in the record.

12. The Single Commissioner erred in ordering that the claimant is entitled to receive temporary total disability compensation from March 24, 2011 to the present and continuing. This award is not supported by the reliable, probative, and substantial evidence in the record.

13. The Single Commissioner erred in failing to find that the claimant had been terminated for cause and therefore is not entitled to temporary total disability benefits.



BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
W.C.C. FILE No.: 1103442

Gayla Ramey, Claimant, vs. Unihealth Post-Acute Care Tanglewood, Employer, and American Zurich Insurance, Carrier, Defendants.	DEFENDANTS' BRIEF

STATEMENT OF THE CASE

This claim was heard before Commissioner G. Bryan Lyndon on August 10, 2011 in Columbia, South Carolina. Both parties and/or their representatives were present and evidence of the claim was presented. This claim arises out of an accident occurring on March 11, 2011 while the claimant was working for the defendant/employer.

The claimant was involved in a fall and landed on her right arm and buttocks. Therefore, the defendants have admitted the injuries to the low back and right arm. The defendants have provided treatment for the claimant; however, her most recent treatment and her ongoing recommendations are focused on her cervical spine and upper back. They assert that the claimant has had problems with her neck for which she has had treatment, including injections, prior to this accident. The defendants question the relationship of the claimant's neck and upper back symptoms to the accident. The defendants have agreed to send the claimant for evaluation by an orthopedist of their choosing and assert that the claimant should be limited to the treatment offered. The claimant requests that she be provided with treatment per the recommendations of

Dr. Zgleszewski in her IME. Because the defendants are providing treatment, the issue of additional or alternative treatment as requested by the claimant was held in abeyance.

The primary issue for determination at the hearing was whether or not the claimant is entitled to temporary total disability benefits from the date of her termination to the present and continuing. The claimant asserts that she is entitled to temporary disability compensation as her termination by the employer is not tantamount to refusal of suitable employment. The defendants, however, assert that the claimant is an RN and her job duties did not involve a great deal of lifting as her tasks were more managerial and clerical in nature, and thus the claimant was being fully accommodated in her restrictions until she was terminated for falsifying paperwork. The defendants note that Medicare is heavily involved with the running of the defendant/employer's facility and that as such there can be no falsification of records. In the incident in question, the claimant left work for a doctor's appointment, but failed to deduct that time from her pay that day. The defendant/employer terminated the claimant for this reason, which is a policy they assert has been enforced in the past and is not unique to the claimant.

The claimant also asserts that her average weekly wage and compensation rate have been incorrectly calculated. She takes the position that her pay for the 52-week period prior to her accident would result in an average weekly wage of $1,099.17, which yields a compensation rate at the maximum rate for 2011 of $704.92. It is the position of the defendants that the Form 20 Statement of Earnings was properly completed according to the terms of the Act and that the claimant's wages for the four quarters prior to the quarter in which the accident occurred show an average weekly wage of $1,007.32 and a resulting compensation rate of $671.58.

On September 28, 2011, Commissioner Lyndon issues an order finding that the claimant was entitled to temporary total disability benefits from March 24, 2011 to the present and continuing. It was found that the claimant was a credible witness and that he did not believe that

her failure to deduct the time for her medical appointment from her pay was done intentionally for the purpose of being deceitful, but was merely an error in procedure due to malfunction of the scanner that would typically be used to clock in and out. It was also found that the defendant/employer led the claimant to believe that she would be paid for the she was at her causally-related medical appointments. Commissioner Lyndon further found that the defendants had properly calculated the claimant's average weekly wage and compensation rate. He also found that the claimant had no previous problems with her spine and had only had treatment for trapezius muscle issues which have resolved.

On October 10, 2011, the claimant filed a Request for Commission Review (Form 30) of the decision and order of the Single Commissioner. The claimant appealed the Single Commissioner's finding and conclusion that the claimant's average weekly wage and compensation rate were correct per the Form 20 Statement of Earnings prepared by the defendant/employer. On October, 12, 2011, the defendants also filed a Request for Commission Review (Form 30) of the decision and order of the Single Commissioner. The defendants' application contained thirteen (13) exceptions to the decision and order of the Single Commissioner, these exceptions are incorporated herein by reference. In summary, the defendants take exception to the Single Commissioner's findings and conclusions regarding the circumstances of the claimant's termination, whether it was justified, and whether it is effective to bar the claimant from receiving temporary total disability benefits. The defendants also take exception to the Single Commissioner's finding that the claimant did not previously suffer from and receive treatment for neck and upper back problems similar to that for which she currently seeks treatment.

STATEMENT OF THE FACTS

At the hearing the claimant testified on her own behalf. She stated that she is 50 years old and that she completed her Associate's Degree to obtain her RN. She explained that she received a scholarship from the defendant/employer in 2008 to go to nursing school. She also noted that she has further educational background prior to obtaining her RN degree. The claimant asserted that her job as an RN with the defendant/employer involves administering treatment to residents and also includes activities like turning residents who are bedridden, assisting residents get in and out of beds and wheelchairs, and pushing wheelchairs to get residents from one part of the facility to another. She also stated that she did clerical duties such medical charting and working with residents' family doctors to coordinate their care needs.

The claimant asserted that prior to the work accident she never had any problems with her back. She noted in 2008 that she was treated for muscle spasms in her right shoulder. She stated that she was having a lot of stress at the time and was having muscle spasms in the right shoulder. The claimant testified that she went to the doctor and received some steroid injections in the muscle and the spasms did relax and the problem went away. The claimant asserted that her previous problems were muscular only and not in her spine.

On the date of the accident, the claimant stated that she was sent to Doctor's Care immediately following her fall. She testified that she had clocked-in that morning via hand-scanning device, but did not clock out when she was sent for treatment. She further stated that her understanding is that she was paid for her normal hours that day despite having to leave work to go to the doctor.

The claimant went on to testify that she was given work restrictions by the providers at Doctor's Care on that first visit. She stated that she was told not to spend more than 30 minutes per hour on her feet; to limit the use of her back; no use of her right arm; no lifting greater than

ten pounds; and no repetitive bending, twisting, stooping, squatting, or pushing. The claimant asserted that she continued working as normal and her restrictions were not accommodated. She asserted that she was required to walk all over the facility, do a great deal of paperwork, pull charts from overhead to file forms, and sometimes she had to push residents in wheelchairs. The claimant stated that she felt that the tasks she was doing were in violation of her restrictions, but that she was scared of losing her job.

The claimant testified regarding her March 18, 2011 appointment with Doctor's Care. The claimant stated that she had discussed her appointment previously with Lynda Burr, the facility Human Resources Director. She stated that she came in early that morning because she needed to see Ms. Burr about the appointment and knew that Ms. Burr was leaving early that day. The claimant stated that Ms. Burr was not at the facility by the time she had to leave to go to her appointment and she had to go ahead and leave without speaking to Ms. Burr.

The claimant asserted that she attempted to clock-out around 7:30 that morning using the hand scanner, but that the scanner would not work when she tried to use it. The claimant stated that she left without doing anything further to sign out because she needed to get to the appointment. She stated that she returned at 9:45 that morning, and was told to go home about 45 minutes later by her supervisor Tonya Shepherd because Ms. Shepherd wanted her to work the next two days. The claimant stated that when she returned from the doctor, she completed a Request for Missed Time form to note the time she missed that would not be reflected on the punch clock due to the scanner malfunction. She indicated on the form the time period of 7:00 a.m. to 10:30 a.m. and asserted that was meant to reflect her time missed for the appointment. She stated that she got the form approved by her supervisors, Carrie Ray and Tonya Shepherd, and that both of those supervisors knew that she had an appointment that morning.

The claimant testified that on the day she was initially injured, she was not told to punch out before she was sent to the doctor. She further stated that she was paid her regular wages for the time that she left and went to the doctor on the date of her injury. The claimant testified that it was her understanding from those events that she would be paid for work time that she missed for appointments related to her work injury and that no one had advised her any differently. The claimant asserted that neither Ms. Ray nor Ms. Shepherd indicated there was any problem when she asked for approval of her missed time form on March 18th.

The claimant stated that she was fired three days later on March 21, 2011. She explained that she was called to Lynda Burr's office and told that she was not allowed to be on the clock while she was out for a doctor's appointment and was terminated.

The claimant stated that since her termination from the defendant/employer, she has not been able to find work within her restrictions. She asserted that since she has not had any treatment she was afraid of doing something that would cause further injury. The claimant asserted that in looking for work she has looked through newspapers to see if there are any available jobs within her restrictions.

On cross examination, the claimant was asked about the paperwork that she completed at the time of her injury. The claimant was shown a notice informing her that she would not be paid for time spent at doctor's visits which she signed as part of her initial workers' compensation paperwork. The claimant admitted that she signed all of the paperwork that she was given, but she didn't actually read all of it closely. The claimant recalled being told that she could use PTO time for medical appointments during the waiting period until workers' compensation insurance kicked in. The claimant confirmed that the appointment on the March 18th that led to her termination was in fact her third doctor's appointment regarding her work injury.

The claimant noted that she had been having problems with the hand scanner for several days prior to March 18th. She stated that she did not even try to clock in using the scanner that morning because there was a certain procedure that had to be done by Ms. Burr to fix it and that since Ms. Burr was not there, she didn't bother to try using the hand scanner. The claimant was read her time correction form whereupon she had written that she was correcting her time because the "clock would not accept punch" which indicated that she was requesting to be pad for the time indicated on the form. The claimant denied that as her intention and asserted that she was attempting to confirm missed time for a medical appointment. The claimant confirmed that she listed her time for the day of March 18th as 7:00 a.m. to 10:30 a.m. and that she had to complete the form because the hand scanner was not working, and agreed that she was listing that time period as her work hours for that day.

The claimant admitted that she has had to miss work for medical problems previously during the time she has been employed with the defendant/employer. She confirmed that she had gallbladder surgery in 2007 and was also out for about a month when her mother passed away. The claimant noted that she did not get fired for those periods of missed time, and it was even after dealing with those issues that she was offered her nursing school scholarship. She also admitted that there is at least one other person in the facility who has a workers' compensation claim and continues working on light duty. The claimant agreed that she was treated fairly up until the point that she was terminated.

The claimant went on to testify that on her initial visit to Doctor's Care that she reported that her right arm, mid back, neck, and "tail" where she had landed where hurting. The claimant was pointed to her own APA, page 109, reflecting that first where there is discussion of the right arm and back, but nothing regarding any neck complaints. She was also pointed to her return visit on March 14, 2011, where she reported to the providers at Doctor's Care that she was "very

improved." There was no discussion of neck pain and no indication from the claimant that she was not capable of performing her job or that the defendant/employer was not complying with the work restrictions. The claimant was then directed to the report from March 18th, which was the first indication that she was experiencing neck pain, but again noted that there was improvement in her condition.

The claimant agreed that the doctor's restrictions did not prevent her from walking on the job, but merely indicated that she should not walk more than 30 minutes of each hour. She disagreed that it was primarily the duty of the CNA's to move the residents around the facility and that the nurses more so supervised the CNA's. The claimant admitted that she did not have to routinely do things like changing residents, but stated that it was in her job description. The claimant also agreed that the defendant/employer's facility is a no-lift facility and there are Hoyer lifts to help them move residents and the staff is required to obtain help before moving the residents. The claimant insisted that her job went well beyond assessing residents' medical conditions and administering medications. She insisted that she was required to do more hands-on care tasks and was required to assist in "any and all" aspects of resident care. The claimant further asserted that, in her opinion, the facility was understaffed. She stated that the two CNA's on the hall cannot see to all 40 residents at all times, so she did a lot of CNA duties.

The claimant admitted that her only efforts to find another job have been through looking at listing in the newspapers and on the internet. She admitted that she has not actually applied for any jobs. The claimant stated that based on the job descriptions that she feels that the jobs she has seen would be beyond her work restrictions, but she has not gone in person to inquire about the job duties.

The claimant was next questioned regarding her annual physical assessment with the defendant/employer. She recalled going through the questionnaire from 2009 and indicating that

she was taking some medication for swelling in her feet. The claimant was also read medical reports from her family doctor from December 2006 wherein she presented with complaints of neck pain and trapezius muscle tenderness. The claimant stated that she recalled only having muscle spasms, but did not recall the dates indicated in 2006. The claimant clarified from her prior testimony that she has had problems with muscle spasms on more than one occasion. The claimant confirmed that she has not previously had an MRI of her cervical spine and did not know what was causing the muscle spasms.

On re-direct examination, the claimant asserted that she was released at full duty on March 18, 2011 because she asked to be. She asserted that she told the providers at Doctor's Care that her arm felt better but that she was still having trouble with her back, but that she wanted to try being on full duty because she was needed at the facility. The claimant asserted that she did this because she was afraid that she would lose her job if she did not get back to full duty. The claimant was again questioned about the March 18th report on re-cross examination. She insisted that she did not tell the doctor that she was 85% improved, as indicated in the report. The claimant also asserted that the statement on the work note that "she feels comfortable performing full work duties" was not entirely accurate and that she only requested to try her full duties.

The Commissioner questioned the claimant regarding the hand scanner. The claimant confirmed that it has malfunctioned in the past and would not accept her hand scan. She explained that she has always been paid when the hand scanner failed to work and that the procedure is to fill out a time correction form and have it approved by a supervisor to confirm that she was actually at work during the time indicated on the form. The claimant also confirmed that it is standard to punch out anytime she leaves the facility for any reason. The claimant stated that on the days prior to March 18, 2011, when the scanner was not working that she

clocked in and out manually and that she was in the facility during her entire shift those days performing her job duties as reflected on her manual time forms. The claimant also confirmed that time form for March 18 only indicated that she worked and needed to be paid for the time indicated on the form, it did not specify that she had left for a doctor's appointment at any point during the hours indicated on the form.

The defendants called Lynda Burr to testify on their behalf. Ms. Burr stated that she is the Human Resources Director at the Tanglewood facility and has been in that position for nine years. Ms. Burr stated that her duties include the handling of all personnel records and any workers' compensation claims in the facility. She further confirmed that she was dealing with the claimant's workers' compensation claim. Ms. Burr stated that someone else, possibly Ms. Elkins the unit supervisor, arranged for the claimant to go to the doctor for treatment on the date of the injury. Ms. Burr talked to the claimant on subsequent occasions about her injury.

Ms. Burr explained that the facility works with injured employees to meet the needs of their individual restrictions. She noted that they do not create new jobs, but they often move people to other positions to suit their restrictions during light duty. Ms. Burr stated that it is policy to do everything possible to accommodate restrictions assigned by the doctors for injured employees.

Ms. Burr confirmed that she was involved in the claimant's termination. She explained that the hand scanner was not working for the claimant to clock in and out on the date in question, March 18, 2011. She stated that the claimant had turned in a time correction form stating that she was present at work from 7:00 a.m. to 10:30 a.m. on that date. However, she later turned in a doctor's note reflecting that she was not present at work for part of the time indicated on the time form for March 18th. The doctor's excuse and the time form where shown

to the facility administrator, who made the decision that the claimant was to be terminated for falsifying her time sheet.

Ms. Burr further confirmed that employees on workers' compensation are not paid for time that they leave work to attend doctor's appointments. She stated that workers are given a packet when injuries occur giving them all the procedural information and someone goes over the materials with the worker. She also confirmed that these materials include a notice to workers that they will not be paid for time during medical appointments. Ms. Burr confirmed that Ms. Elkins had gone over this paperwork with the claimant, but noted that in her subsequent conversations with the claimant that the claimant never asked any questions or expressed a lack of understanding of the materials that she was given.

Ms. Burr went on to testify that in the days following the claimant's injury, she never expressed any inability to perform her assigned tasks or expressed any concern about her restrictions not being properly met. She stated instead that the claimant only told her that she wanted to get back to work on the floor and that she was fine. Ms. Burr stated that she informed the claimant that she could not put her back to regular duty without a release to do so from her doctor. Ms. Burr noted that the claimant had restrictions against pushing so that she could not push the medication cart. She stated that the nursing supervisor had the claimant doing paperwork while she was on restricted duty. She further explained that she always advises employees with restrictions to self-monitor their activities to stay within their restrictions and if they are given a task that is outside their restrictions to come to her to adjust their duties. Ms. Burr testified that the claimant never complained about the modified duty that she was given. She stated that she received the release note from Doctor's Care noting the claimant felt comfortable performing her regular duties and stated that this note was consistent with the claimant's requests to her to be put back to full duty.

Ms. Burr next testified that the facility has terminated other employees for submitting false time requests. She estimated that it has happened about three to five times in the nine years that she has worked for the defendant/employer. Ms. Burr stated that falsification of any document is grounds for immediate termination per corporate policy, not just the policy of the facility. She explained that inconsistencies on the time sheet compared to other facility records create issues for the facility with DHEC and Medicare when the facility records are reviewed. She stated that all facility records must be accurate and consistent with one another. The Commissioner also questioned Ms. Burr as to the nature of the falsification of records of the other employees who were fired for falsification of documents. Ms. Burr stated that several were terminated for falsifying time for entire shifts, but others were terminated for falsification of other records that were not related to time and pay. She also recalled that none of the other persons fired for record falsification had ongoing workers' compensation claims.

The medical records reflect that the claimant initially sought treatment with Doctor's Care on March 11, 2011 on the date of her accident. The claimant reported that she slipped on some stairs and injured her right forearm, right hand, and her thoracic spine. The claimant presented with bruising and swelling in the right arm and hand, and bilateral paraspinal muscle pain in her mid back. (A.P.A. p. 109). The claimant was given restrictions of no lifting more than 10 pounds, no use of her right arm, limited use of her back, no standing for greater than 30 minutes per hour, and no repetitive bending/stooping/pushing/twisting. (A.P.A. p. 110).

The claimant next followed-up with Doctor's Care on March 14, 2011. The claimant reported feeling very improved with no pain in her right arm. The right arm contusion was noted to be healing with only mild ecchymosis, and she was reported to have only mild tenderness to palpation of the left paraspinal muscles. (A.P.A. p. 112). Her work restrictions were reduced to

allow standing without restriction, pushing and twisting without restriction, and she was allowed full use of the right arm. (A.P.A. p. 113).

The claimant was seen again at Doctor's Care on March 18, 2011, reporting new complaints of right lateral neck and trapezius pulling sensation. It was noted that she otherwise denied complaints, that her mid-back felt 85% improved, and that there was no discomfort in the right upper extremity. On exam, the claimant was found to have mild tenderness in the right lateral cervical spine, but with full neck range of motion. It was noted that the claimant had no thoracic spine pain and no shoulder pain. (A.P.A. p. 115). The work note provided on this visit noted the claimant's mild cervical pain, but stated that she felt comfortable performing full work duties, thus she was given no restrictions. (A.P.A. p. 116).

The claimant next returned to Doctor's Care on March 24, 2011, three days after her termination, and was complaining of thirteen days of right shoulder pain radiating into her neck and back. On exam the claimant was noted to have a palpable muscle spasm in the right trapezius. The claimant's diagnosis was amended from a mid back strain and right arm contusion to that of muscle spasm, spondylolisthesis, and neck pain. She was referred for physical therapy and her work restrictions were amended to include limited use of her neck. These symptoms persisted on the claimant's follow-up visit on April 1st, and she complained of difficulty finding a comfortable sleeping position due to neck pain. She also was again found to have tenderness in her cervical spine and palpable muscle spasm.

The claimant was sent for a cervical spine MRI on April 4, 2011, which revealed evidence of chronic degenerative changes and a left disc protrusion at C3-4 and some spurring from C3 to C6. The claimant went back to Doctor's Care for review of the MRI and was noted to have bilateral tenderness to palpation with muscle spasm bilaterally in her trapezius distribution. She was prescribed a stronger pain medication and a steroid taper.

The claimant went for a claimant's IME with Dr. Timothy Zgleszewski. She reported to Dr. Zgleszewski that after the fall she had immediate pain in her mid-back; neck, and right wrist. She further reported that she developed a stabbing sensation in her low back a few days later and reported continued problems with wrist pain, a scar with excess skin growth, and neck pain; despite the records from Doctor's Care that do not corroborate the claimant's statements to Dr. Zgleszewski. Dr. Zgleszewski stated that the claimant has probable facet joint dysfunction at all levels of her back and recommended a course of pain management-related treatment modalities.

The claimant's previous medical records from her family doctor were also submitted into evidence. The claimant presented to her family doctor on December 20, 2006 with complaints of right "neck pain" and noted that she had previously undergone massage therapy that was temporarily helpful, indicating that this was an ongoing problem for the claimant. The claimant was found to have tenderness in her neck and over the right trapezius muscles, (A.P.A. p. 39), substantially similar to that which was noted in the Doctor's Care reports after March 24, 2011. These complaints recurred on April 7, 2008, when the claimant presented to her family doctor with complaints of neck and back pain with pain radiating to her right shoulder and pain with forward flexion. The claimant was noted to again have a palpable muscle spasm in her right trapezius and this was injected at the time. (A.P.A. p. 102). The claimant's most recent documented recurrence of neck pain was on April 16, 2010. She presented to her family doctor on this occasion with complaints of right shoulder pain into the back of her neck that she described as constant and often a burning sensation. She again had a palpable right trapezius muscle spasm. (A.P.A. pp. 95-96).

The personnel records of the defendant/employer regarding the circumstances of the claimant's workers' compensation claim and the false records that led to her termination were

also included in the evidence of the case. Those records correspond with those discussed in the testimony of the witnesses.

ARGUMENTS

I. The Single Commissioner erred in finding that the claimant is entitled to temporary total disability benefits from March 21, 2011 to the present and continuing. The claimant was terminated based on grounds established by corporate policy to which all employees are held accountable, as such, the Single Commissioner's decision interferes with the employer's management of its facility.

The claimant was terminated for providing false information on her time correction form. The claimant testified that she knew that she was supposed to clock out any time she left the facility for any reason. Yet she did not fill out her time form accordingly when she left the facility for her appointment on March 18, 2011. Whether or not her intention was to mislead the defendant/employer for gain in compensation is secondary to the fact that she stated that she knew that she was to clock in and clock out any time she left the facility. The claimant even testified that this was the case to the extent that workers are to clock out when going to retrieve something from their cars and return immediately. Despite her stated knowledge of the company rules, she failed to follow procedure in filling out her manual time sheet for March 18, 2011.

The defendant/employer's policy that records must be accurate across all plains is designed to deal with the heavy regulations of nursing facility administration. It is imperative for the defendant/employer to have a wholly accurate record of what personnel were onsite at any given moment of every day. Strict records must be kept to ascertain details such as resident-to-staff ratios and what personnel is available and providing care to residents at any given time. Proper staffing is imperative in the defendant/employer's industry; therefore, there is a strong emphasis on attendance and record-keeping procedures. The Single Commissioner focused his analysis of the circumstances of the claimant's termination on whether or not she intended to get paid or otherwise deceive the defendant/employer. The claimant's intention is irrelevant as it

was her failure to properly and accurately complete her time correction form to show the time during which she was actually on site at the facility that led to her termination.

The findings of the Single Commissioner that the claimant would have clocked out, and that she was justified by not properly noting her time sheet, and thus granting her temporary total disability benefits are unduly burden the defendant/employer in the management of its facility. The claimant was terminated based on a company policy that sites falsification of any records as grounds for immediate termination. A policy that the testimony shows has been enforced regularly in the past. The Single Commissioner's finding creates a situation where the defendant/employer has to treat workers' compensation claimants as an exception to the general rules to avoid being held responsible for temporary total disability benefits for terminating an employees based on standard policy.

Further, the claimant failed to prove that she was indeed disabled from any form of work. The claimant has achieved a level of education that makes it possible for her to earn a living using her skills above her general physical ability. While there may have been certain physical aspects with the claimant's job as an RN in a nursing care facility, she certainly has a skill set that is transferrable to positions that do not involve taking care of invalids. The claimant expressed that she read advertisements for available positions in the newspapers and on the internet, but she never contacted the potential employers to see if she could perform the jobs within her restrictions. There are work opportunities for nurses beyond that of resident care facilities and hospitals. Nurses are often employed in doctor's offices assisting in the care of able-bodied patients, as well as in various administration and clerical roles where their medical record keeping knowledge is needed. The claimant may have required specific accommodation to avoid working outside of her restrictions in a resident care facility, but in-patient caretaking is not the sole job opportunity for someone with the claimant's skills and she gave no indication

that she had explored these alternative options or that she was incapable of performing other lighter duty positions in which nurses are employed.

Based on the foregoing, the findings of the Single Commissioner that the claimant is entitled to temporary total disability benefits should be reversed.

The Single Commission also made multiple findings regarding the hand scanner at the defendant/employer's facility, whether it was functioning, and whether the claimant would have been fired if it had been working. These findings are not consistent with one another, some are speculative, and they hold no bearing on the merits of the claimant's termination. The Single Commissioner went so far as to find that but for the malfunctioning hand scanner, the claimant would have clocked out and would not have had to use the form that resulted in her termination. This finding is based on nothing but speculation. However, contrary to the Single Commissioner's finding, the claimant also testified that she did not clarify her time spent at the doctor on the time form because she had not been required to clock out when she went to the doctor on the day she was injured. By her statements, the claimant appeared to indicate that based on the events of the date of her injury she did not have to clock out for medical visits. The Single Commission next used the history of the claimant not being asked to clock out and being paid her normal wages on the date of the injury to justify the claimant's purported understanding that she would be paid for time spent at medical appointments. The finding that she was justified in not clocking out based on the prior events and the finding that if the scanner was working then she would have clocked out are in direct contradiction of one another. These findings cannot mutually exist and should be reversed.

II. The Single Commissioner's finding that the claimant was working beyond her restrictions is without merit.

The Single Commissioner found based on the claimant's allegation that she was working outside of her assigned restrictions. The claimant's testimony was extremely vague regarding her duties while under medical restrictions. She primarily described what her regular job duties were, and then asserted that she performed her normal job. The claimant offered testimony that she was required to "walk all over" the facility while she was on modified duty. The restrictions from Doctor's Care did not prevent the claimant from walking or standing, only advised that she not walk or stand for more than 30 minutes per hour on her March 11, 2011 work note. This restriction was removed as of her follow-up visit on March 14, 2011. The claimant could not state with any specificity how far or how much she was required in walk to stand, other than "all over," in the four days for which this restriction applied. The claimant also asserted that she had to assist in turning of residents and pushing residents in wheelchairs. Again, the claimant was only restricted against pushing from March 11th to March 14th before the restrictions were decreased. Also, while she asserted that nurses had to engage in these activities, upon further questioning, she stated that it was something nurses would do when CNA's were not available. Further testimony was also offered by Ms. Burr that employee's with restrictions are charged with self-monitoring and asking for help in task that they should avoid or coming to her for further modification of duties.

To further discredit the claimant's assertion that she was working outside of her restrictions, the medical records indicate that the claimant asked to be released from restrictions so that she could perform her regular work. All available evidence, aside from the claimant's self-serving and vague statements that her restrictions were not being met, indicates that the claimant's job was indeed modified to meet her given work restrictions. The evidence also indicates that the claimant requested to be put back to full duty so that she could perform her

regular work. Based on the forgoing, the finding of the Single Commissioner as to this issue should be reversed.

III. The Single Commissioner erred in concluding as a matter of law that the claimant "met her burden of proof in establishing her claims." This conclusion is overly broad and does not reflect that further issues, such as the extent of the injury, were raised and positions were stated, but where not conclusively ruled upon.

The claimant raised multiple issues for the hearing. She asserted that she was entitled to temporary total disability benefits; that she was entitled to treatment per the recommendations of her IME with Dr. Zgleszewski; and specifically that she was entitled to treatment for her neck in addition to the admitted low back and right wrist injuries. Based on the defendants' agreement to send the claimant for an orthopedic evaluation and to have the claimant's back as a whole evaluated as part of that exam, the issues regarding the asserted right to treatment with Dr. Zgleszewski and relationship of the recommended neck treatment to the injury were not the focus of this hearing. These issues were essentially held in abeyance pending the orthopedic evaluation. The conclusion by the Single Commissioner that the claimant has proved "her claims" is overbroad and appears to indicate that the claimant proved and prevailed on each and every position that was stated at the hearing. This conclusion should be reversed in favor of specific findings and conclusions limited to the issues actually addressed and ruled upon.

IV. The Single Commissioner was correct in determining the claimant's average weekly wage and compensation rate.

The claimant asserts that an alternative method of calculation of her average weekly wage and compensation rate should be used. However, the defendants submitted a properly completed Form 20 Statement of Earnings calculating the claimant's average weekly wage by using her gross earnings from the four quarters prior to that in which the injury occurred. The

claimant has merely stated that by using the period of 52 weeks prior to the date of injury, instead of excluding the quarter in which the injury occurred as the Act dictates, that the claimant's average weekly wage is greater and therefore the greater number should be used. The claimant's request is arbitrary and states no overwhelming reason that the standard method of calculation is unfair to her. To apply an alternate method of determining average weekly wage, the claimant must show some circumstance that created the unfairness and must present detail as to why it is not an accurate reflection of the claimant's earnings. The claimant offered no evidence to this effect and stated only that if differently calculated, different numbers are obtained. This does not meet the requirements to support the need for an alternate method of calculation of average weekly wage in the face of a properly completed Form 20 established by the actual earnings reported on the claimant's pay records.

CONCLUSION

Based upon the foregoing, the defendants respectfully request that the decision and order of the Single Commissioner be reversed. The reliable, probative, and substantial evidence in the record shows that the claimant was provided with suitable modified duty to meet her restrictions, after which she was terminated for violation of company policy, and she has subsequently failed to prove that she is incapable of securing alternate employment that is within her work restrictions.

Respectfully submitted,

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December 15, 2011

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NO. 1103442

Gayla Ramey,

Employee/Claimant,

v.

Unihealth Post Acute Care- Tanglewood,
Employer and

American Zurich Insurance Company,
Carrier/Defendants.

CLAIMANTS REPLY BRIEF

TO THE FULL COMMISSION

STATEMENT OF THE CASE

Commissioner G. Bryan Lyndon heard this case on August 10, 2011 in Columbia, South Carolina and all parties agreed to jurisdiction. The Claimant was injured on March 11, 2011 when she fell down stairs at her place of employment injuring her back and right arm.

The Claimant had been employed by the employer for the previous 9 years and was shortly thereafter terminated for requesting to be paid for one hour missed from work due to an employer authorized medical appointment. Up to the hearing date the Employer had ended medical treatment to the Claimants back, right arm or any other body parts but consented to provide this treatment at the hearing. The Hearing was called upon the filing of the Claimants Form 50. The Claimant was seen prior to hearing by Dr. Zgleszewski for an IME who confirmed that the Claimant had injured her back including the cervical spine, requiring treatment.

The Claimants position on average weekly wage is that she be paid the average for the previous 52 weeks before the date of accident. This gross amount divided by 52 would yield

$1,099.17 which would result in the maximum compensation rate for 2011, $704.92. The Employer alleged that the average weekly wage should be determined based on the figures the provided on the Form 20 which would yield $1,007.32 resulting in a compensation rate of $671.58.

The only issue presented for determination by the Single Commissioner was whether the Employer is allowed to terminate the Claimant's temporary total disability benefits from the date of her termination to the present and continuing. The Claimant was terminated on March 21, 2011 after she had informed her supervisors and Human Resource Manager that she was leaving work to attend an authorized medical appointment at Doctors Care. The Claimant asserts that the Employers supervisors were well informed that the Claimant was going to see a doctor and due to a malfunctioning hand-scanning device could not check-in coming to work or check-out going to the doctor's appointment. The procedure the Claimant was required to use due to the malfunctioning hand-scanning device was filling in a missed time form that had to be signed off on by her supervisor. The Claimants supervisor did this when the Claimant returned from her doctor's appointment. The Employers explanation was that the Claimant was simply terminated because she had requested to be paid for missed time from work due to authorized medical treatment for her workers comp. injury and the Employer classified this as falsifying paperwork. The Claimant further alleged that she was not being accommodated with the work restrictions issued to her by Doctors Care prior to her termination. The Claimant further asserts that she had previously been paid for time missed from work due to authorized medical treatment on this workers comp. case in the previous 10 days since her date of injury.

On September 28, 2011 Commissioner G. Bryan Lyndon issued an Order finding that the Claimant is entitled to temporary total disability benefits from March 24, 2011 to the present and

continuing finding that "I do not find it plausible that the Claimant would intentionally put nine years of service on the line for the 1 hour that she was at the doctor." Commissioner Lyndon found that the Claimant was a credible witness, and was such a valuable employee to the Employer that she was given a scholarship by the Employer in order to obtain her R.N. Degree. Commissioner Lyndon further found that the Claimant has never been previously accused of falsifying paperwork, has had no previous problems with her spine and that the Claimants two supervisors and the human resource manager knew that the Claimant was attending an appointment. That the Employer had the Claimant working outside of her work restrictions. In addition to having knowledge of the March 18th appointment, the Employers actions led the Claimant to believe that she was to be paid for time missed from work for her medical appointment. Commissioner Lyndon believes that the malfunctioning hand scanner was used as an excuse for terminating the Claimant.

Both the Claimant and the employer filed a Request for Commission Review of the Decision and Order of the Single Commissioner. The Claimant only appealed the Single Commissioners finding on the average weekly wage and compensation rate. The Single Commissioner found that the compensation rate on the Form 20 prepared by the Employer was correct. Although the employer's application (Form 30) contained 13 exceptions to the Decision and Order of the Single Commissioner, the only issue litigated at the Single Commissioner Hearing was the Employers termination of the Claimant. The Employer admitted the entire back prior to hearing. The Single Commissioner further found that the only treatment to the back that the Claimant had received prior to the date of injury were for trapezius muscular issues and shoulder.

STATEMENT OF THE FACTS

The Claimant testified that she is a 50 year old woman who was a 9 year employee for the employer. She lives in a household with 11 other people which comprise her children and grandchildren. She obtained her R.N. degree while working for the employer and in fact was given a scholarship by the employer so she could obtain this degree in 2008. Her job duties include providing treatment to patients, assessments, helping patients move, turning patients and helping them get in and out of bed. Also pushing patients in wheelchairs in addition to the medication cart. Ms. Ramey performed charting and working with doctors and family members in order to provide patient care. She had never previously had any problems related to her back. The Claimant stated that she did receive medical treatment for muscle spasms in her shoulder. For approximately 2 weeks she had muscle spasms in her right shoulder that were treated with steroid injections which cleared the issue up.

The Claimant testified that when she was injured on March 11, 2011 she punched-in that morning with a hand scanner (because it was working). Shortly thereafter, the Claimant fell, was injured, and was immediately sent to Doctors Care. She did not punch-out with the hand scanner before she left to Doctors Care. She testified that she was still paid for her normal hours that day including the time she was at Doctors Care, although she did not punch out.

Doctors Care immediately placed the Claimant on work restrictions of no more than 30 minutes per hour on her feet, limited use of the back, no use of the right arm, 10 pound lifting restriction and no repetitive bending, twisting, stooping, squatting or pushing. The Employer kept the Claimant working her full duty. There were two other Employees, Tammy Watkins and Lisa Jacobs, who have pending workers comp. cases who were also working normal duty as was the Claimant. The Claimant stated that she was scared of being terminated, although she was still

working regular duties because she understood one of these two women were about to be fired. This fear was based on hearsay but she was never the less worried about losing her job. Consequently, when the Claimant attended the medical appointment on March 18th, 2011, she requested that the doctor allow her to go off light duty because she needed to work full duty in order to help with the understaffing on her floor. The Claimant was concerned that the understaffing problem and her inability to work full duty, would result in her being terminated. She explained that she did this in attempt to preserve her job even though her back pain still existed. The other two employees with workers compensation claims were also working full duty in violation of their work restrictions and Ms. Ramey felt compelled to do the same or risk termination.

On March 18, 2011 the Claimant attended a doctor's appointment at Doctors Care. The Claimants Human Resource Manager, Linda Burr was aware of this appointment on the morning of the 18th. The Claimant testified that in fact she arrived at work earlier than required (7am) because she understood Ms. Burr would be leaving early and the Claimant wanted to speak to Ms. Burr before she left to her doctor's appointment. When the Claimant arrived to work on the 18th Ms. Burr had already left the premises. The hand scanner punch in device was not working on the 18th so the Claimant was unable to punch in or out of work that day. The Claimant returned from her Doctors Care appointment at approximately 9:45am and left work for the day at 10:30am. The Claimants supervisor Tonya Shephard told the Claimant to leave work early because she wanted her to work the next two days which were a Saturday and Sunday. The Claimant confirmed that on the day she was injured, March 11, 2011, she had punched in, but did not punch out when she left to see the doctor. In fact she never punched out that day because she did not return to work the date of injury but yet was still paid her normal hourly wages

although she was at the doctors receiving treatment. The understanding the Claimant had from her employer was that she was entitled to be paid for time missed due to authorized medical treatment. The Claimant was questioned by Single Commissioner G. Bryan Lyndon on this subject. The Commissioner noted that there were several days that the hand scanner did not work. The Claimant confirmed that she was always paid for the time she submitted when the hand scanner was not working, on the request for missed time form. The Claimant confirmed that her supervisor always verified the time listed on the request for missed time form and approved these forms in writing. That this had been the procedure for the 9 years that the Claimant had worked for the Employer and she had never been denied time using this procedure previous to March 18, 2011. *In fact, supervisor Tonya Shephard approved the missed hour in writing on the request for missed time form on March 11, 2011.*

On March 18, 2011 the Claimant was required to submit a request for missed time form due to the hand scanner being broken. The time that the Claimant submitted that she arrived and left that day were 7:00am to 10:30am. The Claimant had both of her immediate supervisors working on the 18th, Carrie Ray and Tonya Shephard review, approve and sign the request for missed time form. Both supervisors were aware that the Claimant had been to the doctor for approximately one hour that morning. Three days later the Claimant was fired on March 21, 2011. The Claimant was called into the office of resource manager Linda Burr and terminated. No other supervisor was present. The Claimant understood that the reason she was being terminated was that she was not allowed to be paid for time missed while out due to a doctor's appointment.

The Claimant stated that she did not indicate to Ms. Burr that she had done anything wrong and was in fact exercising extra caution to not give her Employer an excuse to fire the

Claimant. The Claimant testified that she could not understand why she was being terminated by Ms. Burr after the Claimant was informed that she was to be paid for missed time due to doctors' appointments, Supervisors Linda Burr, Carrie Ray, and Tonya Shephard knew the Claimant had attended a doctor's appointment the morning of the 18th and supervisor Shephard actually signed a form authorizing the Claimant to be paid for the time she missed work for her doctor's appointment.

She stated that since she was terminated she had been unable to find any employment that does not violate her work restrictions. That the employer has provided no further medical treatment other than that provided by Doctors Care through April 8, 2011. The Claimant desires the only treatment recommended by an Orthopaedic doctor for her back Dr. Zgleszewski.

The Claimant explained that on the day she was injured she was givien a short stack of documents to sign. She stated that she did not read the documents as she was not given an opportunity to read the documents. The Claimant was required to fill the forms out before she was allowed to leave her place of work to see the doctor the day of injury. She further explained that the reason her signature looks "shaky or wobbly", is that she was required to sign the form with her left hand due to her right arm injury. She was not given a copy. The Employer presented a document to the Claimant that she signed on that day, alleging that the Claimant agreed not to be paid for missed time from work due to doctors' appointments. The Claimant stated she did not read that document and did not agree to that statement. However it is to be noted that this agreement was only related to the workers compensation waiting period. The Claimant explained that she understood she would be allowed to use PTO until the workers comp. coverage "kicked in". She stated that before March 18, 2011 the hand scanner had also not worked on the 16th, 17th in addition to the 18th. Due to the previous problems with the hand-scanner, the Claimant did not

attempt to punch-in with the scanner on the 18th because she knew it was not working. On her request for missed time form she wrote "clock not accepting punch". She explained that when she arrived at work at 7am on the 18th, her supervisor knew that the Claimant was there and she was getting ready to leave for a doctor's appointment that morning. She informed the supervisor when she was leaving for the medical appointment and when she returned back from the appointment at approximately 9:45am. Tonya Shephard was the supervisor the Claimant communicated with the morning of the 18th.

The Claimant confirmed that in her 9 years of employment with the Employer she had never had a previous workers compensation claim. When she first appeared for a workers comp. related medical appointment on March 11, 2011 she informed the doctors that she had pain in her right arm, her back and on her buttocks. The medical record from her March 11, 2011 Doctors Care appointment confirms that the Claimant injured her "back".

When questioned on her job duties, the Claimant stated that the job description for a nurse is to "assist with any and all care and that means hands on as well as hands off care of your patients". She says that this encompasses all patient needs in any area in every aspect. This includes lifting patients and moving patients in and out of bed. She explained that the Employers facility is understaffed and as a result she is required to perform job duties that are not typical for a R.N. That her customary job duties as an R.N. and uncustomary job duties were required for her to be performed before and after she was placed under work restrictions. Consequently, the Claimants job search at other facilities was only for positions that did not violate her work restrictions.

The Employer alleged that the Claimant had previously suffered from cervical pain as early as 2006. The Claimant explained and the medical records confirmed that the Claimant had

pain in the right trapezius muscle that was treated with massage and an injection into the right trapezius muscle on two occasions. She stated that periodically over the years 2008 and 2010, she has suffered from muscle spasms in her shoulders and trapezius muscles at the base of her neck. She explained that within 24 hours of receiving a steroid injection into her trapezius muscle, the pain stopped entirely.

The only witness called to testify by the Employer was Human Resource Director Linda Burr. Ms. Burr has also worked for the employer for nine years. Ms. Burr is responsible for handling workers compensation claims. Ms. Burr stated that she did not speak to the Claimant about her workers compensation injury until the day after it occurred, March 12, 2011. She stated that another person scheduled the Claimants medical appointment on March 11, 2011. She believes it was Ms. Elkins (who did not testify). She stated that the employer never requires employees to work in violation of the restrictions that have been issued by doctors on workers compensation cases. She explained that the Employer will "try to do everything you possibly can to meet the restrictions as placed by the doctor,...when they have a workers compensation claim".

Ms. Burr testified that the Claimant was terminated for falsifying a timesheet. She stated that the Claimant turned in a request for missed time form due to the hand scanner not working properly. Ms. Burr explained that the Claimant later turned in a doctor note that said she was not working during a portion of the time on the request for missed time form. She explained that this was considered falsifying a timesheet, although Ms. Burr and the Claimants two supervisors were aware that the Claimant was at the doctor during the missed time and the form was approved by supervisor Shephard. She stated that on workers compensation claims employees are not paid "when they go to the doctor through their pay or where they punch into the clock".

She further stated that employees are given documents after the injury date explaining that they are not to be paid for missed time from work due to authorized medical treatment. She stated that when the packet was given to Ms. Ramey the date of the injury, Ms. Burr was not present and she did not go over the packet with Ms. Ramey in order to determine whether or not the Claimant understood it. She only asked the Claimant if she had any questions concerning the packet on March 12, 2011 the Claimant was given to review. Neither the Claimant nor Ms. Burr testified that the Claimant was given a copy of the documents she was ordered be sign before she was sent to the doctor on the date of injury.

Ms. Burr also confirmed that the claimant was eager to get back on the floor and work her full duties as soon as possible. Ms. Burr told the Claimant that she could not put the claimant back to full duty unless the doctor released the Claimant. She stated that the only work that the Claimant performed before termination was paperwork. Ms. Burr also confirmed that the approximate seven days the Claimant worked before she was fired that the Claimant did not make any complaints to Ms. Burr but did whatever work she was told to do.

Ms. Burr stated that during the 9 years that she and Ms. Ramey worked together the Claimant never complained of pain or problems with her back.

Ms. Burr's testimony as to the reason for the Claimants termination differed as to what she stated in her deposition testimony on August 10, 2011. At the hearing Burr testified that the claimant was " terminated for falsifying a timesheet". During her deposition Ms. Burr stated "an employee was not to be paid for any time that they are receiving treatment on a workers compensation claim". Ms. Burr admitted that she knew the Claimant had a doctor's appointment on the morning of the March 18th, 2011 and each of the Claimants two supervisors knew also. Ms. Burr admitted that it would be "professional suicide" to put the wrong time on a time sheet

when all of the Claimants supervisors knew that she was going to be at a doctor's appointment. Ms. Burr candidly admitted that to falsify a document indicates an intent to deceive. That there could be no deceit when Ms. Burr and each of the supervisors had full knowledge of what the Claimant was doing that morning. Further, the documentation provided to the Claimant upon her termination confirmed that Ms. Burr terminated the Claimant for requesting time while she was out seeing a doctor on a workers comp. case. This further coaborates Ms. Burr's deposition testimony that the Claimant was fired solely for the reason for requesting payment for time missed from work while receiving medical treatment on a workers compensation claim. After further questioning by the single commissioner Ms. Burr also stated that the previous employees (not workers comp. claimants) that have been fired for falsifying records had requested that they be paid for full shifts (8-12 hour shifts), not for one hour missed while the Claimant was at a doctor's appointment.

ARGUMENTS

I. **The Claimant attended a medically authorized doctor's appointment with the consent of her supervisor and submitted a request for missed time form that was approved by her supervisor. The Claimants termination for requesting to be paid for missed time from work due to a workers compensation doctors appointment is purely a pre-textual excuse for termination.**

The Commission lacks statutory authority to make findings on why an employee was terminated- and to bar compensation on this ground. See Smith v. South Carolina Department of Mental Health, 329 S.C. 485, 494 S.E.2d 630 (Ct. App. 1997)("we do not believe [issues of why claimant was terminated] were strictly relevant to the matter before the commissioner—whether [employer] was entitled to discontinue the disability payments being made to [claimant]."). The sole inquiry is whether employment was offered suitable to the employee's capacity and whether the employee accepted it. Here, there is no question Claimant accepted the work that was

offered. The employer *unilaterally* withdrew the offer of suitable employment. As such, they *must* pay temporary compensation.

The sole agency with authority to bar statutory benefits for termination for misconduct is the Department of Employment and Workforce (formerly the Employment Security Commission). See S.C. Code Ann. §42-35-120 (2010)(" worker is ineligible for benefits for: Discharge for cause connected with the employment."). As the Workers' Compensation Commission has no similar statute, it lacks authority to bar temporary compensation to a disabled employee fired from a light duty position for cause.

The Workers' Compensation Act "requires employers to pay temporary total disability to an employee who has been 'out of work due to a reported work related injury' for eight days." Martin v. Rapid Plumbing, 369 S.C. 278, 631 S.E.2d 547 (Ct.App.2006), *quoting* S.C. Code § 42-9-260(a)(Supp. 2006). The Commission must follow the substantive law set forth in Title 42 and the case law, to wit, the law "requires employers to pay temporary total disability to an employee who has 'been out of work due to a reported work related injury' for eight days." Martin v. Rapid Plumbing, 369 S.C. 278, 631 S.E.2d 547 (Ct.App.2006), *quoting* S.C. Code § 42-9- 260(A) (Supp. 2006). Here, the employer unilaterally withdrew its offer of light duty work to Ms. Ramey. As such, the Employer and Carrier must pay temporary total as a matter of law.

The record is clear that on the day the claimant was terminated,(March 21, 2011), she was informed that the reason of termination was for the Claimant requesting to be paid for time missed from work due to attending an authorized and approved workers compensation medical appointment. The Human Resource Director confirmed this fact in her deposition. Once Ms. Burr had been informed that terminating an employee for requesting to be paid for time spent at

Doctors Care was not proper she attempted to change the cause for termination to "falsifying documents". It is clear the Claimant was unable to clock-out on March 18, 2011 and previous days, because the hand- scanner was not working. It is also clear that the Claimant did not clock-out with the hand-scanner although it was working on the date of injury. The Claimant was still paid for the time she was at the doctor's office on March 11, 2011 although she did not clock-out and the hand scanner was working. Most importantly, Ms. Burr and the Claimants two immediate supervisors (Shephard and Ray) were all aware that the Claimant attended a doctor's appointment the morning of March 18, 2011. More specifically, that when the Claimant returned from her doctor's appointment on March 18, 2011 and she filled out the request for missed time form, it was *approved by supervisor Shephard in writing.* Due to information that the Claimant had received, she was scared of being terminated for her position due to her inability to work full duty. She was being especially careful to not give her employer a valid reason to terminate her.

The employer led the Claimant to believe that she would be paid for time missed from work due to authorized medical treatment for her workers comp. injury. After the employer led the Claimant to reasonably believe this fact, they turned around and used it as an excuse to fire her. Ms. Burr changed her testimony at the hearing and attempted to claim that the Claimant was not fired for requesting payment for time missed from work for medical treatment she used the "falsifying documents" as an excuse although the supervisor instructed the Claimant to do so and approved it in writing. It is absurd for the employer to argue that the Claimant would throw away nine years of work in order to be paid for one missed hour. The record is uncontroverted that the supervisors requested that she attend the appointment and approved her missed time form. The record is undisputed that the supervisor approved the Claimants request to be paid for the one hour of missed time. Supervisors Shephard, Ray and Burr all agree that they were fully aware

that the Claimant was attending a doctor's appointment for that one hour. The Single Commissioner was correct in that it would be "professional suicide" for Ramey to do what the employer alleges that she did in falsifying documents. The employer terminated the Claimant for doing precisely what the employer instructed the Claimant to do. It would be a travesty for the employer to be able to terminate the Claimant for requesting payment for the same time missed that the Claimant was paid for under the precise same circumstances ten days earlier. It is to be noted that the Single Commissioner found the Claimant credible, not Ms. Burr.

The employer argues that the Claimant should have made a more extensive job search in looking for other employment. The Claimant testified that she searched newspapers and the internet for job positions that would not violate her extensive work restrictions. She could not find any. The employer argues that if the Claimant had contacted potential employers, she would have somehow found out that the job restrictions did not apply to her. This argument is not based on the record and is pure speculation.

The employer next argues that the Single Commissioners finding that the Claimant being paid on March 11, 2011 after not clocking out to attend a doctor's appointment and the Claimant likely not being terminated if the hand scanner was working on March 18, 2011 are contradictory. The Single Commissioners ruling merely points out that the employer paying the Claimant for a doctor's appointment on March 11, 2011, after not clocking-out reasonably led the Claimant to believe that she was to be paid for time missed for medical treatment. It was this reasonable belief that led the Claimant to process the request for missed time form on March 18, 2011. If the hand scanner had been working on March 18, 2011, the Claimant would not have been required to process the request for missed time form, thereby requesting to be paid for the one hour of time she was led to believe she should be paid for. If the hand scanner had been

working on March 18, 2011 the employer would not have been able to unjustly claim that the Claimant falsified documents. Likewise, these two findings do mutually exist and are consistent with one another.

II. Due to an understaffed floor and the Claimants fear that she may be terminated, the employer kept the Claimant working full duty in violation of her work restrictions.

Although the Claimants work restrictions were temporarily modified on March 18, 2011 at her request, they were later reinstated. She testified that she was required to be on her feet for more than thirty minutes per hour, and to move, help lift and push patients in wheelchairs. In fact, the Claimant was so eager to retain her employment she was working full duty because she did not want the work restrictions to be used as an excuse by the employer to terminate her. Therefore she requested that the doctor allowed her to try working full duty at her appointment on March 18, 2011. Ms. Ramey was doing everything that she could to accommodate her employer, including doing work in violation of her work restrictions. After attempting to do so for three work days, the doctor placed Ms. Ramey back under her original work restrictions and referred her to an orthopaedic doctor.

III. The Employer admitted the entire back prior to the hearing, consequently treatment for the Claimants cervical spine was not litigated at the hearing.

The employer's third argument appears to allege that the employer somehow did not admit the entire back and is still attempting to deny the cervical spine by claiming "these issues were essentially held in abeyance pending the orthopaedic evaluation". The employer clearly admitted the entire spine pre-hearing (Hearing Transcript p. 9-10). Furthermore, the medical evidence is clear that the Claimant reported pain in her back/ neck from the onset of her medical treatment with Doctors Care and the employer. The only orthopaedic evaluation received by the Claimant with Dr. Zgleszewski clearly gives causation in the back including the cervical spine. At no point

in the hearing transcript does the employer contest the Claimants entire spine being admitted or injured including the Claimant and Linda Burr's testimony. The Claimant injured her spine, the employer admitted the entire back and the Claimant is to receive treatment for this body part as per the Single Commissioners Order.

IV. A) Average weekly wage under §42-1-40 means the earnings of the injured employee in the employment in which she was working at the time of the injury during the period of 52 weeks immediately preceding the date of the injury.

The Claimants personnel file and wage record confirm that the Claimant earned $57,156.93 the 52 weeks immediately before the date of injury, March 11, 2011. The wage records also show that the Claimant was working more overtime hours in the year 2011 than was worked 2010. § 42-1-40 of the South Carolina Code of Laws Annotated clearly states that average weekly wage is the earnings of the Claimant during these 52 weeks immediately before the date of injury. See Hinson v. Berkley County School Board (Unpublished Opinion No. 2000-UP-163, filed March 6, 2000) and Breeland v. Colleton County, 216 S.C. 147, 57 S.E. 2d 63(1950). The maximum compensation rate for 2011 is $704.92. Using the average weekly wage of the immediate 52 weeks before the date of injury, the Claimant's compensation rate would be $732.04. This is substantially above the maximum compensation rate for 2011 of $704.92.

The Employer contends that the average weekly wage should be calculated by taking the total wages paid for the last four quarters immediately preceding the quarter in which the injury occurred, pursuant to §42-1-40. However all four of the quarters that the Employer used for an accident that occurred on March 11, 2011 are in the year of 2010. The ending period of the last quarter is December 11, 2010. Using the four quarters for the year 2010 gives the Claimant a compensation rate of $671.58. The Claimants actual compensation rate of $732.04 is already substantially capped by the maximum compensation rate for 2011. The Employers Form 20

compensation rate of $671.58 makes a further substantial reduction to the Claimants actual compensation rate.

B) It is an exceptional circumstance that the Claimant was working more overtime before her injury in 2011 than she worked in the year 2010.

The Claimants wage records clearly confirm that the Claimant was working more overtime in the year 2011 than she worked in the year 2010. The Court of Appeals has ruled this to be an exceptional circumstance. Booth v. Midland Traine Heating & Air Conditioning, 298 S.C. 251, 379 S.E.2d 730 (S.C. A. pp. 1989). Likewise, it would be substantially unfair for the Claimant to receive a compensation rate that is $60.40 lower than her actual compensation rate. Especially in light of the fact that the Claimants actual compensation rate has already been reduced by $27.72 due to the 2011 compensation rate cap. When for exceptional reasons the foregoing would be unfair, either to the Employer or Employee, such other method of commuting average weekly wages may be resorted to as will most nearly approximate the amount which the injured employee would be earning were it not for the injury. South Carolina Code Annotated, §42-1-40. As our Supreme Court has stated, "The objective of wage calculation is to arrive at a fair approximation of the Claimants probable future earning capacity. His disability reaches into the future, not the past, his loss as a result of the injury must be thought of in terms of its impact on probable future earnings." Bennett v. Gary Smith Builders, 271 S.C. 94, 98-99, 245 S.E.2d 129, 131 (1978).

Clearly, the maximum compensation rate for 2011 of $704.92 would most nearly approximate the amount which the Claimant would be earning were it not for her injury on March 11, 2011. It would be unfair for the Claimant for her compensation rate to be further reduced when it has already been capped.

CONCLUSION

Based upon the foregoing, the Claimant respectfully requests that the Decision and Order of the Single Commissioner be affirmed. The credible, reliable and overwhelming evidence in the record shows that the Claimant was terminated for believing and doing exactly what the employer represented to her and requested that she do in obtaining medical treatment. This was used as a pretextual excuse for firing the Claimant after nine years of employment. The Claimant has been unable to find employment that does not violate her work restrictions in a very tumultuous economy. The Claimant should be entitled to obtain treatment to her back until she is placed at maximum medical improvement.

Respectfully Submitted,

Mark R. Calhoun
Attorney for Claimant
Calhoun Law Firm, P.A.
714 East Main Street
Lexington, SC 29072
803-957-8401

January 12, 2012

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Andrea C. Roche, T. Scott Beck, Avery B. Wilkerson, Jr.
Workers' Compensation Commissioners

WCC File No: 1103442

Gayla Ramey, Employee.....Claimant,

v.

Unihealth Post Acute Care Tanglewood, Employer,

and

American Zurich Insurance Co., Carrier.....Defendants,

Of Whom

Claimant is.....Respondent,

and

Defendants are .....Appellants.

NOTICE OF APPEAL

Defendants hereby appeal the Order of the South Carolina Workers' Compensation Commission filed May 23, 2012. Appellant received written notice of entry of this Order on May 24, 2012.

GROUNDS FOR REVIEW

1. The Commission erred in Finding of Fact No. 5 by finding that on *March 11, 2011* and numerous previous occasions the hand-scanning device did not work for the claimant. This contradicts Finding of Fact No. 6 wherein the Commission notes that the hand scanner was working on March 11, 2011; thus this finding appears to be in error and confuses the issues in

the claim. This finding is not supported by the reliable, probative, and substantial evidence in the record.

2. The Commission erred in Finding of Fact No. 6 by finding as follows: "Since the claimant knew the scanner was not working on the morning of March 18, 2011 she did not clock in and out. As a result the claimant was paid for the hours she went to the doctor. She had always previously been paid when the scanner was broken and the claimant was required to clock in and out using the manual form. In Fact, on March 11, 2011 the claimant was paid her normal hours although she did not clock out in order to go to Doctor's Care, even though the hand scanner was working that day." This finding is not supported by the reliable, probative, and substantial evidence in the record. Claimant's injury occurred on March 11, 2011. There is insufficient evidence in the record establishing a period or pattern to support a finding that Claimant was "always" paid for missed time for medical visits and further ignores the fact that Claimant was still required to clock in and out for medical visits, be it by scanner or manual form, and failed to do so on March 18, 2011.

3. The Commission erred in Finding of Fact No. 7 by finding that Claimant was working outside her work restrictions. This finding is in disregard of the evidence that appropriate light duty work had been provided for Claimant and is not otherwise supported by the reliable, probative, and substantial evidence of record.

4. The Commission erred in Finding of Fact No. 8 by finding that it was Claimant's "clear understanding" based upon the acts of Employer and information given to her by Employer that led Claimant to believe she was to be paid for time missed from work for her medical appointments. This finding is not supported by the reliable, probative, and substantial evidence in the record.

5. The Commission erred in Finding of Fact No. 12 by finding Claimant to be a credible witness and that "but for the malfunctioning hand-scanner Claimant would have clocked out, thereby not having to use the missed time form that Employer used as an excuse for terminating [the claimant]." The finding that Claimant would have clocked out had the scanner been working contradicts the previous finding that Claimant believed that she did not have to clock out. With such conflicting information given by Claimant, she cannot be found credible in her testimony in this regard as a matter of law. This finding is not supported by the reliable, probative, and substantial evidence in the record.

6. The Commission erred in Finding of Fact No. 13 by finding that in the past when the hand scanner was working, Claimant would clock into work, out for lunch, and back to work. If the hand scanner had been working on March 18, 2011, Claimant would not have been terminated. This finding is contrary to other findings that Claimant thought she was to be paid for the time missed for medical appointments. Further, this finding is based on speculation due to Claimant's lunchtime practices that have nothing to do with medical appointments, workers' compensation procedures, or other instances more closely related to the circumstances at issue. This finding is not supported by the reliable, probative, and substantial evidence of record.

7. The Commissioner erred in Finding of Fact No. 14 by finding that the "it was obvious [Claimant] was not trying to falsify records, deceive the employer, or hide anything else"

because Employer knew Claimant was at the doctor for an appointment for an admitted work related injury. This finding is not supported by the reliable, probative, and substantial evidence in the record.

8. The Commission erred in Finding of Fact No. 15 by finding that Claimant is temporarily totally disabled and is entitled to benefits commencing March 24, 2011, to the present and continuing. This finding is not supported by the reliable, probative, and substantial evidence in the record. Claimant was terminated for cause while she was working full duty, thus Claimant should not be entitled to TTD pursuant to S.C. Code §42-9-190 and the Commission's determination must be reversed.

9. The Commission erred in Conclusion of Law No. 4 by concluding that Claimant is entitled to temporary total disability benefits commencing March 24, 2011, to the present and continuing. This Conclusion is not supported by the reliable, probative, and substantial evidence in the record. This Conclusion further relies on erroneous Findings of Fact as set forth more fully above.

10. The Commission erred in Conclusion of Law No. 5 by concluding that Claimant has met her burden of proof in establishing her claims by a preponderance of the evidence. This Conclusion is not supported by the reliable, probative, and substantial evidence in the record. This Conclusion further relies on erroneous Findings of Fact as set forth more fully above.

11. The Commission erred in Conclusion of Law No. 9 by concluding that under S.C. Code §42-9-10, Claimant is entitled to received compensation from Defendants for her period of temporary total disability resulting from her March 11, 2011 accident commencing March 24, 2011, until the present and continuing. This Conclusion is not supported by the reliable, probative, and substantial evidence in the record. This Conclusion ignores the mandate set forth in S.C. Code §42-9-190 that an injured worker who refuses suitable employment "shall not" be entitled to compensation. This Conclusion further relies on erroneous Findings of Fact as set forth more fully above.

12. The Commission erred in ordering that Claimant is entitled to receive temporary total disability compensation commencing March 24, 2011, to the present and continuing. This award is not supported by the reliable, probative, and substantial evidence in the record. This award further relies on erroneous Conclusions of Law and Findings of Fact as set forth more fully above.

13. Without waiving any of the specific objections raised above, the Commission erred as a matter of law in failing to find that Claimant had been terminated for cause and therefore is not entitled to temporary total disability benefits in accordance S.C. Code §42-9-190.

June 22, 2012

R. Daniel Addison
Hedrick Gardner Kincheloe & Garofalo, LLP
Post Office Box 11267

Columbia, South Carolina 29211
(803) 727-1200
Attorney for Appellants

NOTICE OF APPEAL IN A CIVIL CASE
THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION APPELLATE PANEL

Andrea C. Roche, Commissioner
T. Scott Beck, Commissioner
Avery B. Wilkerson, Jr., Commissioner

W.C.C. File No.

Gayla Ramey, ... Claimant/Respondent,

v.

Unihealth Post Acute Care Tanglewood, ... Employer/Appellant,

and

American Zurich Ins. Co., ... Carrier/Appellant.

PROOF OF SERVICE

I certify that I have served the Notice of Appeal on Respondent, Gayla Ramey, by depositing a cop of it in the United States Mail, postage prepaid, on June 22, 2012, address to her attorney of record, Mark Calhoun, 714 East Main Street, Lexington, South Carolina, 29072

June 22, 2012

R. Daniel Addison
Hedrick Gardner Kincheloe & Garofalo, LLP
P.O. Box 11267
Columbia, SC 29211
(803) 727-1200
Attorney for the defendants/appellants

because Employer knew Claimant was at the doctor for an appointment for an admitted work related injury. This finding is not supported by the reliable, probative, and substantial evidence in the record.

8. The Commission erred in Finding of Fact No. 15 by finding that Claimant is temporarily totally disabled and is entitled to benefits commencing March 24, 2011, to the present and continuing. This finding is not supported by the reliable, probative, and substantial evidence in the record. Claimant was terminated for cause while she was working full duty, thus Claimant should not be entitled to TTD pursuant to S.C. Code §42-9-190 and the Commission's determination must be reversed.

9. The Commission erred in Conclusion of Law No. 4 by concluding that Claimant is entitled to temporary total disability benefits commencing March 24, 2011, to the present and continuing. This Conclusion is not supported by the reliable, probative, and substantial evidence in the record. This Conclusion further relies on erroneous Findings of Fact as set forth more fully above.

10. The Commission erred in Conclusion of Law No. 5 by concluding that Claimant has met her burden of proof in establishing her claims by a preponderance of the evidence. This Conclusion is not supported by the reliable, probative, and substantial evidence in the record. This Conclusion further relies on erroneous Findings of Fact as set forth more fully above.

11. The Commission erred in Conclusion of Law No. 9 by concluding that under S.C. Code §42-9-10, Claimant is entitled to received compensation from Defendants for her period of temporary total disability resulting from her March 11, 2011 accident commencing March 24, 2011, until the present and continuing. This Conclusion is not supported by the reliable, probative, and substantial evidence in the record. This Conclusion ignores the mandate set forth in S.C. Code §42-9-190 that an injured worker who refuses suitable employment "shall not" be entitled to compensation. This Conclusion further relies on erroneous Findings of Fact as set forth more fully above.

12. The Commission erred in ordering that Claimant is entitled to receive temporary total disability compensation commencing March 24, 2011, to the present and continuing. This award is not supported by the reliable, probative, and substantial evidence in the record. This award further relies on erroneous Conclusions of Law and Findings of Fact as set forth more fully above.

13. Without waiving any of the specific objections raised above, the Commission erred as a matter of law in failing to find that Claimant had been terminated for cause and therefore is not entitled to temporary total disability benefits in accordance S.C. Code §42-9-190.

June 22, 2012

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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION APPELLATE PANEL

Andrea C. Roche, Commissioner
T. Scott Beck, Commissioner
Avery B. Wilkerson, Jr., Commissioner

W.C.C. File No.

Gayla Ramey, ... Claimant/Respondent,

v.

Unihealth Post Acute Care Tanglewood, ... Employer/Appellant,

and

American Zurich Ins. Co., ... Carrier/Appellant.

PROOF OF SERVICE

I certify that I have served the Notice of Appeal on Respondent, Gayla Ramey, by depositing a cop of it in the United States Mail, postage prepaid, on June 22, 2012, address to her attorney of record, Mark Calhoun, 714 East Main Street, Lexington, South Carolina, 29072

June 22, 2012

R. Daniel Addison
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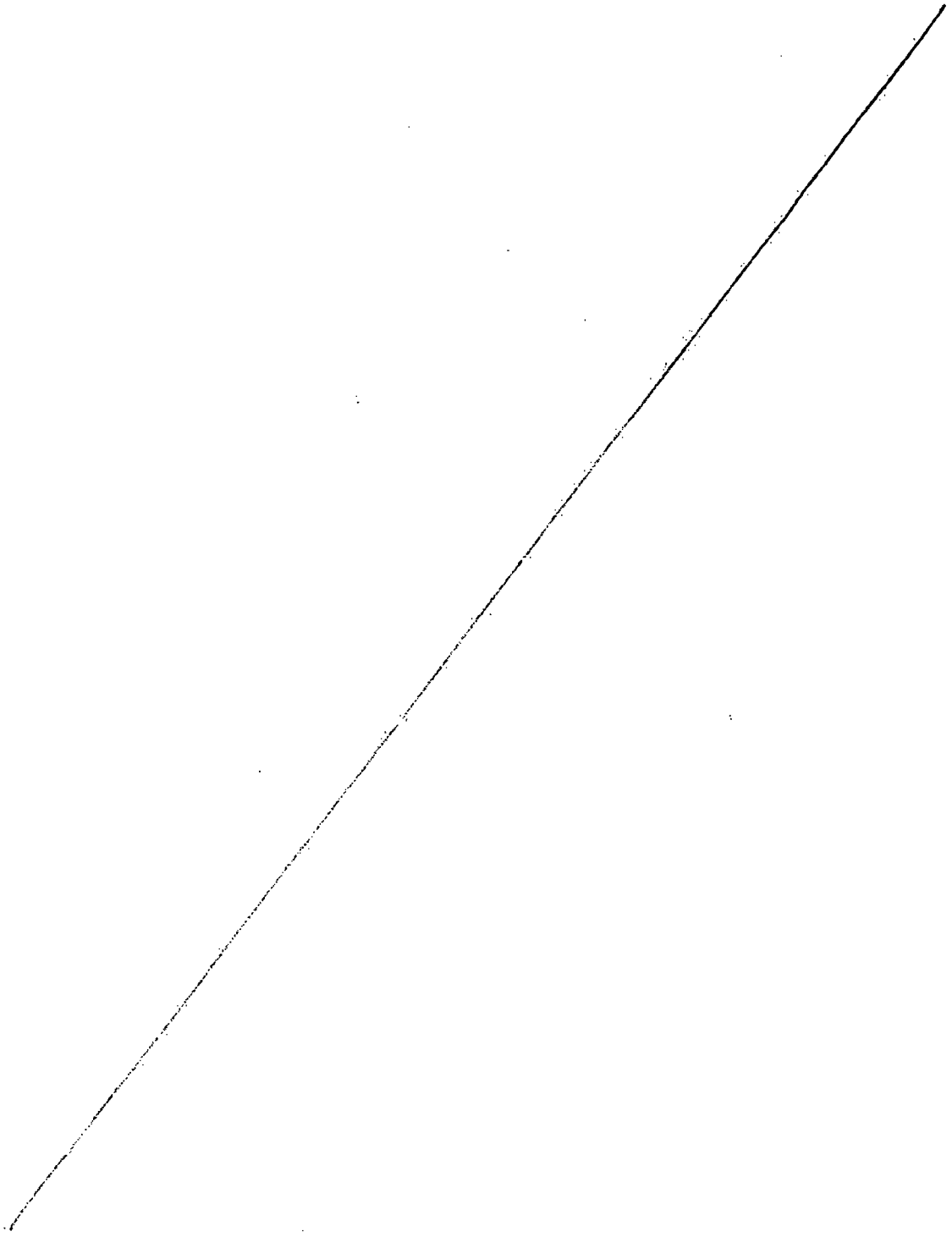


South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1333 Main Street, Suite 500
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # Unassigned
Carrier File # 68174982097623
Carrier Code #
Employer FEIN

Gayla Ramey [redacted] SSN
Claimant's Name
[redacted] City State Zip
Address
[redacted] Work Phone
Home Phone

Unihealth Post Acute Care Tanglewood
Employer's Name
213 Tanglewood Court Ridgeway SC 29130
Address City State Zip
American Zurich Ins. Co.
Insurance Carrier

Lynda C Burr (803)337-3211
Preparer's Name Phone #

Date of injury: 3/11/2011 (month day year)

A. Total Wages Paid

1. Check Applicable Method:
   - ☒ Report of earnings of injured employee based on four completed quarters.
   - ☐ Report of earnings of injured employee who did not complete four quarters based on actual time worked.
   - ☐ Report of earnings of injured employee who did not work sufficient time before alleged injury. Hire Date: _____.
   - ☐ Report of earnings of similar employee. Injured employee did not work sufficient time before alleged injury. Hire Date: _____.
   - ☐ Report of earnings of injured employee based on alternative method because Form 20 results in a compensation rate that is not fair and just. (Attach documentation to show how average weekly wage and compensation rate were calculated.)
2. List total wages paid as reported to Employment Security Commission on the Employer Quarterly Contribution and Wage Reports during the four quarters immediately preceding the quarter in which the injury occurred. Do not include the quarter during which the injury occurred.

Quarter	Ending Date	Total Wages Paid
1st	06/12/2010	$15152.33
2nd	09/04/2010	13474.57
3rd	11/27/2010	12391.67
4th	12/11/10	11361.90

Total Paid 2. 52380.47

3. List total value of other allowances of any character made in lieu of wages during four quarters above. 3. 0
4. Add lines 2 and 3 — TOTAL WAGES PAID: 4. 52380.47
5. List total number of weeks paid to employee during the four quarters immediately preceding the quarter in which the injury occurred. 5. 52

B. Average Weekly Wage

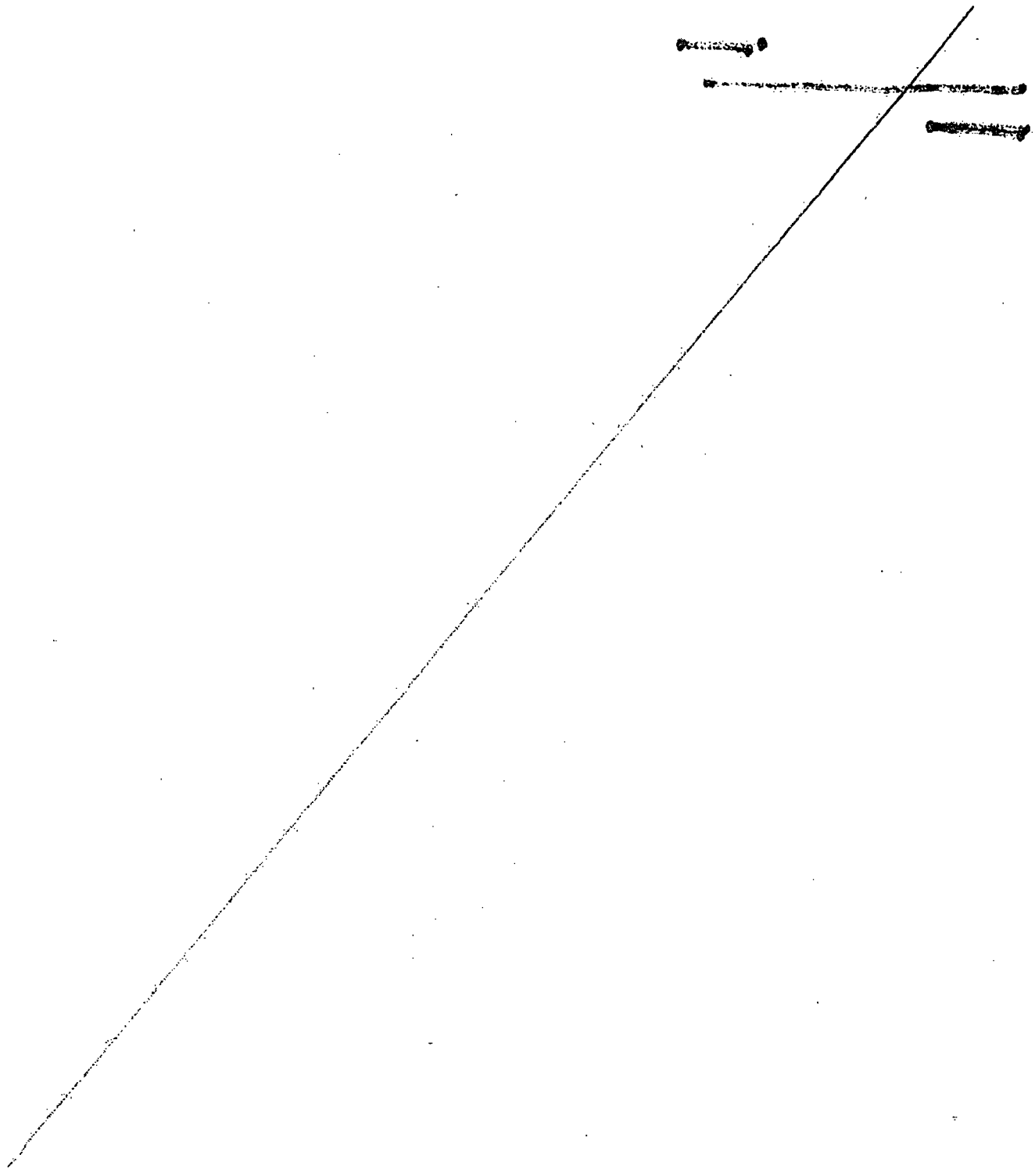
6. To calculate average weekly wage, divide total wages (line 4) by total weeks paid (line 5). — AVERAGE WEEKLY WAGE: 6. 1007.32

C. Compensation Rate

7. The general rule for calculating the compensation rate is to multiply average weekly wage (line 6) by .6667. Estimate compensation rate by multiplying average weekly wage (line 6) by .6667. See part 8 below to determine the actual compensation rate. 7. 671.58
8. The compensation rate is as follows (choose one):
   - ☐ When average weekly wage (line 6) is less than $75.00, the compensation rate is the average weekly wage. Enter average weekly wage on line 8.
   - ☐ When the estimated compensation rate (line 7) is less than $75.00 and average weekly wage (line 6) is more than $75.00, the compensation rate is $75.00. Enter $75.00 on line 8.
   - ☐ When the estimated compensation rate (line 7) is more than the maximum compensation rate for the year in which the injury occurred, enter the maximum compensation rate for the year in which the injury occurred on line 8.
   - ☐ Employee is within the exceptions listed in S.C. Code Ann. Section 42-7-65. List applicable Exception here _____ and enter appropriate compensation rate on line 8:
   - ☒ The calculated compensation rate (line 7) applies. Enter amount from line 7 on line 8.

WEEKLY COMPENSATION RATE: 8. 671.58

Employer's representative shall prepare a Form 20 and serve per R.67-211 a copy on the claimant within thirty days of beginning temporary compensation. See R.67-1603 when no temporary compensation is paid. NOTE: Average weekly wage represents average gross pay before taxes and other deductions. WHEN THE CLAIMANT DOES NOT AGREE WITH THE COMPENSATION RATE ON LINE 8, HE OR SHE SHOULD CONTACT THE EMPLOYER'S REPRESENTATIVE TO TRY TO REACH AN AGREEMENT AS TO THE COMPENSATION RATE. IF NO AGREEMENT CAN BE REACHED THE CLAIMANT SHOULD CONTACT THE CLAIMS DEPARTMENT AT (803) 737-5723.



SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
COLUMBIA, SOUTH CAROLINA
WCC FILE NO. 1103442

EMPLOYEE/CLAIMANT: GAYLA RAMEY

EMPLOYER: UNIHEALTH POST-ACUTE CARE TANGLEWOOD

INSURER: AMERICAN ZURICH INSURANCE COMPANY

SOUTH CAROLINA WORKERS' COMPENSATION HEARING

PURSUANT TO NOTICE OF WORKERS' COMPENSATION HEARING, THE WITHIN HEARING WAS TAKEN ON THE 10TH DAY OF AUGUST, 2011, COMMENCING AT THE HOUR OF 11:57 A.M., IN COLUMBIA, SOUTH CARCLINA, BEFORE THE HONORABLE BRYAN LYNDON, ATTENDED BY COUNSEL AS FOLLOWS:

JAN L. WHITWORTH
VERBATIM REPORTER

JAN L. WHITWORTH
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POST OFFICE BOX 551
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APPEARANCES

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ATTORNEY FOR THE EMPLOYEE/CLAIMANT,

R. DANIEL ADDISON, ESQUIRE, OF THE FIRM
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ATTORNEY FOR THE EMPLOYER/INSURER.

ALSO ATTENDING: WILLIAM BELLOTTI

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PURSUANT TO NOTICE OF HEARING, THE WITHIN HEARING WAS TAKEN BY THE ABOVE-NAMED COURT REPORTER, A NOTARY PUBLIC FOR THE STATE OF SOUTH CAROLINA, IN COLUMBIA, SOUTH CAROLINA.

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BY COMMISSIONER LYNDON:

TODAY'S DATE IS AUGUST THE 10TH, 2011. THIS IS SOUTH CAROLINA WORKERS' COMPENSATION CASE FILE NUMBER 1103442. GAYLA RAMEY IS THE CLAIMANT REPRESENTED BY ATTORNEY MARK CALHOUN VERSUS THE EMPLOYER UNIHEALTH POST-ACUTE CARE TANGLEWOOD. AMERICAN ZURICH IS THE CARRIER. DAN ADDISON IS THE ATTORNEY FOR THE DEFENDANT. THE PURPOSE OF THE HEARING IS TO DETERMINE ISSUES RAISED ON FORMS 50 AND 51. WE'VE HAD A DISPUTE OF SORTS ON THE AVERAGE WEEKLY WAGE AND COMP RATE. THE CLAIMANT'S POSITION IS THAT THE AVERAGE WEEKLY WAGE SHOULD BE $1099.17, WHICH WOULD RESULT IN THE MAXIMUM COMP RATE FOR 2011. I BELIEVE THAT MAY BE $704.32, WHATEVER THE MAXIMUM COMP RATE IS FOR 2011. THE POSITION OF THE DEFENDANT IS A 20 HAS BEEN COMPLETED. THAT COMES OFF DIRECTLY THE REPORT TO THE EMPLOYMENT SECURITY COMMISSION, AND THAT THE CLAIMANT'S AVERAGE WEEKLY WAGE WAS $1007.32, WHICH WOULD RESULT IN A COMP RATE OF $671.58. I'LL MAKE A DECISION ON WHICH. WE HAD

A FAIRLY LONG DISCUSSION ABOUT THAT, AND I'LL DECIDE WHICH I BELIEVE IS CORRECT. THE CLAIMANT'S POSITION WAS THAT THE PREVIOUS 52 WEEKS DO COME OUT TO $1099.17. THE DEFENDANTS' POSITION WAS THAT THE PREVIOUS FOUR QUARTERS THAT WERE REPORTED CONSISTENT WITH THE CODE REQUIREMENTS IS $1007.32. AND THE PURPOSE OF THE HEARING, I BELIEVE I STATED, WAS TO DISCUSS ISSUES RAISED ON FORMS 50 AND 51. THE DATE OF ACCIDENT IS 3/11/2011.

ARE THERE ANY OBJECTIONS TO APAs, JURISDICTION, VENUE, OR ANY OTHER ITEMS?

BY MR. CALHOUN:

NO, YOUR HONOR.

BY MR. ADDISON:

NONE FROM THE DEFENDANTS.

BY COMMISSIONER LYNDON:

ALL RIGHT. WITHOUT OBJECTION, THE COMMISSION FILE BECOMES A PART OF THE RECORD WITH THE EXCEPTION OF SELF-SERVING DECLARATIONS AND UNSTIPULATED MEDICAL REPORTS.

PRIOR TO GOING ON THE RECORD, WE HAD A FAIRLY LENGTHY PREHEARING CONFERENCE. ONE OF THE ISSUES WAS WHAT I JUST MENTIONED, THE AVERAGE WEEKLY WAGE AND COMP RATE. THE OTHER, COUNSEL FOR THE CLAIMANT STATES THE CLAIMANT IS NOT AT M.M.I., AND SHE SEEKS

TREATMENT CONSISTENT WITH THAT THAT HAS BEEN RECOMMENDED BY DR. "Z." I BELIEVE IT HAS BEEN CONCEDED OR AGREED BY THE DEFENDANT TO SEND THE CLAIMANT NOT TO A PHYSIATRIST BUT TO AN ORTHOPEDIST OF THEIR CHOOSING. SO, THAT ISSUE SHOULD BECOME A NON-ISSUE IF I UNDERSTAND THAT CORRECTLY. THE BIGGEST POINT OF THIS CONTEST WOULD BE WHETHER OR NOT THE CLAIMANT SHOULD RECEIVE TEMPORARY TOTAL FROM 3/21/11 TO THE PRESENT AND CONTINUING UNTIL SHE REACHES M.M.I. COUNSEL STATES THAT THE CLAIMANT WAS TERMINATED, I BELIEVE, ABOUT TEN DAYS AFTER GOING TO A DOCTOR. WE REVIEWED THE EXHIBITS THAT ARE ATTACHED TO THE EMPLOYER'S DEPOSITION REGARDING THAT. AND QUITE SIMPLY, AND THIS WILL COME OUT IN TESTIMONY, BUT COUNSEL STATES THAT NUMBER ONE, IT WAS KNOWN THAT THE CLAIMANT WAS GOING TO A DOCTOR, AND SHE HAD TROUBLE NOT ONLY CHECKING IN TO COMING TO WORK AND CHECKING OUT GOING TO THE DOCTOR AND CHECKING BACK IN AFTER COMING FROM THE DOCTOR, THERE IS A HAND APPARENTLY RECOGNITION SYSTEM USED INSTEAD OF JUST AN OLD PUNCH TIME CLOCK. THIS DID NOT FUNCTION IN HER CASE, AND BUT FOR THAT WE WOULDN'T BE HERE TODAY. SHE WOULD HAVE CHECKED IN, CHECKED OUT, AND SHE WAS DISCHARGED FOR FALSIFYING RECORDS, WHICH COUNSEL STATES REALLY IS -- IS A RIDICULOUSLY

HIGH STANDARD BASED ON WHAT HER INTENTIONS WERE THAT SHE WILL TESTIFY TO. SHE IS A NINE-YEAR EMPLOYEE WITH THE DEFENDANT. SO, SHE SHOULD GET THIS T.T., GET THE MEDICAL TREATMENT, AND AGAIN, SHE IS NOT AT M.M.I.

THE POSITION OF THE DEFENDANT IS THAT THE DEFENDANT WILL SEND THE CLAIMANT TO AN ORTHOPEDIST THAT THEY CHOOSE. THE CLAIMANT IS AN R.N. SHE IS A WELL-EDUCATED PERSON AND WAS ON LIGHT DUTY WITH NO HEAVY LIFTING, BUT SHE IS PRETTY MUCH IN CHARGE -- SHE DOES A LOT OF DESK WORK AND CLERICAL-TYPE WORK, CHARTING AND SO FORTH. SO, SHE WAS BEING FULLY ACCOMMODATED. THAT THIS MEDICARE IS HEAVILY INVOLVED IN THE RUNNING OF THIS FACILITY OR IS AUDITED BY THEM. THERE CAN BE NO FALSIFICATION OF RECORDS, AND THE RECORDS DO INDICATE THE CLAIMANT LEFT AND WENT TO A DOCTOR, CAME BACK, HOWEVER DID NOT DEDUCT THOSE HOURS FROM HER PAY THAT DAY. SO, SHE WAS SEPARATED AS A RESULT OF THAT FOR CAUSE. IT'S A POLICY THAT COUNSEL STATES A WITNESS WILL SAY THAT THEY HAVE EXERCISED IN THE PAST, AND THAT ALSO COUNSEL ASKS THAT I MAKE A CREDIBILITY FINDING. THE CLAIMANT HAS HAD PREVIOUS BACK PROBLEMS AND/OR NECK PROBLEMS FOR WHICH SHE HAS RECEIVED TREATMENT, I BELIEVE, INJECTIONS AND SO FORTH, BUT SHE WAS NOT

FORTHCOMING ON AN EMPLOYMENT APPLICATION REGARDING THIS. I BELIEVE THE QUESTION SPECIFICALLY WAS IF YOU HAD HAD BACK PROBLEMS IN THE PAST, AND ONE WAS SILENT AND ONE SAID "NO." SO, COUNSEL STATES IN ITS TOTALITY, THE CLAIMANT SHOULD GET THE MEDICAL TREATMENT THAT THEY ARE WILLING TO OFFER HER. THAT THE COMP RATE SHOULD BE $671.58 BASED ON THE PROPERLY FILLED OUT FORM 20, AND IT'S DENIED THAT SHE SHOULD RECEIVE ANY TEMPORARY TOTAL DISABILITY BENEFITS BECAUSE SHE WAS SEPARATED FOR CAUSE, SOMETHING THAT WAS CONSISTENT WITH THE POLICY THAT THEY HAVE. AND Y'ALL CAN ADD TO THAT AS YOU SEE FIT.

BY MR. CALHOUN:

NOTHING ELSE TO ADD TO THAT, YOUR HONOR.

BY MR. ADDISON:

COMMISSIONER, YOU INDICATED THAT THE TWO THINGS THAT I DISCUSSED IN OUR APAs, ONE WAS SILENT AND ONE SAID "NO." ACTUALLY, ONE HAS THE NO SYMBOL ON IT. IT IS NOT SILENT.

BY COMMISSIONER LYNDON:

OKAY. I SAW IT. IT'S A ZERO WITH A SLASH.

BY MR. ADDISON:

ZERO WITH A SLASH, AND THE OTHER ONE HAS THE ACTUAL WORD "NO" WRITTEN.

BY COMMISSIONER LYNDON:

THAT IS CORRECT. I DID MISS SPEAK.

BY MR. ADDISON:

I WANTED TO CLARIFY THAT FOR THE RECORD.

BY COMMISSIONER LYNDON:

THERE WAS -- IN THAT BLANK WAS A ZERO SLASH.

BY MR. ADDISON:

AND YOU HAD ASKED ME AT THE BEGINNING OF THIS WHEN WE WERE OFF THE RECORD, COMMISSIONER, ABOUT WHAT WAS ADMITTED. WE ADMITTED THE RIGHT ARM AND THE LOW BACK ON THE 12-A, THE ORIGINAL REPORT OF INJURY TO THE EMPLOYER WAS THAT SHE HAD FALLEN AND HIT HER RIGHT ARM AND WENT DOWN AND FALLEN ON HER BUTTOCKS WHEN SHE SLIPPED AND FELL ON THIS LANDING AREA. SO, IT WAS INITIALLY ADMITTED AS TO THE LOW BACK. THAT WAS WHAT WAS PUT ON THE FORM 51. MOST OF THE TREATMENT THAT WAS PROVIDED BY DOCTORS CARE WAS FOR THE UPPER NECK AREA, THE UPPER BACK AND NECK AREA AND HER RIGHT ARM, WHICH WAS QUITE FRANKLY A LITTLE BIT CONFUSING TO US, BUT I DON'T THINK AT ANY POINT ANYBODY EVER DENIED THE CARE TO THAT AREA. SO, WE'VE ADMITTED THE BACK, I SUPPOSE IS WHAT WE'VE DONE.

BY COMMISSIONER LYNDON:

SO, ANY ORTHO WORK THAT SHE WOULD GET WOULD BE

FOR THE BACK, WHICH WOULD BE ALL THREE LEVELS AS I'M UNDERSTANDING IT, RIGHT?

BY MR. ADDISON:

YES, SIR. BUT WE CERTAINLY -- AS I STATED WHEN WE WERE OFF THE RECORD, OUR CONCERN IS THAT THERE WERE PRIOR ISSUES. I BRING THAT UP BECAUSE WE FULLY ADMITTED IT AS A LOW BACK INJURY INITIALLY, YOU KNOW, FOR THE BUTTOCKS AREA, AND IT APPEARS THAT WE WERE -- THE PROBLEM SEEMED TO BE IN THE CERVICAL SPINE, AND THERE WERE PREVIOUSLY ISSUES THERE, WHICH THE M.R.I. REFLECT FROM THERE AS WELL. IT'S A DEGENERATIVE ISSUE GOING ON IN THE CERVICAL SPINE.

BY COMMISSIONER LYNDON:

ALL RIGHT, SIR.

MS. RAMEY.

BY THE WITNESS:

YES, SIR.

BY COMMISSIONER LYNDON:

WOULD YOU STATE YOUR FULL NAME FOR THE RECORD, PLEASE.

BY THE WITNESS:

GAYLA RENEE ISON RAMEY.

BY COMMISSIONER LYNDON:

AND SPELL YOUR MIDDLE NAME.

BY THE WITNESS:

R-E-N-E-E.

BY COMMISSIONER LYNDON:

AND YOUR -- THERE WAS ONE NAME I DIDN'T GET.

BY THE WITNESS:

ISON.

BY COMMISSIONER LYNDON:

ISON, YES.

BY THE WITNESS:

MY MAIDEN NAME, I-S-O-N.

BY COMMISSIONER LYNDON:

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THE WITNESS WAS DULY SWORN TO TELL THE TRUTH, THE WHOLE TRUTH, AND NOTHING BUT THE TRUTH CONCERNING THE MATTER HEREIN:

GAYLA RAMEY

BEING FIRST DULY SWORN, TESTIFIED ON HER OATH AS FOLLOWS:

BY COMMISSIONER LYNDON:

ALL RIGHT. ANSWER ANY QUESTIONS YOUR ATTORNEY MAY HAVE, PLEASE.

BY MR. CALHOUN:

COMMISSIONER, CAN I STAND ON THIS SIDE?

BY COMMISSIONER LYNDON:

SURE. IN FACT, THAT'S BETTER.

DIRECT EXAMINATION BY MR. CALHOUN:

Q. HOW OLD ARE YOU, GAYLA?

A. FIFTY.
Q. AND HOW MANY PEOPLE LIVE IN YOUR HOUSEHOLD?
A. ELEVEN.
Q. ARE THEY ALL RELATED TO YOU?
A. YES.
Q. CHILDREN AND GRANDCHILDREN?
A. YES.
Q. HOW FAR DID YOU GO IN SCHOOL?
A. I GOT AN ASSOCIATE'S DEGREE FOR R.N., AND I'VE HAD OTHER EDUCATIONAL BACKGROUND AS WELL.
Q. WHAT YEAR DID YOU GET YOUR R.N. DEGREE?
A. 2008.
Q. OKAY. IN FACT, DID YOUR EMPLOYER UNIHEALTH GIVE YOU A SCHOLARSHIP TO GET THAT DEGREE?
A. YES, THEY DID.
Q. AND THAT SCHOLARSHIP WAS GIVEN TO YOU IN THE YEAR 2008?
A. IT WAS COMPLETED THEN, YES.
Q. OKAY. BRIEFLY DESCRIBE FOR THE COMMISSIONER WHAT YOUR DUTIES ARE AT UNIHEALTH.
A. AS A R.N., WE WILL DO TREATMENT ON PATIENTS, ASSESSMENTS INCLUDING MOVING AND HELPING, TURNING THEM IN BED, SOMETIMES HELPING THEM GET IN AND OUT OF BED. SOMETIMES PUSHING THEM AROUND IN WHEELCHAIRS IF THEY NEED ASSISTANCE GOING FROM ONE

AREA OF THE FACILITY TO ANOTHER, PUSHING THE MED CART, PULLING CHARTS OUT OF THE WALL AND DOING A LOT OF CHARTING AND DEALING WITH -- WORKING WITH FAMILY AND THE DOCTOR TO TAKE CARE OF THOSE PATIENTS.

Q. MS. RAMEY, HAVE YOU EVER HAD ANY PROBLEMS RELATED TO YOUR SPINE, YOUR BACK?

A. NO.

Q. YOUR FAMILY PRACTICE MEDICAL RECORDS INDICATE THAT, I BELIEVE, IN THE YEAR 2008 YOU RECEIVED FROM TREATMENT FOR MUSCLE SPASMS?

A. YES.

Q. PLEASE EXPLAIN THAT TO THE COMMISSIONER.

A. I WAS HAVING A LOT OF STRESS AT THE TIME, AND FOR ABOUT TWO WEEKS, I KEPT HAVING SOME MUSCLE SPASMS IN MY RIGHT SHOULDER, AND THE DOCTOR GIVE ME SOME STEROID INJECTIONS, WHICH CLEARED IT UP. SHE HAD SAID IT WOULD TAKE ABOUT 24 HOURS FOR THAT MUSCLE TO RELAX AND EVERYTHING WOULD GO AWAY, AND IT IN FACT DID DO THAT.

Q. BUT THOSE ISSUES WITH YOUR SHOULDER WERE NEVER RELATED TO YOUR SPINE IN ANY WAY?

A. NO.

Q. OKAY. THEY WERE MUSCULAR ONLY; IS THAT CORRECT?

A. YES.

Q. ALL RIGHT. WHEN YOU WERE INJURED ON MARCH THE 11TH,

HAD YOU PUNCHED IN THAT MORNING?

A. YES, I DID.

Q. AND WHEN YOU PUNCH IN, IS THAT ACTUALLY DONE THROUGH A SCANNING DEVICE WITH YOUR HAND?

A. A HAND SCANNER, YES.

Q. AND AFTER YOU FELL, YOU WERE IMMEDIATELY SENT TO DOCTOR'S CARE THAT DAY; IS THAT CORRECT?

A. YES.

Q. OKAY. SO, DID YOU EVER PUNCH OUT THAT DAY THAT YOU FELL?

A. NO.

Q. WERE YOU PAID YOUR NORMAL HOURS FROM MARCH THE 11TH, THE DAY THAT YOU FELL?

A. MY UNDERSTANDING IS THAT I WAS.

Q. OKAY. AND DOCTORS CARE PUT YOU ON WORK RESTRICTIONS THAT DAY, CORRECT?

A. YES, HE DID.

Q. OKAY. AND THOSE WORK RESTRICTIONS CONSISTED OF NO MORE THAN 30 MINUTES PER HOUR ON YOUR FEET, LIMITED USE OF YOUR BACK, NO USE OF THE RIGHT ARM, A TEN-POUND LIFTING RESTRICTION, AND NO REPETITIVE BENDING, TWISTING, STOOPING, SQUATTING, OR PUSHING; IS THAT RIGHT?

A. YES.

Q. DID YOUR EMPLOYER ACCOMMODATE THOSE WORK

RESTRICTIONS, OR DID THEY KEEP YOU WORKING?

A. I KEPT WORKING.

Q. WHAT DID YOUR EMPLOYER HAVE YOU DOING AFTER MARCH THE 11TH?

A. WALKING ALL AROUND THE FACILITY IN AND OUT OF RESIDENT'S ROOMS, DOING A LOT OF PAPERWORK, WRITING -- I HAD TO PULL CHARTS FROM OVERHEAD TO GET CERTAIN PERSONAL INFORMATION TO PUT ON THOSE FORMS. SOME TIMES I PUSHED THE RESIDENTS. IF THEY WERE LIKE IN THE SMOKE AREA OR WHEREVER IN A WHEELCHAIR, AND I NEEDED TO INTERVIEW THEM IN PRIVATE, I WOULD PUSH THEM -- I HAD TO PUSH THEM INTO THEIR ROOMS IN ORDER TO INTERVIEW THEM.

Q. SO, DO YOU FEEL THAT THE NEW JOB THAT YOUR EMPLOYER HAD YOU PERFORMING VIOLATED THOSE WORK RESTRICTIONS IN SOME WAY?

A. YES.

Q. WERE THERE OTHER WOMAN WORKING WITH YOU DURING THIS PERIOD OF TIME WHO ALSO HAD BEEN INJURED IN WORKERS' COMPENSATION CLAIMS?

A. YES.

Q. ALL RIGHT. NOW, WHAT WERE THEIR NAMES?

A. TAMMY WATKINS AND LISA JACOBS.

Q. OKAY. AND THESE WOMAN HAD PENDING WORKERS' COMPENSATION CASES; IS THAT CORRECT?

A. YES, THEY DID.

Q. AND THEY WERE KEPT WORKING?

A. YES.

Q. OKAY. WHAT WAS YOUR -- WAS THERE ANYTHING ABOUT YOUR UNDERSTANDING OF THOSE WOMEN THAT HAD YOU WORRIED ABOUT YOUR JOB SECURITY IN THE FUTURE?

A. YES, I WAS UNDER THE UNDERSTANDING THAT ONE OF THEM WAS ABOUT TO GET FIRED.

BY MR. ADDISON:

COMMISSIONER, I'M GOING TO HAVE TO OBJECT TO SPECULATION. SHE HAS NO EVIDENCE OF THAT.

BY COMMISSIONER LYNDON:

I DO AGREE WITH THAT. WE KNOW THAT TWO OTHER PEOPLE HAVE CLAIMS, AND WE CAN MOVE ON.

BY MR. CALHOUN:

OKAY.

DIRECT EXAMINATION RESUMED BY MR. CALHOUN:

Q. I'M NOT GOING TO ASK YOU ABOUT WHAT YOUR UNDERSTANDING WAS, BUT YOU WERE SCARED OF LOSING YOUR JOB; IS THAT CORRECT?

A. YES, I WAS.

Q. OKAY. YOU HAD A DOCTOR'S APPOINTMENT ON MARCH THE 18TH; ISN'T THAT CORRECT?

A. YES.

Q. AND IT WAS IN THE MORNING OF MARCH THE 18TH?

A. YES.
Q. DID LINDA BURR KNOW ABOUT THAT DOCTOR'S APPOINTMENT?
A. YES.
Q. WHAT TIME DID YOU GO TO WORK ON MARCH THE 18TH?
A. SEVEN A.M.
Q. WHY DID YOU GO IN AT SEVEN?
A. I UNDERSTOOD THAT LINDA WAS LEAVING EARLY THAT DAY AND NEEDED TO SEE ME BEFORE SHE LEFT. SO, I WENT IN AN HOUR EARLIER THAN USUAL TO GET -- TO TOUCH BASE WITH HER ABOUT MY DOCTOR'S APPOINTMENT. BUT SHE HAD TOLD ME THE DAY BEFORE TO GO EARLY BECAUSE SHE WAS LEAVING EARLY.
Q. AND LINDA KNEW ABOUT YOUR DOCTOR'S APPOINTMENT ON THE 18TH, CORRECT?
A. YES, SHE DID.
Q. ALL RIGHT. WHEN YOU SHOWED UP AT 7:30, WAS LINDA THERE?
A. NO.
Q. OKAY. AND DID YOU EVENTUALLY LEAVE TO GO TO YOUR DOCTOR'S APPOINTMENT?
A. YES.
Q. WERE YOU ABLE TO PUNCH IN BECAUSE OF THE HAND SCANNER THAT DAY?
A. NO.
Q. WHAT WAS THE PROBLEM?

A. THE HAND SCANNER JUST WASN'T WORKING FOR MY HAND AT THE TIME.

Q. OKAY. AND YOU HAD YOUR APPOINTMENT WITH DOCTORS CARE, RIGHT?

A. YES.

Q. AND ABOUT WHAT TIME DID YOU RETURN TO WORK?

A. PROBABLY AROUND 9:45 A.M.

Q. AND YOU WERE SUPPOSED TO WORK THAT MORNING UNTIL WHAT TIME?

A. I WAS TOLD TO LEAVE EARLY AT 10:30 A.M.

Q. OKAY. WHY WERE YOU TOLD TO LEAVE EARLY?

A. SHE WANTED ME TO WORK -- MY SUPERVISOR, TONYA SHEPHERD, WANTED ME TO WORK THE NEXT TWO DAYS, SATURDAY AND SUNDAY.

Q. OKAY. SO, THEY LEFT YOU OFF WORK EARLY?

A. YES.

Q. WHEN YOU WERE INJURED ON THE 18TH, YOU'VE TESTIFIED THAT YOU WERE PAID FOR THE TIME AFTER YOU FELL AND WENT TO DOCTORS CARE, CORRECT?

A. YES.

Q. AND THAT WAS THE DAY THAT YOU DID PUNCH IN, RIGHT?

A. YES.

Q. AND YOU DIDN'T PUNCH OUT WHEN YOU WENT TO THE DOCTOR?

A. NO.

Q. SO, YOU WERE PAID FOR THAT TIME OUT OF WORK EVEN THOUGH YOU HAD NOT PUNCHED OUT?

A. YES.

Q. OKAY. WAS YOUR UNDERSTANDING THAT YOU ARE ENTITLED TO BE PAID FOR TIME FOR DOCTOR VISITS?

A. YES, AND NOBODY EVER TOLD ME ANY DIFFERENT.

Q. ALL RIGHT. AND THAT HAD BEEN CORROBORATED BY THE FACT THAT YOU WERE PAID FOR THE DAY THAT YOU ACTUALLY WERE INJURED, CORRECT?

A. YES.

Q. SO, WHEN YOU RETURNED TO WORK, YOU HAD TO FILL OUT THIS REQUEST FOR MISSED TIME FORM DUE TO THE PUNCH CLOCK; IS THAT RIGHT?

A. YES.

Q. AND THE TIMES THAT YOU WROTE ON THAT FORM WERE SEVEN TO 10:30 A.M.?

A. THAT'S CORRECT.

Q. DID YOU HAVE TO GET YOUR SUPERVISORS TO APPROVE THAT FORM?

A. YES, I DID.

Q. WHICH SUPERVISORS APPROVED THE FORM?

A. CARRIE RAY AND TONYA SHEPHERD.

Q. DID MS. RAY AND MS. SHEPHERD KNOW THAT YOU HAD BEEN TO THE DOCTOR THAT MORNING?

A. YES.

Q. OKAY. DID THEY INDICATE THEY HAD ANY PROBLEM SIGNING IT?
A. NO.
Q. OKAY. AND THEN YOU WENT HOME THAT DAY?
A. YES, I DID.
Q. NOW, YOU WERE FIRED THREE DAYS LATER ON MARCH THE 21ST, CORRECT?
A. YES.
Q. WHO CALLED YOU INTO HER OFFICE TO FIRE YOU?
A. LINDA BURR.
Q. AND HOW DID MS. BURR EXPLAIN TO YOU THE REASONS WHY YOU WERE BEING FIRED?
A. THAT I WASN'T ALLOWED TO BE OUT TO A DOCTOR'S APPOINTMENT ON THE CLOCK.
Q. OKAY. SHE SAID THAT YOU WERE ALLOWED TO BE PAID FOR TIME GOING TO THE DOCTOR?
A. I UNDERSTOOD THAT TO BE CORRECT.
Q. DID YOU EVER INDICATE TO MS. BURR THAT YOU FELT THAT YOU HAD DONE ANYTHING WRONG?
A. NO.
Q. YOU WERE ALREADY SCARED OF BEING FIRED; IS THAT CORRECT?
A. YES.
Q. WOULD YOU HAVE DONE ANYTHING AT ALL TO GIVE YOUR EMPLOYER AN EXCUSE TO FIRE YOU?

A. CERTAINLY NOT.

Q. IF MS. BURR AND YOUR TWO SUPERVISORS KNEW YOU WERE AT THE DOCTOR THAT MORNING, HOW COULD THAT HAVE BEEN FALSIFYING RECORDS?

A. THAT'S THE SAME EXACT QUESTION THAT I ASKED LINDA WHEN SHE WAS TALKING TO ME ABOUT THE REASON WHY I WAS TERMINATED. I DIDN'T UNDERSTAND WHY I WAS BEING TERMINATED FOR GOING TO THE DOCTOR WHEN I WAS UNDER THE UNDERSTANDING THAT I DID GET PAID ON WORKMANS' COMP WHEN I WAS OUT TO THE DOCTOR, AND TONYA SHEPHERD WHO IS MY DIRECTOR OF NURSING SIGNED MY CLOCK IN AND OUT SHEET APPROVING ME TO GET PAID FOR THAT TIME, SEVEN A.M. TO 10:30 A.M., AND...

Q. AND SHE KNEW YOU HAD LEFT AND GONE TO THE DOCTOR THAT MORNING, CORRECT?

A. SHE DID. THAT'S WHY SHE SENT ME HOME EARLY. SHE WAS THERE. SHE WAS THE FIRST PERSON -- TONYA SHEPHERD WAS THE FIRST -- ONE OF THE FIRST PEOPLE I SEEN WHEN I CAME BACK FROM THE DOCTOR.

Q. OKAY. SINCE YOU WERE FIRED, HAVE YOU BEEN ABLE TO FIND ANY WORK?

A. NO. I'VE LOOKED AT VARIOUS DIFFERENT TYPES OF JOBS ON THE INTERNET AND IN THE NEWSPAPER TO SEE IF THERE WAS ANYTHING THAT I COULD DO, BUT THERE'S REALLY NOTHING THAT I'VE FOUND THAT I COULD ACTUALLY DO

THAT WOULDN'T GO AGAINST MY WORK RESTRICTIONS. AND SINCE I HAVEN'T HAD ANY TREATMENT, AND I DON'T REALLY -- I'M REALLY KIND OF IN FEAR OF DOING ANYTHING TO FURTHER INJURE MYSELF.

Q. DO YOU WANT THE TREATMENT THAT DR. "Z" HAS RECOMMENDED FOR YOU?

A. YES.

Q. ARE YOU REQUESTING TO BE PAID FOR TEMPORARY TOTAL DISABILITY BENEFITS UNTIL THE DOCTORS HAVE AN OPPORTUNITY TO HELP YOU?

A. YES, I AM.

Q. AND ARE YOU REQUESTING THE PAST DUE T.T.D. FROM THE DAY THAT YOU WERE FIRED, MARCH THE 21ST?

A. YES, I AM.

Q. WHAT HAVE YOU DONE TO LOOK FOR WORK SINCE YOU WERE FIRED?

A. I'VE PICKED UP A COUPLE OF NEWSPAPERS, THE STATE AND THE CAMDEN CHRONICLE, AND I'VE LOOKED ON LINE AT SOME OF THE JOB SITES TO SEE IF THERE WAS ANYTHING THAT I COULD POSSIBLY DO, BUT I HAVEN'T FOUND ANYTHING THAT DIDN'T ACTUALLY REQUIRE ANYTHING THAT WOULDN'T HURT ME AS FAR AS MY WORK RESTRICTIONS GO.

BY MR. CALHOUN:

OKAY. THAT'S ALL I HAVE, COMMISSIONER.

BY COMMISSIONER LYNDON:

ALL RIGHT. MA'AM, ANSWER ANY QUESTIONS THAT MR. ADDISON MAY HAVE, PLEASE.

BY THE WITNESS:

OKAY.

CROSS EXAMINATION BY MR. ADDISON:

Q. MS. RAMEY.

A. YES.

Q. THE DAY YOU HAD YOUR INJURY, YOU FILLED OUT A BUNCH OF PAPERWORK; DO YOU REMEMBER THAT?

A. YES, SIR.

Q. YOU TOLD ME THAT IN YOUR DEPOSITION. DO YOU REMEMBER TELLING ME THAT?

A. YES.

Q. OKAY. WITHIN THAT PAPERWORK WAS A PIECE OF PAPER THAT TOLD YOU YOU DIDN'T GET PAID WHEN YOU WENT TO THE DOCTOR.

BY MR. ADDISON:

PAGE 136 OF THE DEFENDANTS' APA, COMMISSIONER.

BY COMMISSIONER LYNDON:

ALL RIGHT.

BY MR. ADDISON:

MAY I APPROACH, COMMISSIONER?

BY COMMISSIONER LYNDON:

YES, SIR.

CROSS EXAMINATION RESUMED BY MR. ADDISON:

Q. DO YOU REMEMBER SIGNING THAT PIECE OF PAPER RIGHT THERE ON THE 11TH?

A. (REVIEWING DOCUMENT)

Q. I ASKED YOU THIS IN YOUR DEPOSITION.

A. I GUESS I DID SIGN IT.

Q. OKAY. IN THE LATER PART, IT SAYS "IN THE EVENT I HAVE TO ATTEND A DOCTOR APPOINTMENT, CANNOT COME INTO WORK BECAUSE OF MY INJURY OR HAVE TO LEAVE EARLY, I UNDERSTAND I MUST CONTACT MY SUPERVISOR, AND I WILL NOT BE COMPENSATED BY MY EMPLOYER FOR ANY LOST TIME. IN ADDITION, I UNDERSTAND THAT WHENEVER POSSIBLE, ALL APPOINTMENTS MUST BE MADE AROUND MY WORK SCHEDULE." THE EMPLOYER SPECIFICALLY TOLD YOU THE DAY YOU GOT INJURED ON THIS PIECE OF PAPER YOU WEREN'T GOING TO BE PAID FOR WHATEVER TIME YOU MISSED WHEN YOU WENT TO A DOCTOR'S OFFICE BY THE EMPLOYER?

A. MY MISTAKE FOR NOT READING ALL OF THE -- THE BOOKLET THAT I WAS GIVEN.

Q. OKAY. BUT YOU'VE MADE STATEMENTS THAT IT WAS YOUR UNDERSTANDING THAT THE EMPLOYER WAS GOING TO PAY YOU WHEN YOU WENT TO THE DOCTOR?

A. YES, SIR.

Q. BUT THEY SPECIFICALLY TOLD YOU THE DAY YOU GOT HURT ON A PIECE OF PAPER AND YOU SIGNED THAT PIECE OF

PAPER THAT YOU WEREN'T GOING TO BE PAID WHEN YOU WENT TO THE DOCTOR?

A. I SIGNED THE PAPERWORK, BUT I ACTUALLY DIDN'T GO THROUGH AND READ EVERYTHING, YES, SIR.

Q. OKAY.

BY MR. ADDISON:

THAT'S PAGE 137 OF THE APA.

CROSS EXAMINATION RESUMED BY MR. ADDISON:

Q. "I, GAYLE RAMEY, ELECT TO USE MY PERSONAL LEAVE IN LIEU OF WORKERS' COMP DISABILITY BENEFITS FOR THE FOLLOWING REASONS DURING THE WORKERS' COMP WAITING PERIOD." SO, THE WAITING PERIOD, THIS WAS DONE ON 3/11. DO YOU REMEMBER SIGNING THIS DOCUMENT?

A. YES, AND I ASKED ABOUT THAT PAPERWORK RIGHT THERE.

Q. ALL RIGHT. THE EMPLOYER ASSERTS THE RIGHT UNDER THE WORKERS' COMP SYSTEM TO NOT START BENEFITS WITHIN THE FIRST TWO WEEKS.

A. I WASN'T TOLD HOW LONG, BUT I WAS TOLD THAT I WOULD BE ALLOWED TO USE P.T.O. TIME IF I NEEDED TO UNTIL ANY KIND OF INSURANCE KICKED IN.

Q. ALL RIGHT. NOW, THE DAY THAT THIS ALL HAPPENED ON THE 18TH, YOU WENT TO THE DOCTOR. IT WAS NOT THE FIRST TIME YOU HAD BEEN TO THE DOCTOR. IT WAS ACTUALLY THE THIRD TIME YOU HAD BEEN TO THE DOCTOR TO DOCTORS CARE, CORRECT?

A. YES.
Q. WE HAVE THAT YOU WENT ON THE 11TH; YOU WENT ON THE 14TH, AND THEN YOU WENT ON THE 18TH.
A. YES.
Q. YOU HAD BEEN HAVING SOME PROBLEMS WITH THE MACHINE GETTING YOUR HAND SCANNED BEFORE THAT DATE; BEFORE THE 18TH, YOU HAD BEEN HAVING ISSUES, CORRECT?
A. YES.
Q. YOU WENT IN AND TRIED TO SCAN YOUR HAND, AND IT WOULDN'T SCAN THAT MORNING AT 7:00, RIGHT?
A. (NO VERBAL RESPONSE)
Q. WHEN YOU WENT INTO THE FACILITY AT 7:00 ON THE DATE OF THE 18TH, YOU TRIED TO SCAN YOUR HAND, AND THE MACHINE WOULD NOT SCAN YOUR HAND AT 7:00?
A. NO.
Q. IS THAT NO YOU DIDN'T DO THAT OR NO IT DIDN'T SCAN YOUR HAND?
A. NO, I DIDN'T DO THAT, BECAUSE I KNOW THE CLOCK WON'T SCAN MY HAND IF IT ALREADY HAD A PROBLEM, AND MS. BURR HAS TO DO A PROCEDURE WITH YOU AT THE CLOCK WITH YOUR HAND IN ORDER FOR IT TO WORK AGAIN.
Q. SO, YOU DID NOT EVEN TRY TO SCAN IT THAT DAY?
A. NO.
Q. OKAY, ALL RIGHT. BECAUSE IT HAD BEEN FOR SEVERAL DAYS HAD NOT BEEN SCANNING YOU?

A. YES.

Q. OKAY. ON THE 16TH, YOU TRIED TO CLOCK IN, AND IT SAYS THE CLOCK WOULDN'T LET YOU PUNCH ---

BY MR. ADDISON:

THIS IS UNDER TAB ONE, WHICH I KNOW YOU DON'T HAVE TABS, COMMISSIONER, BUT IT'S IN MS. BURR'S DEPOSITION.

BY COMMISSIONER LYNDON:

OKAY.

BY MR. ADDISON:

IT'S IN DEFENDANTS' EXHIBIT ONE, THE FOURTH PAGE. IT'S A TIME CARD REPORT.

CROSS EXAMINATION RESUMED BY MR. ADDISON:

Q. ON THAT TIME CARD REPORT, IT INDICATED THAT ON THE 15TH, YOU TRIED TO PUNCH IN AND IT WOULDN'T LET YOU, AND ON THE 16TH, YOU TRIED TO PUNCH IN, THE 16TH -- EXCUSE ME, THE 17TH AND THEN THE 18TH; IS THAT RIGHT, SEVERAL DAYS IN A ROW?

A. YES.

Q. OKAY. WHEN WAS THE LAST TIME YOU HAD TRIED TO SCAN YOUR HAND BEFORE THE 18TH?

A. I DON'T REMEMBER THE LAST TIME I TRIED TO SCAN IT AND IT DIDN'T WORK.

Q. OKAY. YOU WOULD AGREE WITH ME, I MEAN, THAT DAY YOU WERE AT THE DOCTOR, NO QUESTION, ON THE 18TH?

A. YES, I WAS.
Q. OKAY. AND YOU WENT TO YOUR SUPERVISOR AND FILLED OUT THIS DOCUMENT THAT WAS PRESENTED ON THE 18TH "A REQUEST TO CORRECT OR ENTER A MISSED PUNCH"? YOU ASKED THE EMPLOYER TO DO THAT FOR YOU?
A. YES.
Q. ALL RIGHT. IT WAS APPROVED BY CARRIE RAY AND TINA SOMEBODY, I THINK?
A. TONYA SHEPHERD.
Q. TONYA SHEPHERD. WHICH ONE OF THOSE TWO DID YOU GO TO?
A. BOTH.
Q. BOTH AND TOLD THEM THAT YOU WANTED THE CLOCK -- YOUR PUNCH TO BE ACCEPTED BECAUSE ---
A. NO, THAT'S NOT WHAT I HAD TO DO.
Q. OKAY. ALL RIGHT. "REASON FOR REQUEST: CLOCK NOT ACCEPT PUNCH." DID YOU WRITE THAT?
A. THAT'S RIGHT.
Q. OKAY. IT LOOKS LIKE YOUR HANDWRITING. THAT'S WHY I'M ASKING.
A. THAT'S SO LINDA KNOWS THAT THE CLOCK IS STILL NOT TAKING YOUR PUNCH.
Q. OKAY.
A. AND SHE STILL HASN'T GOT WITH YOU IN ORDER TO CORRECT THAT.

Q. WHAT WAS SPECIFICALLY WRITTEN WAS "CLOCK WOULD -- CLOCK NOT ACCEPT PUNCH." I'M READING ---

A. THAT'S RIGHT.

Q. --- IT VERBATIM.

A. CLOCK NOT ACCEPTING PUNCH; THAT'S RIGHT.

Q. OKAY. YOU DIDN'T TRY TO PUNCH IT THAT DAY. YOU HAD BEEN HAVING PROBLEMS THE DAY BEFORE. YOU THEN PUT IN A REQUEST TO HAVE THE EMPLOYER PAY YOU FOR THE TIME THAT YOU LISTED ON THAT DOCUMENT, WHICH WAS SEVEN A.M. TO 10:30 A.M.?

A. WHEN I ARRIVED AT WORK, THE SUPERVISOR THAT DID CLOCK ME IN KNEW I WAS THERE AND KNEW I WAS GETTING READY TO LEAVE FOR A DOCTOR'S APPOINTMENT AT SOME POINT THAT MORNING, AND I TOLD HER WHEN I WAS LEAVING. AND WHEN I RETURNED FROM MY DOCTOR'S APPOINTMENT, I TOLD TONYA SHEPHERD WHO IS MY DIRECTOR OF NURSING THAT I WAS BACK FROM THE DOCTOR.

BY MR. ADDISON:

COMMISSIONER, I'M GOING TO HAVE TO -- THIS IS NON RESPONSIVE. I ASKED A PRETTY SIMPLE QUESTION, IF IN THE STATEMENT THAT SHE FILLED OUT AND GAVE TO THE EMPLOYER WAS ASKING TO BE PAID FROM SEVEN O'CLOCK TO 10:30.

BY COMMISSIONER LYNDON:

ASK THE QUESTION AGAIN.

YOU CAN EXPLAIN YOUR ANSWER, BUT IF YOU WOULD ANSWER SPECIFICALLY THAT QUESTION. AND ALSO, YOUR ATTORNEY IS GOING TO GET A CHANCE TO ASK YOU TO CLARIFY ANYTHING YOU WANT TO.

BY THE WITNESS:

OKAY.

CROSS EXAMINATION RESUMED BY MR. ADDISON:

Q. I MEAN, THE DOCUMENT WAS FILLED OUT ON THE 18TH AND SPECIFICALLY STATED THAT THE IN TIME WAS SEVEN O'CLOCK A.M. AND THE OUT TIME WAS 10:30 A.M. THAT'S WHAT YOU WERE REQUESTING TO BE PAID FOR?

A. YES.

Q. OKAY. AND THAT WAS BECAUSE THE MACHINE HAD SCREWED UP BEFORE AND YOU HAD NOT EVEN TRIED TO PUNCH IN THAT MORNING BECAUSE IT HAD BEEN SCREWING UP FOR A COUPLE OF DAYS?

A. YES, I HAD TO USE ONE OF THOSE SHEETS BECAUSE THE CLOCK HADN'T BEEN WORKING.

Q. OKAY, ALL RIGHT. NOW, YOU SAID THAT YOU WERE SCARED ABOUT LOSING YOUR JOB WHEN YOU HAD THIS WORKER'S COMP INJURY. I MEAN, YOU'VE HAD PROBLEMS; YOU'VE HAD MEDICAL PROBLEMS BEFORE WORKING WITH THE EMPLOYER, HAVEN'T YOU? YOU'VE BEEN OUT FOR SURGERY. YOU HAD A GALLBLADDER REMOVAL EARLIER IN 2007, I BELIEVE?

A. YES, I DID.

Q. YOU'VE HAD SOME OTHER MEDICAL ISSUES THAT HAVE HAD TO BE DEALT WITH. YOU HAVEN'T HAD ANY WORKERS' COMP CLAIMS, BUT YOU'VE HAD SOME OTHER MEDICAL ISSUES WHERE YOU'VE MISSED TIME FROM WORK FOR VARIOUS MEDICAL ISSUES HERE AND THERE, HAVEN'T YOU?

A. WHEN MY MOTHER DIED, I HAD TO BE OUT FOR LIKE A MONTH.

Q. OKAY. DID THEY FIRE YOU FOR ANY OF THAT?

A. NO.

Q. THEY ACTUALLY PAID FOR YOU TO GO TO NURSING SCHOOL; DID THEY NOT?

A. YES, THEY DID.

Q. IN 2008 OR 2007 AND 2008. YOU APPLIED FOR IT AND GOT A SCHOLARSHIP THROUGH THE EMPLOYER. SO, I MEAN, YOU WERE INDICATING TO THE COMMISSIONER SOMEHOW THAT YOU HAD SOME FEAR OF THIS EMPLOYER ONCE YOU HAD A WORKERS' COMP CLAIM -- YOU WOULD AGREE WITH ME THERE ARE OTHER PEOPLE THAT ARE AT THAT FACILITY THAT HAVE COMP CLAIMS THAT CONTINUE TO WORK ON LIGHT DUTY; WOULD YOU NOT?

A. THERE IS ONE OF THE NURSES WORKING ON LIGHT DUTY.

Q. OKAY. SO, YOU SAID YOU HAVE THIS GREAT FEAR OF BEING FIRED, BUT I MEAN, THE EMPLOYER HAD TREATED YOU FAIRLY WELL UP TO THE POINT WHERE YOU ACTUALLY

WERE TERMINATED ON THE 18TH, HAVE THEY NOT?

A. YES.

Q. OKAY. THE DAY YOU REPORTED THE INJURY, YOU WENT INTO DOCTORS CARE AND TOLD DOCTORS CARE THAT YOUR LOW BACK WAS BOTHERING YOU, THE PARASPINAL MUSCLES IN YOUR BACK AND YOUR RIGHT ARM; DO YOU REMEMBER THAT?

A. RESTATE THAT.

BY MR. ADDISON:

STARTING AT PAGE 109 IN THE CLAIMANT'S APA, COMMISSIONER.

BY THE WITNESS:

ON WHAT DATE? I'M SORRY.

BY MR. ADDISON:

ON 3/11.

THE WITNESS ANSWERS:

A. YES, I TOLD DOCTORS CARE THAT MY ARM AND MY MID BACK AND MY NECK WAS HURTING ME AS WELL AS MY TAIL WHERE I HAD LANDED ON MY TAIL.

Q. OKAY. AND THE REASON I'M ASKING, MA'AM, IS BECAUSE I'VE LOOKED OVER THE DOCTORS CARE NOTE, AND THERE IS ZERO MENTION OF YOUR NECK ANYWHERE ON THE DOCTORS CARE NOTE. IT SAYS "FELL AT WORK. RIGHT HAND -- RIGHT ARM/HAND BRUISE SWOLLEN," AND DOWN AT THE BOTTOM IT SAYS THAT YOU'VE "GOT PARASPINAL MUSCLES

WITH P.T.P. AND MIDLINE PAIN. RIGHT DISTAL F.A. PALMAR ASPECT ON YOUR ARM WITH A LARGE ABRASION ON THE ARM."

A. YES.

Q. PAIN WITH YOUR GRIP IN YOUR RIGHT HAND AND THEN OVER BESIDE THAT, IT SAYS "RIGHT FOREARM, RIGHT HAND, AND T-SPINE." DOWN BELOW, "ASSESSMENT DIAGNOSIS: HAS ABRASIONS, CONTUSIONS RIGHT ARM, NUMBER TWO IS BACK PAIN, AND NUMBER THREE IS RIGHT ARM PAIN." WHEN YOU WENT IN ON THE 11TH -- EXCUSE ME, ON THE 14TH, A COUPLE OF DAYS LATER, THIS IS PAGE 12 OF THE CLAIMANT'S APA. IT STATES, "STRAIGHT LEG RAISE IS NEGATIVE." THAT'S "NEGATIVE S.L.R." ON THERE. IT SAYS "MILD P.T.P. OF THE LEFT PARASPINAL MUSCLES, PLUS TWO RIGHT PATELLAR REFLEX AND CONTUSION/ABRASION OF HAND WITH MILD ECCHYMOSIS." AND IT SAYS "PATIENT STATES VERY IMPROVED, NO RIGHT ARM." NOTHING IN HERE SAYS THAT YOU TOLD THE DOCTOR THAT DAY THAT THE EMPLOYER WASN'T MEETING THE RESTRICTIONS AS YOU JUST TOLD THE COMMISSIONER. THERE'S NO INDICATION FROM YOU TO THE DOCTOR AT DOCTORS CARE THAT YOU WEREN'T CAPABLE OF DOING WHAT YOU WERE DOING AT THE JOB. IT ACTUALLY STATES THAT YOU TOLD THE DOCTOR THAT YOU WERE VERY IMPROVED ON THAT DATE. ON THE 18TH WHEN YOU CAME BACK TO

DOCTORS CARE, IT'S THE FIRST TIME YOU TALK ABOUT YOUR NECK. IT SAYS -- AND WHAT YOU SAID THERE WAS -- I'M NOT REAL SURE WHY THE DOCTOR WROTE IT THIS WAY, BUT HE'S GOT "ZERO TENDERNESS IN CERVICAL SPINE, MILD TENDERNESS LATERAL RIGHT CERVICAL SPINE, FULL NECK RANGE OF MOTION. UPPER EXTREMITY STRENGTH IS BILATERAL. ZERO SHOULDER PAIN. ZERO THORACIC SPINE PAIN. COMPLAINS OF SLIGHT RIGHT LATERAL NECK TRAPEZIUS PULLING, OTHERWISE DENIES COMPLAINTS. MID BACK FEELS A-P-P-R," I GUESS APPROPRIATE -- "APPROXIMATELY 85 PERCENT IMPROVED. RIGHT UPPER EXTREMITY WITH NO DISCOMFORT. SOMA CAUSES PATIENT TO BE SEDATED AT WORK." SO, YOU TOLD HIM ABOUT THE ---

BY MR. CALHOUN:

COMMISSIONER, I'VE GOT TO OBJECT. HE'S JUST READING MEDICAL RECORDS.

BY COMMISSIONER LYNDON:

AND WE DON'T NEED TO GO IN -- I'VE ACTUALLY READ AHEAD OF THAT. WE CAN GO ---

BY MR. ADDISON:

AND I'M READING IT FOR A REASON, COMMISSIONER. I MEAN, SHE STATED THAT SHE WASN'T BEING MET WITH THE RESTRICTIONS BY THE EMPLOYER. AGAIN, SHE WENT OVER A LOT OF STUFF WITH THE DOCTOR ON THE 18TH, AND

THERE'S ZERO MENTION OF ANY PROBLEM WITH WORKING OTHER THAN SHE DIDN'T LIKE TAKING THE SOMA AND DOING THE JOB, THAT IT INTERFERED WITH HER ABILITY TO WORK. THERE'S NO INDICATION TO THE EMPLOYER -- EXCUSE ME, TO THE PHYSICIAN THAT THE EMPLOYER WAS NOT MEETING THE RESTRICTIONS PLACED ON HER BY DOCTORS CARE.

BY COMMISSIONER LYNDON:

ALL RIGHT. WE CAN MOVE ON.

CROSS EXAMINATION RESUMED BY MR. ADDISON:

Q. YOU CONTINUED ON WITH TREATMENT WITH THAT. YOU RETURNED TO WORK WITH CERTAIN RESTRICTIONS. NOW, YOU TOLD THE COMMISSIONER THAT YOU WERE HAVING TO WALK ALL OVER THE PLACE. I MEAN, YOU WOULD AGREE THE DOCTOR HAD STATED THAT YOU WEREN'T TO WALK MORE THAN 30 MINUTES IN AN HOUR. THAT'S HALF OF THE TIME YOU COULD BE WALKING IN OTHER WORDS, CORRECT?

A. I'M SORRY.

Q. YOUR RESTRICTIONS WERE THAT YOU COULD WALK HALF OF THE TIME. THERE'S 30 -- YOU KNOW, IF YOU COULD WALK 30 MINUTES IN AN HOUR, THAT MEANS YOU COULD WALK HALF OF THE TIME THAT YOU WERE WHEREVER YOU WERE?

A. YES.

Q. OKAY. NOW, YOU WERE SAYING THAT -- YOU SEEMED TO BE INDICATING THAT THE JOB REQUIRE THAT YOU DO CERTAIN

THINGS. WHEN YOU SAID THAT YOUR JOB DUTIES THAT YOU WERE DISCUSSING WITH YOUR ATTORNEY, DID YOU MEAN THE JOBS THAT YOU WERE DOING WHEN YOU WERE ON LIGHT DUTY, OR DO YOU MEAN THE JOBS THAT ARE REQUIRED OF YOU AS A NURSE AT THE FACILITY, REGULAR JOB DUTIES?

A. I DON'T KNOW WHICH TIME YOU'RE TALKING ABOUT.

Q. WHEN YOU SAID THAT YOU HAD TO PUSH PATIENTS IN WHEELCHAIRS AND CARRY THE MED -- OR HAD TO PUSH THE MED CART, HAD TO PULL CHARTS OFF OF THE SHELF AND WRITE STUFF IN CHARTS, THAT YOU HAD TO ASSESS PATIENTS INCLUDING ROLLING THEM OVER.

A. THAT WOULD BE THE ROLE OF THE NURSE.

Q. OKAY.

A. THAT WAS SOME OF THE JOB DUTIES.

Q. OKAY. YOU WOULD AGREE WITH ME THAT THE PRIMARY RESPONSIBILITIES FOR ATTENDING TO THE PATIENT'S REGULAR NEEDS, MOVING THEM AROUND AND WHATEVER, THAT BELONGS TO THE C.N.A.s. YOU AS A NURSE WERE OVERSEEING WHAT THE C.N.A.s WERE DOING.

A. NO, I DON'T AGREE WITH THAT.

Q. SO, YOU WOULD CHANGE PATIENTS; YOU WOULD ACTUALLY CHANGE DIAPERS ---

A. I HAVE ---

Q. --- ROUTINELY? LET ME FINISH MY QUESTION. DID YOU ROUTINELY HAVE TO DO THAT?

A. NO, BUT IT IS IN MY JOB DESCRIPTION TO DO ---

Q. OKAY.

A. --- ANYTHING THAT I NEEDED TO DO CONCERNING A PATIENT.

Q. YOU WOULD AGREE WITH ME THIS IS A NO-LIFT FACILITY, CORRECT?

A. YES.

Q. OKAY. Y'ALL HAVE HOYER LIFTS TO USE FOR PATIENTS IF YOU HAVE TO LIFT THEM, AND YOU ARE REQUIRED BY THE RULES OF THE FACILITY TO OBTAIN HELP BEFORE YOU DO ANYTHING LIKE THAT?

A. YES.

Q. OKAY. AS A NURSE, YOU'RE HANDING OUT MEDICATION. MORE OFTEN THAN NOT, WHAT YOU'RE DOING IS HANDING OUT MEDICATIONS AND CHECKING ON PATIENTS' MEDICAL CONDITIONS, TAKING BLOOD PRESSURE, ASSESSING THEM MEDICALLY AS TO WHAT THEIR -- WHAT THEIR STATS ARE; THAT'S PRIMARILY WHAT YOU WOULD DO AS AN R.N. AT THE FACILITY?

A. NO. BECAUSE THE JOB DESCRIPTION FOR A NURSE IS TO ASSIST WITH ANY AND ALL CARE, AND THAT MEANS HANDS ON AS WELL AS HANDS OFF CARE OF YOUR PATIENTS.

Q. BUT Y'ALL HAVE ---

A. IN INCLUDES THEIR NEEDS IN EVERY AREA, IN EVERY ASPECT. AND THE EMPLOYER THERE DOES ACTUALLY

REQUIRE AND REQUESTS YOU TO DO THAT.

Q. BUT THERE ARE LOTS OF C.N.A.s AT THE FACILITY, AREN'T THERE, MA'AM, THAT ARE THERE TO DEAL WITH THE PATIENTS?

A. ACTUALLY, THEY'RE UNDERSTAFFED. BY LAW, THEY MAY HAVE ENOUGH, BUT THEY'RE TECHNICALLY UNDERSTAFFED IN MY OPINION AND MOST EVERYBODY THAT WORKS IN THE FACILITY. THAT'S THEIR OPINION AS WELL.

Q. THERE ARE MORE THAN TWO C.N.A.s ON A HALL. IT'S NOT LIKE THERE'S NOT C.N.A.s THERE TO DO THIS WORK? YOU SEEM TO BE INDICATING YOU'RE DOING C.N.A. WORK IS WHY I'M ASKING THIS, MA'AM.

A. I HAVE DONE PLENTY OF C.N.A. WORK TO ASSIST THEM, BECAUSE SOME SHIFT THERE ARE ONLY TWO C.N.A.s ON THE FLOOR AND YOU'VE GOT 40 PATIENTS.

Q. OKAY.

A. AND IT'S A VERY HIGH DEMANDING JOB WHENEVER THEY CAN'T GET TO 20 EACH AT THE SAME TIME. SO, YES, A NURSE DOES GO IN AND DO THAT KIND OF CARE WITH THE PATIENT.

Q. WELL, LET'S TALK ABOUT OTHER PLACES THAT YOU'VE WORKED. DID YOU DO SOMETHING DIFFERENT AT THIS FACILITY VERSUS OTHER JOBS THAT YOU'VE HAD AS A NURSE?

A. NO, WHEN I WORKED AT THE HOSPITAL, I DID THE SAME.

I DID PATIENT CARE, AND THAT'S EXPECTED OF YOU AS A NURSE.

Q. BUT YOU WEREN'T AN R.N. ON THE FLOOR, RIGHT?

A. I WAS STILL A NURSE, AN L.P.N.

Q. OKAY. YOU WERE AN L.P.N. BUT NOT AN R.N.?

A. AND NOT A C.N.A.

Q. OKAY. THE ONLY PLACE THAT YOU'VE BEEN AN R.N. IS AT THIS FACILITY, CORRECT?

A. YES.

Q. OKAY. YOU INDICATED THAT YOU ATTEMPTED TO FIND WORK BY LOOKING IN THE STATE NEWSPAPER AND LOOKING IN THE CAMDEN NEWSPAPER?

A. AND ON THE INTERNET.

Q. AND ON THE INTERNET. HAVE YOU ACTUALLY APPLIED AT A HOSPITAL FOR ANY POSITIONS TO SEE IF THERE IS ANYTHING OPEN?

A. THOSE JOBS AT THE HOSPITAL WOULD REQUIRE FOR ME TO GO OVER ---

Q. THAT WASN'T MY QUESTION, MA'AM. MY QUESTION WAS HAVE YOU ACTUALLY GONE TO A HOSPITAL AND APPLIED FOR A JOB?

A. I HAVE NOT.

Q. HAVE YOU ATTEMPTED TO FIND A JOB WITH ANY HEALTH FACILITY WHERE YOU ACTUALLY WENT TO THE HEALTH FACILITY AND APPLIED FOR A POSITION?

A. I HAVE NOT ACTUALLY GONE TO THE FACILITY AND APPLIED FOR A JOB.

Q. SO, YOU DON'T KNOW WHETHER THEY WOULD HAVE ANYTHING THAT WOULD MEET THE RESTRICTIONS THAT YOU HAVE, DO YOU?

A. I FEEL LIKE IN THEIR JOB -- THOSE JOB DESCRIPTIONS, THAT I WOULD BE VIOLATING THOSE RESTRICTIONS.

Q. NO, MA'AM. MY QUESTION IS YOU DON'T KNOW FROM YOUR OWN KNOWLEDGE THAT ANY OF THE FACILITIES THAT PROVIDE MEDICAL SERVICES IN THE COLUMBIA, SOUTH CAROLINA AREA OR THE CAMDEN, SOUTH CAROLINA AREA OR THE WINNSBORO, SOUTH CAROLINA AREA WOULD HAVE ANY JOBS THAT MEET THE RESTRICTIONS THAT THE PHYSICIANS HAVE PLACED ON YOU, DO YOU?

A. NO.

BY MR. ADDISON:

COMMISSIONER, THAT'S ALL I HAVE.

BY COMMISSIONER LYNDON:

ALL RIGHT.

BY MR. ADDISON:

I'M SORRY. I DO HAVE A FEW OTHER QUESTIONS. I'M SORRY.

CROSS EXAMINATION RESUMED BY MR. ADDISON:

Q. DO YOU REMEMBER FILLING THESE MEDICAL QUESTIONNAIRE STATEMENTS OUT FOR THE EMPLOYER?

BY MR. ADDISON:

PAGES 205 AND 206 OF THE DEFENDANTS' APA. CAN I APPROACH, COMMISSIONER?

BY COMMISSIONER LYNDON:

YES, SIR.

CROSS EXAMINATION RESUMED BY MR. ADDISON:

Q. DO YOU REMEMBER HAVING TO DO THESE? THAT ANNUAL PHYSICAL.

A. I DON'T KNOW. LET ME SEE.

Q. DO YOU REMEMBER HAVING TO GO OVER THIS?

A. I DIDN'T FILL ANY OF THIS OUT.

Q. I UNDERSTAND YOU DIDN'T FILL IT OUT. I MEAN, DO YOU REMEMBER GOING THROUGH THE PHYSICAL ASSESSMENTS WITH THE EMPLOYER ON AN ANNUAL BASIS STARTING IN 2008?

A. I DON'T REMEMBER SEEING THAT ONE, BUT I DO REMEMBER SEEING THAT ONE.

Q. OKAY. SO, YOU REMEMBER GOING THROUGH THIS?

A. YES.

Q. OKAY. YOU WERE TAKING SOME MEDICATION BACK IN 2009, H.C.T.Z.?

A. YES.

Q. WHAT WERE YOU TAKING THAT FOR?

A. I HAD BEEN WORKING A LOT OF NIGHT SHIFTS WHEN I FIRST STARTED TAKING THAT, AND I HAD SOME SWELLING IN ONE OF MY FEET, AND THE DOCTOR FELT THAT WAS

DEPENDENT EDEMA, AND THAT THE H.C.T. LOW DOSE WOULD PROBABLY HELP.

Q. AND THE ONLY REASON I'M ASKING THAT IS THAT'S ACCURATE, YOU WERE TAKING ---

A. YES.

Q. --- THE PRESCRIPTION MEDICATION IN 2009?

A. YES.

Q. OKAY. ALL RIGHT. NOW, WOULD YOU AGREE WITH ME, AND YOUR ATTORNEY WAS ASKING YOU -- HE SAID IT WAS ONLY IN 2008, BUT YOU STARTED SEEING YOUR FAMILY DOCTOR FOR ISSUES WITH YOUR NECK AND RIGHT SHOULDER STARTING IN 2006, CORRECT? I'LL READ IT TO YOU. IT'S PAGE 39 OF PLAINTIFF'S APA. THIS IS ON 12/20 OF 2006. "PATIENT ALSO COMPLAINS OF RIGHT NECK PAIN. MASSAGE HELPED. THEN PAIN RETURNED, ONE MONTH DURATION." DO YOU REMEMBER HAVING PAIN IN YOUR NECK FOR ONE MONTH IN DECEMBER OF 2006?

A. NO, I REMEMBER I WAS HAVING MUSCLE SPASMS BEFORE, BUT I DON'T REMEMBER THAT.

Q. THE DOCTOR SPECIFICALLY WROTE "THE NECK IS TENDER OVER THE TRAPEZIUS MUSCLE, RIGHT. THERE IS NO TENDERNESS MIDLINE." DO YOU REMEMBER THAT?

A. I HAD AN INJECTION IN THE MUSCLE ON TWO SEPARATE OCCASIONS, BUT I DON'T REMEMBER THOSE DATES.

Q. OKAY. IN 2008 -- THIS IS PAGE 102 OF PLAINTIFF'S

APA. YOU WENT AND SAW YOUR DOCTOR, DR. ALICE BROOKS. THAT'S YOUR FAMILY DOCTOR, RIGHT?

A. YES.

Q. YOU WENT AND SAW DR. BROOKS ON APRIL THE 7TH OF 2008. YOUR COMPLAINT -- "CHIEF COMPLAINT WAS NECK AND BACK PAIN. THE PAIN RADIATES INTO RIGHT SHOULDER. BURNING PAIN WORSE WITH FORWARD FLEXION. ALSO WORSE IN A.M. OCCASIONAL FLEXION CAUSES BILATERAL HEAT SENSATION. TWO WEEKS DURATION. GETTING WORSE." AND YOU ENDED UP HAVING A TRIGGER-POINT INJECTION AS A RESULT. DO YOU REMEMBER THAT?

A. I HAD AN INJECTION.

Q. OKAY. ALL RIGHT. AND THEN PAGE 95 OF PLAINTIFF'S APA, YOU WENT AND SAW DR. BROOKS ON APRIL THE 16TH OF 2010 WITH THE SAME ISSUES. YOU COMPLAINED OF "PAIN IN THE RIGHT SHOULDER UP INTO YOUR -- INTO THE BACK OF YOUR NECK. PAIN IS CONSTANT. BURNING SENSATION BECOMES INTENSE. SHE STATES IT WAS ABOUT A WEEK AND A HALF AGO THAT IT STARTED. IT'S PROGRESSIVELY GOTTEN WORSE," AND YOU ULTIMATELY ENDED UP HAVING ANOTHER INJECTION AT THAT POINT, CORRECT?

A. YES, I HAD AN INJECTION ON A COUPLE SEPARATE OCCASIONS.

Q. OKAY. ALL RIGHT. NOW, WHEN YOU HAD TALKED WITH

YOUR ATTORNEY EARLIER, HE WAS ASKING YOU ABOUT THE ONE TIME. THIS WAS NOT A ONE-TIME THING. YOU'VE BEEN HAVING PROBLEMS WITH YOUR NECK AND RIGHT SHOULDER FOR A NUMBER OF YEARS; HAVE YOU NOT? IT'S WAXED AND WANED. IT'S FLARED UP FROM TIME TO TIME?

A. I'VE HAD MUSCLE SPASMS A FEW TIMES, YES.

Q. OKAY. MA'AM, YOU KEEP CALLING IN MUSCLE SPASMS, AND I'M JUST READING MEDICAL RECORDS. YOU WOULD AGREE WITH ME YOU WENT AND SAW A DOCTOR FOR PROBLEMS WITH YOUR NECK AND YOUR RIGHT SHOULDER?

A. WITH -- YES, THAT MUSCLE RAN UP -- THE NO -- THE MUSCLE THAT RUNS FROM HERE UP THIS WAY (WITNESS INDICATES) WAS INFLAMED WHEN SHE GAVE ME A STEROID INJECTION. WITHIN 24 HOURS, THE PAIN WAS GONE.

Q. OKAY.

A. AND I NEVER HAD ANY PROBLEMS AGAIN FOR A GOOD WHILE.

Q. YOU NEVER HAD AN M.R.I. BEFORE THE ONE THAT WAS DONE IN CAMDEN BEFORE THIS THOUGH, HAVE YOU?

A. NO.

Q. OKAY. SO, YOU HAVE NO IDEA WHAT WAS GOING ON IN YOUR NECK. YOU CALL IT MUSCULAR, BUT YOU DON'T KNOW; YOU'RE NOT A PHYSICIAN OR AN ORTHOPEDIC SPINE SPECIALIST, ARE YOU?

A. NO, I'M NOT.

Q. OKAY.

BY MR. ADDISON:

THAT'S ALL I HAVE, COMMISSIONER.

BY COMMISSIONER LYNDON:

OKAY. MR. CALHOUN?

BY MR. CALHOUN:

JUST A FEW, COMMISSIONER.

RE-DIRECT EXAMINATION BY MR. CALHOUN:

Q. MS. RAMEY, WHEN WE'VE BEEN TALKING ABOUT PUNCHING IN THIS MORNING, WHAT WE'VE REALLY BEEN TALKING ABOUT IS PUTTING YOUR HAND ON A SCANNER, RIGHT?

A. YES.

Q. SO, IF THE PUNCH MACHINE IS NOT WORKING, WHAT IT IS NOT ACTUALLY DOING IS ACCEPTING YOUR HAND SCAN; IT'S NOT IDENTIFYING IT; DOES THAT MAKES SENSE?

A. THAT'S WHAT HAPPENED.

Q. OKAY. AND ACCORDING TO YOUR TIME CARD REPORT, THIS SCANNING PROBLEM STARTED ON MARCH THE 16TH. DOES THAT SOUND RIGHT?

A. I THINK SO, YES.

Q. OKAY. SO, THERE WASN'T A PROBLEM THE DAY THAT YOU ACTUALLY WERE INJURED ON MARCH THE 11TH, CORRECT?

A. RIGHT.

Q. AND ON THE DAY THAT YOU WERE ACTUALLY INJURED, YOU SCANNED YOUR HAND OR YOU PUNCHED IN THAT DAY, CORRECT?

A. I DID PUNCH IN THAT DAY.
Q. OKAY. AND THEN AFTER YOU FELL AND WHERE INJURED, YOU WERE TAKEN TO DOCTORS CARE, RIGHT?
A. YES.
Q. AND YOU NEVER SCANNED OR PUNCHED OUT, CORRECT?
A. RIGHT.
Q. AND YOU WERE ACTUALLY PAID FOR THAT TIME, WEREN'T YOU?
A. YES.
Q. OKAY. NOW, THESE DOCUMENTS THAT YOU SIGNED THAT MR. ADDISON WAS ASKING YOU ABOUT, WERE YOU GIVEN THESE DOCUMENTS AND ALLOWED TO TAKE THEM HOME AND READ THEM, OR WERE YOU TOLD TO SIGN THEM THE DAY THAT THEY WERE PUT IN FRONT OF YOU?
A. I HAD TO FILL THEM OUT BEFORE I WAS ALLOWED TO LEAVE TO GO TO THE DOCTOR.
Q. OKAY. IN FACT, SOME OF THE DOCUMENTS THAT HAVE YOUR HANDWRITING ON THEM, YOUR SIGNATURE IN WRITING APPEARS TO BE SHAKY OR WOBBLY. IS THAT BECAUSE YOU WERE USING YOUR LEFT ARM?
A. I WAS USING MY LEFT HAND BECAUSE MY RIGHT WAS HURTING TOO BAD TO SIGN.
Q. OKAY. SO, THAT HAPPENED WHICH DAY, THE DAY THAT YOU FELL OR ---
A. THE DAY THAT I FELL.

Q. THE DAY THAT YOU FELL, OKAY. NOW, WHEN YOU WERE TAKEN TO DOCTORS CARE ON MARCH THE 11TH, THE MEDICAL RECORD FROM THAT DATE SAYS THAT YOU HAD INJURED YOUR BACK, CORRECT?

A. YES.

Q. AND DO YOU UNDERSTAND YOUR BACK TO INCLUDE YOUR NECK?

A. YES.

Q. ALL RIGHT. THERE'S ANOTHER ISSUE THAT MR. ADDISON ASKED YOU ABOUT CONCERNING YOUR DOCTOR'S CARE OR MEDICAL RECORDS FOR MARCH THE 18TH. NOW, THOSE RECORDS INDICATE THAT YOU COULD -- THAT WHEN YOU LEFT, THAT YOU COULD WORK FULL DUTY. EXPLAIN TO THE COMMISSIONER WHAT HAPPENED THAT DAY WHEN YOU WENT TO DOCTORS CARE.

A. WHEN I WENT TO DOCTORS CARE ON THE 18TH, I WANTED TO -- I SEEN ANOTHER DOCTOR FOR ONE THING. I DIDN'T SEE THE SAME DOCTOR I HAD BEEN SEEING. BUT I REQUESTED THAT DOCTOR LET ME TRY BEING OFF LIGHT DUTY BECAUSE THEY NEEDED ME TO BE ON THE FLOOR TO HELP THEM. THEY WERE REALLY SHORT, AND THEY WERE TRYING TO GET A LOT OF EXTRA HELP, AND I SAID, WELL, MY HAND FEELS BETTER, AND I THINK I CAN DO THAT. I DON'T KNOW ABOUT PUSHING THE CARTS. SO, LET ME TRY OFF DUTY -- OFF OF THE LIGHT DUTY FOR A LITTLE BIT

JUST TO SEE HOW IT GOES. BUT I TOLD HER THAT MY BACK WAS STILL HURTING ME, IT WAS STILL BOTHERING ME. BUT I WANTED TO SEE IF I COULD ACTUALLY GET BACK ON THE FLOOR AND GET BACK ON FULL-TIME DUTY AND HELP THEM OUT EVEN THOUGH I WAS STILL HAVING PROBLEMS.

Q. WHY WERE YOU TRYING TO GET BACK ON THE FLOOR EVEN THOUGH YOU WERE STILL HAVING PROBLEMS? WAS THERE ANYTHING THAT YOU WERE WORRIED ABOUT?

A. I WAS WORRIED ABOUT LOSING MY JOB. THE OTHER LADIES THAT WERE DOING LIGHT DUTY WERE WORKING BEYOND THEIR WORK RESTRICTIONS, AND THEY ---

BY MR. ADDISON:

COMMISSIONER, I'M GOING TO HAVE TO OBJECT, BECAUSE SHE DOESN'T KNOW ---

BY THE WITNESS:

THEY HAD CONCERNS AS WELL AS I DID.

BY COMMISSIONER LYNDON:

WAIT. HE'S OBJECTING, BUT I'LL NOTE YOUR OBJECTION, BUT I'LL LET THE ANSWER STAND. WE NEED TO MOVE ON.

BY MR. ADDISON:

OKAY.

RE-DIRECT EXAMINATION RESUMED BY MR. CALHOUN:

Q. FINALLY, MS. RAMEY ---

BY MR. CALHOUN:

PAGE 102 OF THE CLAIMANT'S APAs, COMMISSIONER.

RE-DIRECT EXAMINATION RESUMED BY MR. CALHOUN:

Q. THE DIAGNOSIS FROM YOUR APRIL 7TH, 2008, VISIT TO YOUR FAMILY PRACTICE DOCTOR ACTUALLY SAYS THAT YOU HAVE A RIGHT TRAPEZIUS SPASM. IS THAT WHAT YOU REMEMBER?

A. YES.

Q. OKAY. AND YOU RECEIVED A TRIGGER-POINT INJECTION INTO THAT MUSCLE; IS THAT CORRECT?

A. YES.

Q. OKAY.

BY MR. CALHOUN:

THAT'S ALL I HAVE, COMMISSIONER.

BY COMMISSIONER LYNDON:

MR. ADDISON.

RE-CROSS EXAMINATION BY MR. ADDISON:

Q. MA'AM, I'M READING THE MARCH THE 18TH RECORD FROM THE DOCTOR AT DOCTORS CARE, AND THAT DOCTOR WROTE A LOT OF THINGS. NO WHERE IN THERE DOES IT SAY "I WANT TO GO BACK TO WORK BECAUSE I THINK I'M GOING TO GET FIRED IF I DON'T GO BACK TO REGULAR DUTY." WHAT IT SAYS WAS THAT YOU FELT 85 PERCENT IMPROVED. DID YOU TELL THE DOCTOR THAT THAT YOU FELT 85 PERCENT IMPROVED?

A. NO, I DID NOT.

Q. SO, THE DOCTOR MADE THAT UP THAT DAY?

A. I DID NOT GIVE HER A PERCENTAGE OF HOW I FELT. I ASKED HER IF SHE WOULD TAKE ME OFF OF SOME OF THE LIGHT DUTY, THAT MY BACK WAS STILL BOTHERING ME.

Q. OKAY. DID YOU ---

A. I FELT LIKE I NEEDED TO GET BACK ON THE FLOOR TO HELP THEM OUT AND MY JOB, AND NO, I DIDN'T TELL THE DOCTOR I FELT LIKE I WAS GOING TO GET FIRED. THAT ISN'T A CONCERN FOR THE DOCTOR. BUT I TOLD THEM THAT I WANTED TO TRY AND SEE HOW IT GOES FOR ME.

Q. DID YOU TELL THE DOCTOR ---

BY MR. ADDISON:

AND THIS IS ON PAGE 116 OF PLAINTIFF'S APA, COMMISSIONER.

RE-CROSS EXAMINATION RESUMED BY MR. ADDISON:

Q. ON THE 18TH, THIS IS A RETURN-TO-WORK FORM THAT'S BEEN IN QUESTION. DID YOU TELL THE DOCTOR THAT YOU FELT COMFORTABLE PERFORMING FULL WORK DUTIES?

A. I TOLD THE DOCTOR I WANTED TO TRY TO PERFORM FULL-WORK DUTIES AND SEE HOW IT GOES. THAT'S WHY SHE TOLD ME TO -- IF I HAD ANY MORE PROBLEMS WITH MY NECK OR MY BACK, THAT I COULD RETURN IN SEVEN TO TEN DAYS.

Q. OKAY. SO, IF THE DOCTOR WROTE "SHE FEELS

COMFORTABLE PERFORMING FULL WORK DUTIES," THAT WAS NOT ACCURATE?

A. I REQUESTED TO PERFORM FULL WORK DUTIES TO TRY IT OUT.

Q. OKAY. SO, JUST SO WE'RE REAL CLEAR, WHEN YOU WERE AT THE DOCTOR THAT MORNING, YOU HAD BEEN PROVIDED ALL OF THE MEDICALS UP TO THAT POINT, YOU WERE WORKING THE EMPLOYER WAS PROVIDING TO YOU, AND THERE WAS NO INDICATION THAT THERE WAS ANY ISSUE WITH YOUR EMPLOYMENT. SO, WHEN THIS WAS ALL WRITTEN, THERE WAS NO SPECIFIC EVIDENCE OF ANY CONCERNS WITH YOUR EMPLOYMENT, AND YOU WERE TELLING THE DOCTOR WHO WAS THE TREATING DOCTOR AT THE TIME THAT YOU FELT CAPABLE OF RETURNING TO THE REGULAR FULL-DUTY JOB THAT YOU DID WITH THE EMPLOYER?

A. (NO VERBAL RESPONSE)

Q. DO YOU AGREE WITH ME THAT THERE IS NO WRITTEN ANYTHING ANYWHERE THAT SUGGESTS THAT YOU WERE IN DANGER OF LOSING YOUR JOB?

A. NO, THERE'S NO WRITTEN ON THAT DOCTOR'S THING THAT I WAS SCARED I WAS GOING TO LOSE MY JOB.

Q. YOUR SCHEDULE THAT YOU WORKED, WERE YOU WORKING EIGHT-HOUR DAYS OR 12-HOUR DAYS BEFORE, OR DID IT VARY?

A. NO. IT DID VARY. THERE WERE SOME TWELVES AND SOME

EIGHTS.

Q. OKAY, ALL RIGHT. AND THE REASON YOU WERE ONLY GOING TO BE THERE THREE AND A HALF HOURS ON THIS PARTICULAR DAY ON THE 18TH WAS BECAUSE YOU WERE JUST WORKING KIND OF A PARTIAL DAY SO THAT YOU COULD WORK SATURDAY AND SUNDAY SHIFT THAT WEEKEND?

A. THAT'S WHAT MS. SHEPHERD WANTED ME TO DO.

Q. OKAY, ALL RIGHT. MS. SHEPHERD IS YOUR SUPERVISOR?

A. THE DIRECTOR OF NURSING.

Q. BUT SHE WAS YOUR SUPERVISOR?

A. SHE SAID SHE COULD LET ME WORK SATURDAY AND SUNDAY, BUT SHE DIDN'T KNOW WHAT SHE WAS GOING TO DO WITH ME AFTER THAT FOR THE SCHEDULE.

Q. OKAY. ALL I ASKED YOU IS WAS SHE YOUR SUPERVISOR?

A. YES.

BY MR. ADDISON:

COMMISSIONER, THAT'S ALL I HAVE.

BY COMMISSIONER LYNDON:

MR. CALHOUN?

BY MR. CALHOUN:

NO, SIR.

EXAMINATION BY COMMISSIONER LYNDON:

Q. LET ME ASK YOU ONE QUESTION, MA'AM. I'M LOOKING AT THAT ONE EXHIBIT THAT SAYS -- I THINK IT WAS MARCH 16TH THROUGH THE 18TH, THE CLOCK WOULD NOT LET

EMPLOYEE PUNCH IN, REASON UNKNOWN. YOU SEE IT TIME AFTER TIME.

A. YES.

Q. WERE YOU ALWAYS PAID FOR THOSE DAYS? I THINK YOU'VE ANSWERED THE QUESTION. WERE YOU ALWAYS PAID FOR THE TIME THAT THE SCANNER DID NOT WORK?

A. YES, WE WERE ALWAYS PAID FOR IT. IF YOU FILL OUT THE TIME CORRECTION SHEET, YOUR SUPERVISOR HAS TO SIGN THAT VERIFYING THAT YOU WERE ACTUALLY DURING THOSE TIMES AND APPROVING FOR YOU TO BE PAID FOR THOSE TIMES.

Q. RIGHT. AND PRIOR TO MARCH IN ANY TIME -- YOU'VE BEEN THERE NINE YEARS. I DON'T KNOW WHETHER Y'ALL HAVE A SCANNER UP FOR NINE YEARS LIKE THAT. MOST PEOPLE USED TO HAVE THOSE LITTLE PUNCH CLOCKS, BUT...

A. RIGHT.

Q. SINCE THEY'VE HAD THE SCANNER, HAS IT EVER NOT WORKED FOR YOU BEFORE?

A. YES, IT HAS.

Q. AND HAVE YOU ALWAYS BEEN PAID?

A. YES, I HAVE.

Q. RIGHT. YOU JUST HAVE TO VERIFY IT ON A MANUAL TIME SHEET, IS THAT RIGHT?

A. THAT IS RIGHT.

Q. SO, HAD IT BEEN WORKING ON THE 18TH, IF YOU HAD PUNCHED -- YOU WOULD HAVE PUNCHED IN, AND THEN YOU WOULD HAVE HAD TO GO TO THE DOCTOR. WOULD YOU NORMALLY HAVE TO PUNCH BACK OUT AND THEN PUNCH BACK IN WHEN YOU CAME ---

A. I WOULD HAVE PUNCHED OUT TO LEAVE THE FACILITY, YES.

Q. IS THAT NORMAL IF YOU HAVE TO LEAVE THE FACILITY FOR ANY REASON OTHER THAN SAY MAYBE GO OUT TO YOUR CAR TO GET SOMETHING?

A. YES.

Q. OKAY.

BY COMMISSIONER LYNDON:

I DON'T THINK I HAVE ANY OTHER QUESTIONS.

BY MR. ADDISON:

CAN I ASK ONE OR A COUPLE JUST TO CLARIFY THAT, COMMISSIONER?

BY COMMISSIONER LYNDON:

ALL RIGHT.

RE-CROSS EXAMINATION BY MR. ADDISON:

Q. THE EVIDENCE THAT WE HAVE IN HERE, THESE DATES PRIOR TO THE 18TH WHERE YOU HAD MISSED A PUNCH, YOU DIDN'T GO TO THE DOCTOR ON THE 15TH, 16TH, OR THE 17TH, DID YOU? THE ONLY DATE YOU WENT WAS THE 14TH.

A. YES.

Q. OKAY. SO, THOSE DATES WHERE YOU HAD MISSED A PUNCH,

YOU HAD ACTUALLY TURNED IN A SHEET ON THOSE DATES AS WELL INDICATING THAT YOU HAD A MISSED PUNCH THAT YOU NEEDED TO BE PAID FOR, CORRECT?

A. YES.

Q. AND YOU WERE ACTUALLY IN THE FACILITY THOSE ENTIRE HOURS, CORRECT?

A. YES.

Q. OKAY. YOU WOULD HAVE BEEN PHYSICALLY PRESENT IN THE FACILITY AND THERE DOING YOUR JOB AS AN R.N. FOR THE TIME THAT YOU WERE ACTUALLY ON THE CLOCK THAT YOU WERE REQUESTING TO BE PAID FOR ON THE 15TH, 16TH, AND THE 17TH?

A. I DON'T BELIEVE I WENT OUT ANYWHERE ON THOSE DAYS.

Q. OKAY.

A. BECAUSE SOMETIMES IN THE PAST I USED TO WOULD GO OUT FOR LUNCH FOR OTHER PEOPLE AND CLOCK IN AND OUT TO GO DO THAT.

Q. I'M SPECIFICALLY REFERRING TO THOSE THREE DAYS, THE 15TH, THE 16TH, AND THE 17TH. WE HAVE EVIDENCE THAT YOU MISSED A PUNCH. YOU PUT IN A TIME PUNCH ENTRY REQUEST THAT WAS SUBMITTED AND FILLED OUT AND PREPARED, AND YOU WERE PAID FOR THAT TIME, BECAUSE YOU WERE ACTUALLY WORKING IN THE FACILITY ON THOSE THREE DAYS?

A. YES.

Q. ON THE 18TH, YOU PUT IN ANOTHER ONE THAT INDICATED THAT YOU WERE AT THE FACILITY, BUT YOU WERE ACTUALLY AT THE DOCTOR FOR PART OF THAT TIME. YOU DON'T DISPUTE THAT?

A. I WAS AT THE DOCTOR PART OF THAT TIME.

Q. OKAY, ALL RIGHT. AND YOU UNDERSTAND THAT THE DISTINCTION HERE IS NOT WHETHER YOU SUBMITTED THE FORM OR NOT. IT'S THAT YOU INDICATED TO THE EMPLOYER THAT YOU WERE IN THE FACILITY WHEN YOU WERE NOT. DID YOU UNDERSTAND THAT WHEN YOU HAD THE COUNSELING SESSION WITH MS. BURR?

BY MR. CALHOUN:

I'M GOING TO OBJECT. THAT'S NOT A QUESTION, AND THAT'S AN ARGUMENT. THAT'S HIS ARGUMENT.

BY COMMISSIONER LYNDON:

I THINK -- I BELIEVE THAT QUESTION WAS FRAMED SOMEWHAT ALREADY EARLIER ON CROSS, TOO. SO, WE CAN MOVE ON.

BY MR. ADDISON:

COMMISSIONER, THE POINT I'M TRYING TO GET TO IS -- I THINK YOU'RE STATING THAT SHE -- YOU KNOW, HER UNDERSTANDING SOMEHOW IS THAT THIS PUNCH -- BECAUSE THE MACHINE WASN'T WORKING, THAT SOMEHOW WAS AN EXCUSE. SHE HAD BEEN PAID BEFORE. THAT'S NOT THE ISSUE. THE ISSUE IS THAT SHE TURNED IN A FALSE

DOCUMENT TO THE EMPLOYER, AND I WAS GOING TO ASK ONE MORE QUESTION HERE AFTER THAT.

BY COMMISSIONER LYNDON:

WELL, SHE TESTIFIED UNDER OATH ON DIRECT THAT SHE WAS UNDER THE IMPRESSION, AND I KNOW YOU'VE GOT WITNESSES HERE, THAT NOT ONE, NOT TWO, BUT THREE, AND I BELIEVE FOUR PEOPLE NOT ONLY KNEW SHE WAS GOING TO GO TO THE DOCTOR, BUT IT WAS HER UNDERSTANDING THAT SHE GOT PAID FOR IT. EVEN THOUGH I KNOW SHE SIGNED SOMETHING EARLIER IN HER WORK HISTORY SAYING WHEN YOU GO TO THE DOCTOR, YOU DON'T DO IT. SHE TESTIFIED UNDER OATH THAT HER IMPRESSION WAS THAT SHE WOULD GET PAID FOR THAT. HOW MANY HOURS WAS IT THAT SHE WAS ACTUALLY GONE FROM THE FACILITY?

BY MR. ADDISON:

ABOUT AN HOUR.

BY COMMISSIONER LYNDON:

ONE HOUR?

BY MR. CALHOUN:

ACTUALLY GONE ABOUT AN HOUR TO AN HOUR AND 15 MINUTES.

BY COMMISSIONER LYNDON:

ALL RIGHT.

BY MR. ADDISON:

AN HOUR AND 15 MINUTES.

BY COMMISSIONER LYNDON:

BUT GO AHEAD AND ASK YOUR SECOND QUESTION.

RE-CROSS EXAMINATION RESUMED BY MR. ADDISON:

Q. WHEN YOU HAD YOUR MEETING -- EXCUSE ME, THE DAY THAT YOU HAD YOUR INJURY AND YOU WERE PROVIDED THE PACKET OF MATERIALS THAT YOU SAID YOU DIDN'T HAVE TIME TO READ, DID ANYBODY GO OVER THAT PACKET WITH YOU?

A. NO, THEY DID NOT.

Q. NO ONE SAT THERE AND SAID "HERE'S WHAT YOU'RE SUPPOSED TO BE DOING"?

A. NO, THEY DID NOT.

Q. THEN WHY IS THERE ANOTHER SIGNATURE ON THERE, MA'AM?

A. THE SUPERVISOR BROUGHT ME THE PACKET. SHE SAT THERE BESIDE ME WHILE I FILLED IT OUT. WELL, SHE WALKED OFF A FEW TIMES. BUT SHE DID NOT ACTUALLY GUIDE ME THROUGH THAT, BECAUSE SHE DIDN'T HAVE ANY UNDERSTANDING OF THE WORKMAN'S COMP PAPERWORK HERSELF.

Q. DID YOU ASK HER ANY QUESTIONS?

A. I ASKED HER A QUESTION ABOUT THE P.T.O. SHEET THAT WAS IN THERE.

Q. DID YOU ---

A. AND SHE SAID SHE DID NOT KNOW. I WOULD HAVE TO WAIT AND ASK LINDA BURR.

Q. OKAY. AND DID YOU ASK MS. BURR ---

A. I DID.

Q. --- THAT DAY?

A. I DID.

Q. OKAY. AND DID MS. BURR EXPLAIN THE PACKET ---

A. SHE TOLD ME ---

Q. --- TO YOU?

A. THE ONLY SHEET THAT I ASKED ABOUT WAS THE P.T.O. SHEET, AND SHE TOLD ME THAT I WAS ELIGIBLE TO BE PAID P.T.O. TIME IF I NEEDED IT, BECAUSE YOU ALWAYS HAVE TO HAVE P.T.O. TIME APPROVED BEFORE YOU'RE ALLOWED TO GET IT IF I NEEDED IT WHILE I WAS OUT IF I WAS OUT OF WORK, AND IT HAD NOTHING TO DO WITH WORKERS' COMP. THAT WAS MY QUESTION TO LINDA, AND THAT WAS HER RESPONSE.

Q. OKAY. BUT YOUR STATEMENT EARLIER THAT NOBODY EXPLAINED ANYTHING TO YOU IS NOT ACCURATE. YOU HAD AN OPPORTUNITY TO DISCUSS THIS ON THE DATE OF THE INJURY WITH THE EMPLOYER?

A. TO DISCUSS WHAT?

Q. THIS PACKET, THE MATERIALS THAT WERE PROVIDED TO YOU BY THE EMPLOYER, ALL OF THESE THINGS YOU SIGNED INCLUDING THE PIECE OF PAPER WHERE YOU INDICATED THAT YOU UNDERSTOOD YOU WOULDN'T BE PAID FOR TIME WHEN YOU WENT TO THE DOCTOR.

A. I WAS SUPPOSED TO TURN IT INTO LINDA BEFORE I LEFT. SHE JUST GAVE ME A NAME OF A REPRESENTATIVE THAT WOULD BE WORKING WITH ME AND TOLD ME WHERE TO GO TO THE DOCTOR.

BY COMMISSIONER LYNDON:

WE NEED TO FAST FORWARD THIS. THERE WAS NO EXTRA TIME ADDED, AND THESE CASES ---

BY MR. ADDISON:

I THINK I'M DONE, COMMISSIONER.

BY COMMISSIONER LYNDON:

--- USUALLY RUN ABOUT THREE HOURS, AND, YOU KNOW, THEY'RE 30 MINUTE HEARINGS.

BY MR. ADDISON:

I THINK I'VE GOT WHAT I NEED ON IT. ALL RIGHT. ANYTHING IN FOLLOW UP?

BY MR. CALHOUN:

NOTHING FURTHER.

BY COMMISSIONER LYNDON:

OKAY. YOU CAN STEP DOWN AND SIT BY YOUR ATTORNEY.

AND YOU'VE GOT HOW MANY WITNESSES?

BY MR. ADDISON:

LINDA BURR, JUST ONE.

BY COMMISSIONER LYNDON:

I WANT TO LEAVE THAT OUTSIDE, BECAUSE HE --

LET'S GO OFF THE RECORD.

(OFF THE RECORD)

BY COMMISSIONER LYNDON:

DO YOU HAVE ANY OTHER WITNESSES?

BY MR. CALHOUN:

NO, YOUR HONOR.

BY COMMISSIONER LYNDON:

OKAY. HAVE A SEAT UP HERE, MA'AM. IF YOU WOULD STATE YOUR FULL NAME FOR THE RECORD, PLEASE.

BY THE WITNESS:

MY NAME IS LINDA BURR.

BY COMMISSIONER LYNDON:

* * * * * * * * * * * * * * * *

THE WITNESS WAS DULY SWORN TO TELL THE TRUTH, THE WHOLE TRUTH, AND NOTHING BUT THE TRUTH CONCERNING THE MATTER HEREIN:

LINDA BURR,

BEING FIRST DULY SWORN, TESTIFIED ON HER OATH AS FOLLOWS:

BY COMMISSIONER LYNDON:

ALL RIGHT. ANSWER ANY QUESTIONS MR. ADDISON MAY HAVE, PLEASE.

DIRECT EXAMINATION BY MR. ADDISON:

Q. MS. BURR, WHAT DO YOU DO FOR A LIVING?

A. I'M A HUMAN RESOURCES DIRECTOR AT U-PAC TANGLEWOOD.

Q. HOW LONG HAVE YOU BEEN THERE?

A. NINE YEARS.
Q. DO YOU KNOW MS. RAMEY?
A. I DO.
Q. HOW LONG HAVE YOU KNOWN HER?
A. THE NINE YEARS THAT I'VE BEEN AT TANGLEWOOD.
Q. OKAY. ALL RIGHT. WHAT IS YOUR JOB THERE; WHAT DO YOU SPECIFICALLY DO?
A. I HANDLE THE PERSONNEL RECORDS ALONG WITH ANY WORKERS' COMP CLAIMS AND JUST MAINTAINING THE PERSONNEL RECORDS.
Q. OKAY. AS A RESULT OF THAT, WERE YOU DEALING WITH MS. RAMEY'S WORKERS' COMP CLAIM?
A. YES, I WAS.
Q. OKAY. DO YOU ROUTINELY FIRE PEOPLE FOR HAVING WORKERS' COMP CLAIMS AT U-PAC TANGLEWOOD?
A. I'M SORRY; WHAT WAS THE QUESTION?
Q. DO YOU FIRE PEOPLE FOR HAVING WORKERS' COMPENSATION CLAIMS ROUTINELY ---
A. OH, NO, SIR.
Q. --- AT TANGLEWOOD?
A. NO, SIR.
Q. ALL RIGHT. DO YOU HAVE ANY -- DO YOU PERSONALLY HAVE ANY BELIEF TO SEE WHY MS. RAMEY MIGHT BE CONCERNED THAT SHE MIGHT LOSE HER JOB BECAUSE SHE HAD A WORKERS' COMP CLAIM?

A. NO, SIR.

Q. ALL RIGHT. ONCE SHE HAD HER INJURY ON THE DATE MARCH THE 11TH, DID YOU DEAL WITH HER ON THAT DATE; DID YOU SEE HER THAT DAY?

A. ON THE 11TH, I DON'T RECALL IF IT WAS ON THE 11TH. I THINK IT WAS THE NEXT DAY.

Q. THE DAY SHE GOT INJURED, WHATEVER IT WAS.

A. YES.

Q. DID YOU TALK WITH HER THAT DAY?

A. YES.

Q. ALL RIGHT. AND DID YOU ARRANGE FOR HER TO HAVE MEDICAL TREATMENT?

A. ALL OF THAT WAS HANDLED.

Q. OKAY. DID YOU DO THAT, OR DID SOMEBODY ELSE HANDLE THAT?

A. I DID NOT. SOMEONE ELSE DID THAT.

Q. AND WHO ELSE WOULD HAVE DONE THAT?

A. I BELIEVE THAT WAS MS. ELKINS, THE UNIT SUPERVISOR.

Q. OKAY, ALL RIGHT. DID YOU DENY HER ANY MEDICAL TREATMENT DURING THAT WEEK, THAT FIRST TIME FRAME?

A. NO, I DID NOT.

Q. ALL RIGHT. YOU ALLOWED HER TO SEE DOCTORS CARE. WHEN SHE HAD SEEN DOCTORS CARE, WHAT DID YOU DO IN TERMS OF TRYING TO MEET WHAT THE DOCTORS HAD INDICATED SHE WAS CAPABLE TO AS AN EMPLOYEE?

A. WE WORK WITH THE EMPLOYEES ACCORDING TO THE RESTRICTIONS THAT ARE GIVEN TO US BY THE DOCTORS, AND WE DON'T CREATE JOBS, BUT WE DO PLACE THEM IN OTHER AREAS WHERE THEY CAN WORK UNDER THE RESTRICTIONS.

Q. HOW MANY PEOPLE WOULD YOU ESTIMATE THAT YOU'VE HAD THAT HAD A WORKERS' COMP CLAIM THAT HAVE HAD SOME SORT OF LIGHT DUTY WITHIN THE PAST TWO YEARS IN YOUR FACILITY?

A. GOSH, WITHIN THE PAST TWO YEARS, I'D SAY BETWEEN SIX AND EIGHT.

Q. OKAY. DO YOU TRY TO DO EVERYTHING YOU POSSIBLY CAN TO MEET THE RESTRICTIONS AS PLACED BY THE EMPLOYER - OR EXCUSE ME, AS PLACED BY A DOCTOR ON AN EMPLOYEE WHEN THEY HAVE A WORKERS' COMPENSATION CLAIM?

A. YES, SIR.

Q. IS THAT A POLICY OF JUST YOUR FACILITY, OR IS THAT A POLICY OF U.H.S. PRUITT?

A. THAT'S A POLICY OF U.H.S. PRUITT.

Q. OKAY. AND U.H.S. PRUITT OWNS THE TANGLEWOOD FACILITY?

A. THAT IS CORRECT.

Q. ALL RIGHT. WERE YOU INVOLVED IN THE TERMINATION OF MS. RAMEY?

A. YES, SIR.

Q. OKAY. CAN YOU EXPLAIN TO THE COMMISSIONER WHY MS. RAMEY WAS TERMINATED.

A. WE HAVE -- WE USE THE HAND-SCANNER CLOCKS, AND SHE HAD PREVIOUSLY BEEN HAVING PROBLEMS CLOCKING IN AND OUT. SO, WE HAD TO RE-SCAN HER HAND. BUT THIS DAY, SHE HAD TURNED IN WHAT WE CALL A REQUEST TO MISSING PUNCH OR TIME CORRECTION, AND SHE HAD STATED THAT SHE WAS IN THE BUILDING -- I DON'T RECALL THE EXACT TIME; I THINK FROM LIKE 7:30 TO 10:30. THEN LATER ON, SHE TURNED IN A DOCTOR'S NOTE WHERE SHE HAD BEEN AT THE DOCTOR. THE TIME ON THAT NOTE DIDN'T JUSTIFY THAT SHE STATED SHE WAS IN THE BUILDING. SO, SHE HAD FALSIFIED HER REQUEST FOR A CORRECTION TO COME IN. SO, ONCE THAT WAS PRESENTED TO THE ADMINISTRATOR, THE ADMINISTRATOR STATED THAT SHE WOULD NEED TO BE TERMINATED FOR FALSIFYING A TIME SHEET.

Q. OKAY. WHEN PEOPLE ARE ON WORKERS' COMPENSATION CLAIMS, DO Y'ALL PROVIDE PAY TO THEM WHEN THEY GO TO THE DOCTOR THROUGH THEIR PAY OR WHERE THEY CLOCK INTO THE CLOCK?

A. NO, SIR.

Q. OKAY, ALL RIGHT. IS THERE A DOCUMENT GIVEN TO THE EMPLOYEES AT THE TIME THAT THEY HAVE AN INJURY INDICATING THAT?

A. THEY ARE GIVEN A PAMPHLET THAT SAYS WHAT TO DO WHEN YOU'RE INJURED ON THE JOB. IT IS ALSO -- SOMEONE GOES OVER IT WITH THEM, WHOEVER THEY TALK TO WHEN IT'S CALLED IN.

Q. OKAY.

BY MR. ADDISON:

I'M GOING TO APPROACH, COMMISSIONER.

BY COMMISSIONER LYNDON:

MM-HMM.

DIRECT EXAMINATION RESUMED BY MR. ADDISON:

Q. I'M GOING TO SHOW YOU WHAT'S MARKED AS PAGE 136 OF DEFENDANTS' APA. DO YOU RECOGNIZE THAT DOCUMENT?

A. YES, SIR.

Q. IS THAT SOMETHING THAT IS PART OF THE PACKET THAT YOU PROVIDE -- THAT THE FACILITY PROVIDES THE EMPLOYEE WHEN THEY'RE INJURED?

A. IT IS.

Q. OKAY. AND WOULD YOU AGREE WITH ME THAT PART OF WHAT THAT STATES IS THAT WHEN YOU GO TO THE DOCTOR, YOU WILL NOT BE PAID ON THE CLOCK?

A. THAT IS CORRECT.

Q. OKAY, ALL RIGHT. IS IT YOUR UNDERSTANDING THAT MS. RAMEY SIGNED THIS DOCUMENT?

A. IT IS MY UNDERSTANDING THAT SHE DID.

Q. YOU WERE NOT THE PERSON WHO SIGNED THIS. SOMEONE

ELSE SIGNED HERE AT THE BOTTOM?

A. THAT'S MS. ELKINS.

Q. MS. ELKINS. DID YOU EVER DISCUSS THE PACKET THAT DAY WITH -- THE PACKET OF MATERIALS THAT WERE GIVEN TO MS. RAMEY, DID YOU DISCUSS IT WITH HER AT ALL ON THE 11TH?

A. I DID NOT GO OVER IT. I DID ASK HER IF SHE HAD ANY QUESTIONS.

Q. DID SHE TELL YOU IF SHE HAD ANY QUESTIONS?

A. NO, SIR.

Q. DID SHE SAY "I DON'T UNDERSTAND THIS. I WANT MORE TIME TO GO OVER IT"?

A. NO, SIR.

Q. DID SHE SAY "I NEED SOMEBODY ELSE TO TALK TO ME ABOUT IT"?

A. NO, SIR.

Q. DID SHE INDICATE ANYTHING TO YOU THAT WOULD SUGGEST THAT SHE WAS HAVING ANY PROBLEMS OR DIFFICULTIES UNDERSTANDING WHAT THE POSITION OF THE EMPLOYER WAS WITH HER INJURY AND WHAT HER RESPONSIBILITIES WERE ONCE SHE HAD AN INJURY?

A. NO, SIR.

Q. IN THAT NEXT SEVEN DAYS, AT ANY POINT, DID SHE COME TO YOU AND TELL YOU "I HAVE CONCERNS ABOUT WHAT'S GOING ON WITH ME WITH MY INJURY AND HOW I'M BEING

USED IN THE FACILITY"?

A. SHE WANTED TO GET BACK OUT ON THE FLOOR. SHE DIDN'T WANT TO WORK THE MODIFIED DUTY. SHE WANTED TO GET BACK ON THE FLOOR ON HER MED CART.

Q. WHAT DOES THAT MEAN?

A. I MEAN, SHE KEPT SAYING SHE WAS FINE. SHE WANTED TO GO BACK TO WORK.

Q. MEANING GO ---

A. AND I TOLD HER I COULDN'T PUT HER BACK TO REGULAR DUTY UNTIL I HAD SOMETHING FROM THE DOCTOR RELEASING HER.

Q. AND WHAT WERE YOU HAVING HER DO?

A. MOSTLY PAPERWORK. WITH RESTRICTIONS THAT SHE HAD, SHE COULDN'T PUSH THE MED CART. SO, THE NURSING SUPERVISORS WOULD HAVE HER FILING PAPERWORK OR WHATEVER.

Q. ALL RIGHT. AND THE RESTRICTIONS YOU HAD WERE ONES THAT HAD BEEN GIVEN TO YOU BY DOCTORS CARE?

A. THAT'S CORRECT.

Q. AND THOSE RESTRICTIONS ARE AS LISTED IN THE PLAINTIFF'S APAs. DID YOU HAVE ANY UNDERSTANDING DIFFERENTLY THAT SHE COULD -- "NO LIFTING MORE THAN 10 POUNDS, GROUND-LEVEL WORK ONLY, NO REPETITIVE BENDING, STOOPING, SQUATTING," WHAT ALL THE STUFF SAYS ON THIS THING?

A. CORRECT.

Q. AND SHE HAD NO USE OF HER RIGHT ARM. WERE YOU HAVING HER USE HER RIGHT ARM TO DO THESE CHARTS THAT SHE WAS DOING?

A. SHE WAS TOLD NOT TO.

Q. OKAY. DID YOU TELL HER, YOU KNOW, ---

A. I ALWAYS ADVISE EVERY ONE OF THEM TO STICK WITH THE RESTRICTIONS, AND IF THERE ARE ANY PROBLEMS WITH SOMETHING THAT THEY'VE BEEN GIVEN TO DO, THEY SHOULD COME BACK TO ME SO THAT I CAN DISCUSS IT FURTHER WITH ANYONE THAT'S GIVING THEM WORK TO DO.

Q. OKAY. DID SHE EVER COME TO YOU IN THAT SEVEN-DAY PERIOD AND SPECIFICALLY STATE "I'M HAVING TROUBLE DOING THE JOB THAT I'M DOING. I DON'T WANT TO DO WHAT I'M DOING. YOU NEED TO HAVE ME DO SOME OTHER MODIFIED DUTY"?

A. NO, SIR.

Q. OKAY. FROM WHAT YOU JUST TOLD ME, THE ONLY THING SHE DISCUSSED WITH YOU DURING THAT WEEK WAS THAT SHE FELT FINE AND THAT SHE WANTED TO RETURN TO HER REGULAR JOB?

A. THAT'S CORRECT.

Q. ALL RIGHT. YOU RECEIVED A NOTE FROM -- ON THE 18TH; IS THAT CORRECT, FROM DOCTORS CARE?

A. CORRECT.

Q. WAS IT YOUR UNDERSTANDING THAT DOCTORS CARE HAD RELEASED HER TO REGULAR DUTY AS OF MARCH THE 18TH OF 2011?

A. THAT IS CORRECT.

Q. ALL RIGHT. DID YOU RECEIVE ANYTHING DIFFERENT FROM DOCTORS CARE AS TO THAT DATE, AS TO AN INDICATION THAT SHE WAS NOT CAPABLE OF WORKING FULL DUTY?

A. NO, SIR.

Q. ALL RIGHT. IF THE DOCTOR WROTE ON THE 18TH THAT THE PATIENT WAS REQUESTING TO BE ABLE TO RETURN TO FULL-DUTY WORK, WOULD THAT BE CONSISTENT WITH WHAT SHE WAS TELLING YOU AT THE FACILITY THAT SHE WANTED TO DO THAT?

A. YES, SIR.

Q. ALL RIGHT. HAD YOU EVER TERMINATED ANYBODY AT THIS FACILITY BEFORE FOR FALSE -- FOR SUBMITTING A FALSE TIME REQUEST?

A. YES, SIR, WE HAVE.

Q. HOW MANY TIMES HAVE YOU DONE THAT IN THE PAST?

A. I'D SAY OVER THE LAST NINE YEARS PROBABLY THREE TO FIVE.

Q. OKAY. WHY IS THAT IMPORTANT TO THIS -- TO YOUR COMPANY? WHY IS IT IMPORTANT THAT SOMEONE NOT FALSIFY A TIME SHEET?

A. WELL, NOT ONLY ARE THEY DOCUMENTING WITH THEIR TIME

SHEETS, BUT MOST OF THEM ARE DOCUMENTING IN OTHER AREAS THAT WE DON'T NEED FALSIFICATION OF RECORDS ON EITHER.

Q. WHAT DO YOU MEAN BY "OTHER AREAS"?

A. WELL, LIKE IN NURSING, WE'RE GOVERNED BY DHEC. I MEAN, THE CHARTS AND ALL THAT THEY DOCUMENT IN HAVE TO BE ACCURATE.

Q. OKAY. IS IT A PRETTY BIG DEAL IF SOMEBODY FALSIFIES ANY KIND OF DOCUMENT ---

A. YES, SIR.

Q. --- WITHIN U.H.S. PRUITT?

A. YES, SIR.

Q. ALL RIGHT. IS THAT, TO YOUR KNOWLEDGE, A SPECIFIC GROUNDS FOR TERMINATION ---

A. YES, SIR.

Q. --- FOR FALSIFICATION OF ANY DOCUMENT?

A. THAT IS A PRUITT POLICY.

Q. OKAY. ALL RIGHT. YOU'VE BEEN AT THE FACILITY FOR A LONG TIME. YOU WERE THERE WHEN MS. RAMEY GOT HER SCHOLARSHIP TO BE AN R.N.?

A. YES, SIR.

Q. IS THAT A PRETTY BIG DEAL GETTING THAT SCHOLARSHIP?

A. SURE IT IS.

Q. I MEAN, IS THAT A LOT OF MONEY THAT THE COMPANY SPENDS ON SOMEONE?

A. I IMAGINE IT IS, YES.

Q. OKAY. SO, YOU'VE MADE -- THE COMPANY HAS MADE AN INVESTMENT IN EHR AS AN EMPLOYEE?

A. YES.

Q. A FAIRLY SUBSTANTIAL INVESTMENT?

A. YES, SIR.

Q. BASED UPON THAT, WOULD YOU -- I MEAN, DO YOU ROUTINELY INVEST A BUNCH OF MONEY IN PEOPLE AND THEN FIRE THEM AT THE FACILITY?

A. NO, SIR.

Q. OKAY, ALL RIGHT.

BY MR. ADDISON:

THAT'S ALL I HAVE, COMMISSIONER.

BY COMMISSIONER LYNDON:

OKAY.

BY MR. CALHOUN:

I'LL BE AS BRIEF AS I CAN, COMMISSIONER.

CROSS EXAMINATION BY MR. CALHOUN:

Q. MS. BURR, WE TOOK YOUR DEPOSITION JUST THIS PAST FRIDAY MORNING, CORRECT?

A. THAT IS CORRECT.

Q. AND THAT'S WHEN YOU GAVE US SEVERAL OF THE DOCUMENTS THAT YOU JUST TESTIFIED ABOUT, CORRECT?

A. YES, SIR.

Q. AND ONE OF THE THINGS THAT YOU SAID IN YOUR

DEPOSITION IS THAT DURING THE NINE YEARS THAT YOU AND MS. RAMEY HAVE WORKED TOGETHER, YOU CANNOT EVER REMEMBER HER COMPLAINING ABOUT HER BACK; IS THAT CORRECT?

A. THAT IS CORRECT.

Q. OKAY. AND YOU ALSO TESTIFIED IN YOUR DEPOSITION THAT THE REASON SHE WAS TERMINATED WAS BECAUSE EMPLOYEES ARE NOT ALLOWED TO BE PAID FOR TIME THEY MISSED FROM WORK FOR MEDICAL TREATMENT FOR WORKERS' COMP?

A. NO, SIR. SHE WAS NOT TERMINATED FOR THAT. SHE WAS TERMINATED FOR FALSIFYING A TIME SHEET.

Q. OKAY. WELL, IF ---

BY MR. CALHOUN:

COMMISSIONER, IF YOU LOOK AT PAGE 15, LINES SIX THROUGH 13.

CROSS EXAMINATION RESUMED BY MR. CALHOUN:

Q. IN YOUR DEPOSITION TESTIMONY, MS. BURR, WOULD YOU LIKE ME TO READ IT TO YOU VERBATIM?

A. THAT'S FINE.

Q. OKAY.

BY MR. ADDISON:

I'LL HAND HER MY COPY, COMMISSIONER.

BY COMMISSIONER LYNDON:

ALL RIGHT.

BY MR. ADDISON:

FIFTEEN -- PAGE 15?

BY MR. CALHOUN:

YES.

CROSS EXAMINATION RESUMED BY MR. CALHOUN:

Q. LINE SIX STATES "OKAY. AND YOUR UNDERSTANDING AT THAT TIME WAS THAT AN EMPLOYEE WAS NOT TO BE PAID FOR ANY TIME THAT THEY'RE RECEIVING TREATMENT ON A WORKERS' COMPENSATION CLAIM?" YOUR ANSWER, "THAT IS CORRECT." QUESTION, "ALL RIGHT. AND IS THAT YOUR UNDERSTANDING OR OPINION AS YOU SIT HERE TODAY?" "YES, IT IS." SO, YOU STATED ON FRIDAY THAT EMPLOYEES ARE NOT TO BE PAID FOR TIME THAT THEY'VE MISSED FROM WORK TO RECEIVE MEDICAL TREATMENT ON WORKERS' COMPENSATION CASES?

A. THAT IS CORRECT. I AGREE WITH THAT.

Q. YOU AGREE WITH THAT.

A. YOU ASKED ME WAS SHE TERMINATED FOR THAT. SHE WASN'T TERMINATED FOR THAT.

Q. OKAY. AND THE REASON SHE WAS TERMINATED IS THAT YOU'VE ALLEGED THAT SHE HAS FALSIFIED HER TIME SHEET; ISN'T THAT CORRECT?

A. THAT IS CORRECT.

Q. OKAY. AND IN ORDER TO FALSIFY A DOCUMENT, YOU ARE TRYING TO DECEIVE SOMEONE; IS THAT CORRECT?

A. CORRECT.

Q. AND YOU KNEW THAT SHE HAD A DOCTOR'S APPOINTMENT ON THE 18TH, CORRECT?

A. I WAS AWARE THAT SHE HAD ONE COMING UP.

Q. OKAY. AND YOU TESTIFIED FRIDAY ---

A. YES.

Q. --- YOU KNEW SHE WAS GOING TO THE DOCTOR ON THE MORNING OF THE 18TH, RIGHT?

A. THAT IS CORRECT.

Q. AND IF YOU KNEW SHE WAS GOING TO THE DOCTORS ON THE MORNING OF THE 18TH, AND HER TWO SUPERVISORS KNEW SHE WAS GOING, THEN IT WASN'T ANY SECRET THAT SHE HAD A DOCTOR'S APPOINTMENT THAT MORNING, CORRECT?

A. THAT IS CORRECT.

Q. OKAY. SO, TO PUT THE WRONG TIME ON HER TIME SHEET WHEN EVERYBODY KNEW SHE WAS GOING TO THE DOCTOR, DOESN'T REALLY INDICATE SOMEONE WHO IS TRYING TO DECEIVE ANYBODY, DOES IT?

A. I WOULD SAY NOT, BUT I WAS NOT AWARE OF WHAT TIME HER DOCTOR'S APPOINTMENT WAS.

Q. IN FACT, IT WOULD BE PROFESSIONAL SUICIDE TO DO THAT, TO TELL EVERYBODY THAT YOU'RE -- I MEAN, THAT YOU DIDN'T GO TO THE DOCTOR WHEN EVERYBODY KNEW THAT YOU WENT TO THE DOCTOR.

A. OKAY.

Q. OKAY. SO, IT WASN'T ANY SECRET TO YOU OR ANYONE ELSE THAT SHE HAD A DOCTOR'S APPOINTMENT THAT MORNING, CORRECT?

A. THAT SHE HAD ONE THAT MORNING, THAT IS CORRECT.

Q. OKAY. AND SHE HAS WORKED FOR YOUR FACILITY FOR NINE YEARS, CORRECT?

A. SHE'S BEEN THERE -- YEAH, ABOUT THE SAME LENGTH OF TIME.

Q. OKAY. AND YOU DON'T FIND IT STRANGE THAT SHE WAS FIRED TEN DAYS AFTER HER WORKERS' COMP CASE?

A. I DO NOT.

Q. OKAY. AND HER T.T.D. BENEFITS ARE ACTUALLY -- TYPICALLY DON'T START UNTIL 14 DAYS AFTER HER DATE OF INJURY, CORRECT?

A. OKAY.

Q. OKAY. AND SHE WAS FIRED 11 DAYS AFTER HER INJURY.

A. THAT HAD NO BEARING ON WHY SHE WAS TERMINATED.

Q. OKAY.

BY MR. CALHOUN:

THAT'S ALL I HAVE, COMMISSIONER.

BY COMMISSIONER LYNDON:

OKAY.

RE-DIRECT EXAMINATION BY MR. ADDISON:

Q. YOU'VE DEALT WITH A LOT OF WORKERS' COMP CLAIMS, CORRECT?

A. YES, SIR.

Q. DO PEOPLE GET PAID TEMPORARY TOTAL DISABILITY WHEN THEY'VE BEEN RETURNED TO FULL DUTY?

A. NO, SIR.

Q. WAS SHE RETURNED TO FULL DUTY ON MARCH THE 18TH ---

A. YES.

Q. --- BY THE DOCTOR THAT SAW HER MARCH THE 18TH?

A. YES, SIR.

Q. SO, SPECULATION THAT SOMEHOW WE FIRED HER BECAUSE SHE WAS GOING TO BE GETTING T.T.D. IS NOT BASED ON ANYTHING PER WHAT YOU KNOW, IS IT?

A. NO, SIR.

Q. AS FAR AS YOU KNOW, ON MARCH 18TH, SHE WAS RETURNING TO HER REGULAR JOB?

A. THAT IS CORRECT.

Q. PER THE TREATING PHYSICIAN'S RELEASE OF HER TO HER REGULAR JOB ON THAT DATE?

A. THAT IS CORRECT.

BY MR. ADDISON:

THAT'S ALL I HAVE, COMMISSIONER.

BY COMMISSIONER LYNDON:

OKAY.

BY MR. CALHOUN:

COMMISSIONER, FOR THE RECORD, ON PAGE 14, LINES ONE THROUGH 18, IN ADDITION TO THE LANGUAGE ON PAGE

15, IT ALL CLEARLY STATES THAT MS. BURR TOLD MS. RAMEY THE DAY THAT SHE WAS FIRED THAT SHE WAS FIRED FOR REQUESTING TIME WHILE SHE WAS OUT SEEING A DOCTOR ON A WORKERS' COMP CASE. IN OTHER WORDS, HER DEPOSITION CORROBORATES WHAT MS. RAMEY TESTIFIED AS THAT WAS THE REASON THAT SHE WAS TERMINATED.

BY COMMISSIONER LYNDON:

WERE THERE ANY OTHER QUESTIONS?

BY MR. ADDISON:

I JUST -- COMMISSIONER, I THINK THE DEPOSITION SPEAKS FOR ITSELF, AND I THINK SHE'S TESTIFIED BOTH IN THE DEPOSITION AND HERE TODAY WAS THE REASON SHE WAS FIRED WAS TURNING IN A FALSE TIME SHEET. WHETHER IT OCCURRED DURING A DOCTOR'S APPOINTMENT OR NOT DOESN'T MATTER.

BY COMMISSIONER LYNDON:

I MEAN, I UNDERSTAND THAT. I UNDERSTAND THAT PERFECTLY. HAD IT BEEN FIVE MINUTES OR HAD IT BEEN A FULL DAY, APPARENTLY IT WOULDN'T HAVE MATTERED EITHER. I MEAN, THAT'S JUST APPARENTLY THE WAY IT WAS. EXPLAIN TO ME AGAIN, AND I'LL ASK EITHER PERSON. IT WAS MY IMPRESSION FOR WHATEVER REASON THE CLAIMANT STILL WAS ON LIGHT DUTY. I MEAN, SHE ASKED THE DOCTOR, AND I BELIEVE HER TESTIMONY WAS THAT SHE WANTED TO HELP OUT; THEY WERE SHORT OR

WHATEVER, TO GO BACK ON REGULAR DUTY, BUT WAS SHE EVER -- THE DOCTOR SAID "RETURN TO FULL DUTY," RIGHT?

BY MR. ADDISON:

RIGHT.

BY COMMISSIONER LYNDON:

BUT SHE NEVER GOT TO DO THAT, RIGHT?

BY MR. ADDISON:

NO, SHE WORKED -- THERE WERE THREE DAYS. SHE WORKED THE 18TH, AND SHE WASN'T FIRED UNTIL THE 21ST.

BY COMMISSIONER LYNDON:

SHE WORKED FULL DUTY THOSE THREE DAYS?

BY MR. ADDISON:

AS FAR AS I KNOW. SHE WORKED THAT WEEKEND.

BY MR. CALHOUN:

SHE WORKED THE NEXT TWO DAYS, AND THEN SHE WAS FIRED ON THE THIRD DAY, THE 21ST.

BY COMMISSIONER LYNDON:

BUT IT'S MY UNDERSTANDING THAT THE REASON SHE WAS PUT ON FULL DUTY IS THAT SHE ASKED TO BE PUT ON FULL DUTY. IS THAT -- IS THAT CORRECT?

BY MR. ADDISON:

THAT'S WHAT THE MEDICAL RECORDS REFLECT.

EXAMINATION BY COMMISSIONER LYNDON:

Q. MA'AM, YOU SAID THAT THREE PEOPLE IN THE LAST NINE YEARS -- ROUGHLY YOU GUESSED ABOUT THREE?

A. YES, SIR.

Q. HAD BEEN FIRED FOR FALSIFYING RECORDS?

A. YES, SIR.

Q. NONE WERE WORKERS' COMP CASES?

A. NO, SIR.

Q. OR DO YOU KNOW?

A. I KNOW THAT THEY WEREN'T WORKERS' COMP CASES.

Q. AND DO YOU KNOW HOW MUCH TIME ROUGHLY THAT JUST OUT OF CURIOSITY WAS FALSIFIED?

A. FULL SHIFTS ON THOSE.

Q. SO, BIG JAGS OF TIME, LIKE EIGHT HOURS?

A. YES, SIR.

Q. OR WAS IT 12-HOUR SHIFTS?

A. EIGHT-HOUR SHIFTS. AND WE'VE TERMINATED FOR FALSIFYING DOCUMENTS OF OTHER NATURES AS WELL.

Q. RIGHT.

BY COMMISSIONER LYNDON:

I DON'T THINK I HAVE ANY OTHER QUESTIONS UNLESS Y'ALL DO.

BY MR. CALHOUN:

NO, SIR.

BY MR. ADDISON:

NONE FROM THE DEFENDANTS.

BY COMMISSIONER LYNDON:

OKAY. IF THERE IS NOTHING ELSE, THEN THAT CONCLUDES THE HEARING. THANK YOU VERY MUCH. GOOD LUCK TO YOU, MA'AM.

(THERE BEING NO FURTHER QUESTIONS, THIS HEARING WAS CONCLUDED AT THE HOUR OF 1:15 P.M.)

CERTIFICATE OF NOTARY PUBLIC
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
COLUMBIA, SOUTH CAROLINA
WCC FILE NO. 1103442

EMPLOYEE/CLAIMANT: **GAYLA RAMEY**

EMPLOYER: **UNIHEALTH POST-ACUTE CARE TANGLEWOOD**

INSURER: **AMERICAN ZURICH INSURANCE COMPANY**

I, JAN L. WHITWORTH, A NOTARY PUBLIC FOR THE STATE OF SOUTH CAROLINA, DULY COMMISSIONED AND QUALIFIED AS SUCH, DO HEREBY CERTIFY THAT THE FOREGOING 81 PAGES REPRESENTS A TRUE AND ACCURATE TRANSCRIPT OF THE FOREGOING HEARING OF **GAYLA RAMEY** TAKEN ON THE 10TH DAY OF AUGUST, 2011.

THAT THE WITNESS WAS DULY PLACED UNDER OATH AND ADMONISHED TO SPEAK THE WHOLE TRUTH. THAT THE ORAL HEARING WAS DULY TAKEN AND TRANSCRIBED AS TO THE QUESTIONS PROPOUNDED AND THE ANSWERS GIVEN.

THAT ALL THE OFFERED EXHIBITS, STIPULATIONS AND OBJECTIONS, IF ANY, INVOLVED IN THIS CASE ARE DULY ATTACHED OR INCLUDED HEREIN.

IN WITNESS WHEREOF, I HAVE SET MY HAND THIS 29TH DAY OF AUGUST, 2011.

JAN L. WHITWORTH
NOTARY PUBLIC FOR SOUTH CAROLINA
MY COMMISSION EXPIRES: 3-12-2014

* THIS TRANSCRIPT MAY CONTAIN QUOTED MATERIAL. SUCH MATERIAL IS REPRODUCED AS READ OR QUOTED BY THE SPEAKER.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE #1103442

GAYLA RAMEY
CLAIMANT,
VS.
UNIHEALTH POST-ACUTE CARE TANGLEWOOD
EMPLOYER,
AND
ZURICH AMERICAN INS
CARRIER.

SC WORKERS' COMPENSATION COMMISSION
HEARING OF
GAYLA RAMEY
VS
UNIHEALTH POST-ACUTE CARE TANGLEWOOD

This is the Transcript of the South Carolina Workers' Compensation Hearing of Gayla Ramey versus Unihealth Post-Acute Care Tanglewood, taken before Gloria Davis, a Court Reporter and Notary Public in and for the State of South Carolina, commencing at the hour of 8:57 A.M., Tuesday, March 20, 2012, at South Carolina Workers' Compensation Commission, 1333 Main Street Columbia, South Carolina.

COPY

REPORTED
BY
GLORIA DAVIS

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COMMISSIONERS PRESENT:

T. Scott Beck, Chairman
Andrea Pope Roche
Avery Wilkerson

*Reporter's Note: -- Indicates incomplete thought or sentence, trailing off or interruption by speakers.

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STIPULATIONS

Commissioner Beck: All right, please call the case.

Court Reporter: Today is Tuesday, March 20th, 2012. This is South Carolina Workers' Compensation case number 1103442. This is the case of Gayla Ramey, Claimant versus Unihealth Post-Acute Care Tanglewood and Zurich American Insurance Company is the Carrier. This is a cross appeal. The First Appellant is the Defendant represented by R. Daniel Addison. The Second Appellant is the Claimant represented by Mark R. Calhoun. Each side is allowed eight (8) minutes for oral argument with two (2) minutes in reply. You are requested to argue the grounds of exception and stay within the record. The single hearing Commissioner was Commissioner was Commissioner Lyndon.

Commissioner Beck: Mr. Addison.

ARGUMENT FOR THE FIRST APPELLANT

By Mr. Addison:

May it please the Commission? Commissioners, I appealed several things but primarily the main thing that we have an appeal on is the finding that the Claimant was entitled to temporary total

disability benefits subsequent to her termination. I've cited quite a bit of stuff in my brief on that particular issue but I'm kind of -- kind of honing in on one (1) thing. If you look at the date, the -- the -- basically the current chronological order of what happened here. There was an injury; she had a slip and fall injury where she slipped and fell, indicated she had injured her low back and her right arm in -- in catching herself when she went down. And we sent her to the doctor; she went to Doctor's Care and was treating. She is an RN; she -- she has worked in this facility for some period of time. She actually got her RN through the facility; they actually helped pay for her to get her RN degree. She was working on the floor doing her regular -- this is a nursing home; it's a Medicare nursing home where she was working doing basic RN duties. She went to the doctor two (2) separate times to Doctor's Care. On the second time she told them that she was feeling a good bit better and that she felt like she could do her full duty job. She goes back to the facility and they give her her full duty job. In that next week she was working her full duty job and then some events occurred

that got her terminated. Quite frankly, I mean, we went through a lot of information at the hearing about that particular incidence. Commissioner Lyndon said that he didn't think that the -- that what she did rose to the level of being a terminable offense but he basically didn't speak that; he just said that he didn't think that it interfered with her employment such that it evoked 42-9-190 such that she was refusing suitable employment. Our position was that in essence it did; we said that she had falsified some records. The falsification was her turning in time sheets instead of -- they have a hand system where they put their hand up on some type of reading device and it reads that it's you; it basically reads your palm print and says its you and that's how they clock in and out of the facility. That particular week the clock mechanism was not working for her; when she put her hand on it it wouldn't register. She went to the doctor for one of the appointments with our position and they have all these no clock out policies when someone goes to the doctor. I don't -- I'm not going to stand here and tell you all that I think it's probably something that you all

wouldn't order us to pay for; however, what she did when she turned in time sheets that said that she was at work working when she was actually at the doctor. It was a very brief period of time but the employer at corporate said -- not the local facility but corporate said this is a violation of policy, we can't allow -- we can't kind of look the other way because somebody is on Workers' Comp, we've got to follow policy and she has to be terminated; so, the local facility terminated her for that reason. They -- there was testimony from someone from the facility that they do terminate people for those types of things. Ms. Burr, who testified, said basically if it was up to her she probably wouldn't have terminated her but she was told by corporate that she had to terminate her because that is policy. Mrs. Ramey is terminated by the facility. She then goes back to the doctor and her complaints become what -- and should be no surprise to anyone, considerably worse. She is saying that she's much worse off; she feels a whole lot worse and the doctor then puts her on some restricted duty at that point. That's what Commissioner Lyndon based his decision on why she should be on TT is because she had gone

back to the doctor and they had increased her restrictions and said that she was no longer on full duty. My argument to you all is that that was a self-serving statement by the Claimant to the physicians. She clearly told them on the visit prior to the termination --

Commissioner Wilkerson: Whose doctor was it?

Mr. Addison: -- it was ours.

Commissioner Wilkerson: Okay.

Mr. Addison: It was Doctor's Care is where she was going and the visit before, and I've put all of this in my brief, the visit before she told them that she was feeling a whole lot better and felt like she could do full duty without any problem and she wanted to return to full duty; basically begged them to return her to full duty. They put her back on full duty and then the termination occurs and when she goes back to the doctor after the termination all of a sudden it's a woe is me, I'm awful, I can't do anything statement to the doctor and the doctor is going -- did what any doctor is going to do in that situation, he says, okay, you feel worse; I'm going to write you out of work and that's where we have the TT statement from that point until now.

We are providing her additional medical; at the time of the hearing we agreed to provide her some additional medicals. We're continuing to pay medical for her --

Commissioner Wilkerson: But even your person at the facility said that if she had made the decision she would not have terminated her.

Mr. Addison: -- she alluded to that. She didn't say it specifically that way, Commissioner, I'm just -- I was kind of trying to be as honest as I could --

Commissioner Wilkerson: Okay.

Mr. Addison: -- about what Linda Burr said. She said basically she was told I have to fire this person to follow corporate policy; this is corporate policy, bam, bam, bam. And whether or not the decision itself was a good decision I think a -- a -- you know, clearly the policy was there, everybody, you know, there was no contrary evidence that there wasn't a policy of the facility -- of the Employer. This is a fifteen thousand (15,000) employee nursing home company; they have a hundred and twenty-five (125) facilities all over the southeast. So, it's not a small company and they are following what they --

you know, what was corporate policy. If some -- if somebody false -- turns in falsified records regarding any kind of time sheet it's an automatic terminable offense; it's just a, bam, you've got to do it. And that's what they turned -- and that's what they told the facility; you can't -- you know, we can't make an exception. I think the bigger issue is really just her -- her own statements. I asked her at the hearing, I said, you know, you went to the doctor and told him you felt a lot better -- excuse me; I've got a giant frog in my throat this morning. You told them you felt a whole lot better before you got fired and told them you wanted to work full duty. Her statements at the hearing were, I never told them any of that; that that's all made up. You all know how we do that in hearings all the time with the Claimants; we always cross them with medical records and if the medical records aren't lining up the only person that has a self-serving interest is the Claimant, not the physician. It wasn't like the physician got a call from the facility that said gen up some records so that we can fight up a Workers' Comp claim down the road. We were providing her benefits at the time. There

wasn't really any issue until she got fired. And so, my position was -- at the hearing with Commissioner Lyndon was I thought that was the most important factor was she was able to work full duty and worked full duty for one (1) week before she got fired and then when she --

Commissioner Roche: Yes, but I think the fire -- I agree, I think the firing is a red herring; I don't think it has anything to do with anything.

Commissioner Wilkerson: Yes, I don't either.

Commissioner Roche: What you do have is you have somebody that's not working --

Mr. Addison: -- yes.

Commissioner Roche: -- who was on full duty, not working, gets written out to light duty.

Mr. Addison: No, she was working. She actually was working.

Commissioner Roche: -- I know. Well, then she was fired.

Mr. Addison: Right.

Commissioner Roche: She wasn't working after she was fired.

Mr. Addison: Right.

Commissioner Roche: So, there was a period

of time when she was on full duty and not working because she got fired. And then she got on light duty?

Mr. Addison: Right, for a couple of days --

Commissioner Roche: Right.

Mr. Addison: -- like three (3) or four (4) days.

Commissioner Roche: And then, the doctor wrote her out at light duty. Now, your whole point is, the only reason he wrote her out at light duty is because she's -- she's telling him she can't work and that's not true?

Mr. Addison: Correct.

Commissioner Roche: Now, Commissioner Lyndon found that she was credible.

Mr. Addison: Right.

Commissioner Roche: Now, you tell me what -- that's -- that's the error; if -- if there is an error that's the error and I think the firing really doesn't have anything to do with it.

Mr. Addison: I think the credibility because I -- again, it's back to the self-serving statements, Commissioner. If you look at the record I -- I crossed her on that particular issue about what the record said and she kept trying to

say I never told the doctors I felt better and -- when they put me on full duty. She was basically trying to assert I was never really on full duty or shouldn't have been on full duty. I never told the doctors any of the stuff that I told them before I got fired and -- and she clearly did. I mean, the medical records speak -- you know, as we all say, speak for themselves. The medical records state she came in before she was terminated and told them I feel a whole lot better; I want to work full duty. Would you please write me out to full duty? And the doctor did; he put her on full duty and she then worked full duty up until this termination occurred.

Commissioner Wilkerson: Was the hand scanner malfunctioning or that --

Mr. Addison: It was malfunctioning and we agreed to that.

Commissioner Wilkerson: -- okay.

Mr. Addison: All that was -- you know, was clearly was going on and the Claimant agreed that she had turned in these records; that she actually turned in records. She just -- her belief was -- is that she wasn't really violating anything by turning in her time at the doctor as being work

related time and, quite frankly, I agree, Commissioner Roche, it's somewhat of a red herring on that issue because the Claimant could have been confused on that particular issue but from an employment -- this is not employment law and it's not the employment law arena and they clearly were following policy at the corporate level. They had a policy that said if you turned in falsified documents it's an automatic terminable offense and they have terminated other people for that exact same infraction at this facility -- at this same facility they had done that in the past; Ms. Burr testified to that. So, you know, you've got a -- you've got a corporate policy kind of running a foul, somewhat if you want to call it that, of the Workers' Comp system but I think the most important --

Commissioner Wilkerson: Well, the -- the problem with that is they're so large they have to do that because they're threatened to be sued by other --

Mr. Addison: -- right.

Commissioner Wilkerson: -- outside entities. They take a position as a major employer that the cost to do that is less than the cost to what

we're facing here today.

Mr. Addison: Correct. And then they -- you're absolutely right. I mean, if they don't follow -- if they don't have a consistent policy --

Commissioner Wilkerson: Yes, they have --

Mr. Addison: -- and follow it --

Commissioner Wilkerson: -- exactly.

Mr. Addison: -- they open themselves up to big giant law suits.

Commissioner Wilkerson: Exactly.

Mr. Addison: And, you know, you set a policy, you have to follow the policy --

Commissioner Wilkerson: Yes, that's right and I'm fine with that.

Mr. Addison: -- and the unfortunate results such as Ms. Ramey.

Commissioner Wilkerson: Yes.

Mr. Addison: And, you know, I -- well, I'll -- I'll get into this later; it's a -- you all -- it's a long story. But anyway, I do want to talk to a -- briefly on the issue of the comp rate calculation. We turned in materials, we turned in a Form 20, we actually had testimony from Ms. Burr about what the earnings were. This was a first

quarter of the new year injury, it's in March -- the beginning of March; so, we used the prior four (4) quarters in calculating the average weekly wage per the Statute and the Regs and it produced a particular average weekly wage and compensation rate. The Claimant is alleging that the compensation rate should be higher because according to her, in her brief to the court, she had worked some additional overtime hours before -- in the month or two (2) before the injury, no evidence was produced that showed that; the Claimant didn't even testify to it nor was there any cross of the Defense witness as to that issue. So, the only anything that's in the record as to that particular issue is the Claimant's pre-hearing brief stating that she had worked additional hours. There was no time sheet, there was no nothing that went in that said here is all the stuff where she has worked all of this additional time and she would be entitled to some increased amount of -- of -- of compensation rate where its an exception to the rule. All we did was look at what the Statute specifically says we're supposed to do, we did it and it produced the average weekly wage and compensation rate that

Commissioner Lyndon found, which was per what the Form 20 showed. I don't think there is any exceptional reasons here; there's no --

Commissioner Wilkerson: Which is the max comp rate, right?

Mr. Addison: -- she is just below it.

Commissioner Wilkerson: Oh, below, okay.

Mr. Addison: She's about --

Commissioner Wilkerson: Seven (7) -- that's right, it's seventy-three (73).

Mr. Addison: -- she's about thirty dollars ($30.00) below what the max comp rate would be for the year. The Claimant's position is, is that she's entitled to the maximum compensation rate.

Commissioner Wilkerson: It can't be thirty ($30.00) because thirty ($30.00) would get you over seven hundred ($700.00) -- was it seven oh four ($704.00) for '11?

Mr. Addison: Right -- right in there.

Commissioner Wilkerson: Okay.

Mr. Addison: Yes, sir.

Commissioner Wilkerson: That's fine. Okay. I'm fine with that.

Mr. Addison: I mean, it may be twenty-eight ($28.00) or whatever it is --

Commissioner Wilkerson: Okay.

Mr. Addison: -- but, I mean, I -- quite frankly I don't -- I think it was six seventy-one ($671.00) that was what was found; if I remember correctly.

Commissioner Wilkerson: Yes, it is six seventy-one, fifty-eight ($671.58).

Mr. Addison: So, it --

Commissioner Wilkerson: This is '11; I'm sorry, I thought it was a '10 case. I apologize.

Mr. Addison: -- so, about thirty ($30.00) some odd dollars.

Commissioner Wilkerson: Okay.

Mr. Addison: But -- so, you know, our position is basically that the compensation rate was accurately determined by the --

Commissioner Wilkerson: Yes.

Mr. Addison: -- Single Commissioner.

Commissioner Wilkerson: Okay. Thanks.

Mr. Addison: Thank you.

Commissioner Beck: Mr. Calhoun.

ARGUMENT FOR THE SECOND APPELLANT

By Mr. Calhoun:

Let me ask the Court, do I give my rebuttal next before I argue my appeal; is that correct?

Commissioner Beck: You'll -- you'll get two (2) minutes in reply as well.

Mr. Calhoun: Okay.

Commissioner Roche: You can do it however you want to but you've got eight (8) minutes now and then two (2) minutes in reply.

Mr. Calhoun: Okay. All right. Then I'll do my rebuttal if that's -- pleases the Court. On the day that Ms. Ramey was injured, March the 11th, there -- there's a hand scanning device that they use to punch in and out. That hand scanning device was working that day and after she fell she was immediately taken to Doctor's Care, she did not punch out with the hand scanning device; she was paid her normal hours that day even though she did not punch out. She began treating with Doctor's Care and she testified that there were two (2) other women that had Workers' Comp claims and -- and her understanding was that one (1) of the women was going to be fired. She was scared of being fired for that reason and the fact that the floor was understaffed and that they had her working in violation of her work restrictions and these other two (2) ladies also and they weren't complaining about it, quite frankly, because they

wanted to keep their jobs. On the day that she -- March 18th, the day that she was fired for -- for requesting to miss time for the doctor's appointment, the hand scanning device was not working; so, she could not use it to punch in and out. When the -- when the hand scanning device was not working the procedure was that you filled in a request for missed time form where you write in the time that you -- you arrived that day and left and you give it to your supervisor working that day, she reviews it and approves it. The glaring error that I feel that the Employer fails to address in -- in his brief is that Ms. Ramey's supervisor was there that day, she knew she had the doctor's appointment, as did Ms. Burr who testified for the Employer, she was the Human Resources Manager; they both knew she had a doctor's appointment that day. Ms. Sheppard, the supervisor working, approved the missed time form; the supervisor approved the missed time from work that Ms. Ramey was fired for, quite frankly. Ms. Ramey also testified that the day that she was fired -- her understanding that the reason she was fired was because she requested to be paid for a missed hour from work to get medical treatment on

a Workers' Comp case; that her Employer told her that -- that you can't do that and Ms. Burr, when her deposition was taken, confirmed that. She said she was fired because she requested to be paid for that hour and we can't -- we don't pay employees for missed time on Workers' Comp cases. Now, Ms. Burr changed her testimony at the hearing and she said that the reason she terminated Ms. Ramey was for falsifying documents and I believe that's where the Court needs to take into consideration that Ms. Ramey was found credible; Ms. Burr was not. But the bottom line is it -- and Commissioner Lyndon stated this, it would be professional suicide for an employee working nine (9) years, who has never had a Workers' Comp case before, who all the --

Commissioner Roche: And, Mr. Calhoun, I really don't think any of this matters to this case.

Commissioner Wilkerson: No.

Commissioner Roche: Whether she was fired correctly or not, what she was -- when she was fired she was on fully duty. So, it doesn't -- none of that really matters whether or not they properly terminated her, should have terminated

her, shouldn't terminate her. You -- I want you to speak to the fact that you've got somebody whose -- whose been written out at light duty and they've not offered employment; I think that's the issue. Now, what -- and Mr. Addison is saying well she wasn't credible in her complaints to the doctor that she -- that -- that for -- that made the doctor write her out for light duty. So, tell me what makes her credible. Commissioner Lyndon found her credible. Tell me what makes her credible and why she should -- she should be on -- I think it's a slam dunk if she's written out on light duty and they're not offering her any work. Right now it doesn't really matter whether she got fired because she was on full duty when she got fired. Do you see?

Mr. Calhoun: -- yes.

Commissioner Roche: Okay. Speak to --

Mr. Calhoun: But --

Commissioner Roche: -- speak to that.

Mr. Calhoun: -- but one issue I was working at, Commissioner, is that this fear of being fired that I think all of the employees had because they were understaffed is she was using special care not to do anything to give her Employer any reason

to fire her. When she went to the doctor's appointment on the 18th, which was the day that she -- she was just fired, she told the doctor -- her testimony was that she told the doctor I want -- you need to put me back on full duty; I'm worried about losing my job. The medical records from March the 18th indicate that she requested to be -- she requested, not the doctor, she requested to be put back on full duty and that's what she testified. She wanted to work full duty because she was in fear of losing her job; she was scared of losing her job and that's why she went back on full duty. She didn't want to; it wasn't the doctor's decision at Doctor's Care. The doctor at Doctor's Care had recommended that she go see an orthopedic doctor; that's what he wanted her to go do, which -- which didn't happen. So, at any rate, that's why she requested to be placed on full duty. And so, three (3) days later, on March the 21st, after she was fired and she had her follow up appointment at the Doctor's Care, you know, of course she -- she's not going to go back in there after she'd been fired and say, yeah, I want to keep working full duty; she didn't have a job at that point but that is the reason -- you

know, that was the reasoning for her doing what she did. But whether she was fired for requesting to be paid for one (1) missed hour at a doctor's appointment or falsifying documents, the supervisor approved her form. If she was falsifying documents, which is not what Ms. Burr says the reason -- was reason for her termination but even if that was the reason then the supervisor was a part of that and the supervisor wasn't fired. Ms. Ramey was paid on March the 11th for -- when she didn't clock out; that lead her to believe -- her testimony was that my understanding I was to be paid for time that I was at the doctor on my Workers' Comp case and that is corroborated by the fact that she was paid on the day that she was injured even though she didn't clock out. So, it would -- would be professional suicide; it would be throwing nine (9) years away for her to try to get paid for one (1) hour when everything that the Employer did, everything that the Employer told her up to that point, ever action that the Employer performed corroborated that her belief was that she was to be paid if she was at the doctor. And her supervisors working that day approved it; they okayed it. Ms. Burr

knew she was at the doctor -- the lady who fired her knew that she was at the doctor that day; she approved it. Commissioner Lyndon simply said that he did not find it plausible that she would put nine (9) years on the line to get paid for one (1) hour at the doctor and Ms. Burr also, in her testimony, stated that all the other employees that we've fired in the past were falsifying documents. They were employees that requested to be paid for full shifts, nine (9) to twelve (12) hour shifts, that they did not work. They were not testified -- I mean, terminated for requesting to be paid for one (1) hour that Ms. Ramey was at the doctor. That's all I have on that issue.

Commissioner Beck: All right. Thank you, sir. Mr. Addison, you have two (2) minutes.

Mr. Addison: Thank you, sir.

REPLY FOR THE FIRST APPELLANT

By Mr. Addison:

Very quickly, Commissioners, I -- I do not object typically at appeal hearings and that's why I did not. There was a lot of discussion there by Mr. Calhoun about what was said by anyone. Ms. Sheppard was not at this hearing. When he says Ms. Sheppard said something he's basing that on

testimony the Claimant alleged at the time of the hearing, which, again, I believe are self-serving statements. There is no corroborating the evidence that the Claimant was working outside of her restrictions; we also put that in our brief. There is a finding in the order, I don't really know that Commissioner Lyndon found that in his notes or order but it was in the order that was signed by Commissioner Lyndon. The only evidence on that was the Claimant saying that she was doing that. There was no other employee that was brought in by the Claimant to corroborate any of this. There was no other Claimant that was brought in by the Claimant to corroborate that anybody at the facility was scared to lose their job. Every one of you all sitting on this panel has had a hearing with this particular employer; this is UHS Pruitt. This is my client where I bring -- and he is going to kill me for saying this but the little guy that comes with me to all the hearings. You all know them; they are tough but they're fair. They have a lot of people that are on light duty all over this state. There are thirty (30) plus facilities in South Carolina and they have a bunch of people on light duty all the

time; it is something they do routinely. They don't fire people just because they're on light duty or have Workers' Comp claims. They are tough on people when they're on Workers' Comp claims, they don't let them just live outside the rules; if somebody violates the rules they go ahead and fire them. But if they work like they're supposed to and do what they're supposed to do they get back to work and they do their job. I mean, it's a tough but fair Employer. There was a statement that seemed to indicate that Ms. Burr was not found credible; there is no statement by Commissioner Lyndon that he didn't find her credible. He just took her testimony and didn't write anything on his notes for her. He specifically did not find her to be not credible, which is the requirement to state that she was somehow not credible before this panel. As for the issues of the Claimant's inability to do any work, I would just state that she's an RN. The injuries, you can see what's on the medicals to suggest what's wrong with her; there's nothing that seems to indicate that she's not capable of doing the work as an RN somewhere.

Commissioner Beck: Thank you, sir.

Mr. Addison: Thank you.

Commissioner Beck: Mr. Calhoun.

REPLY FROM THE SECOND APPELLANT

By Mr. Calhoun:

Very briefly, the supervisor, Sheppard, signed the missed time form; she signed it on March the 18th of that year. On the average weekly wage issue, very simply our position is that under 42-40 in the Hinson and Breland cases we're contending that the average weekly wage should be based on the fifty-two (52) weeks previous to the date of injury; not on the four (4) quarter -- fifty-two (52) weeks prior to the date of injury, not the four (4) quarters that are on the Form 20 that the Employer uses; the last quarter being December 11th of 2010, which is three (3) months before the date of accident. Now, if you use -- hear me out please -- if -- if you use those fifty-two (52) weeks it gives you an actual compensation rate of seven hundred and thirty-two dollars and four cents ($732.04), which of course is above the cap, the seven hundred and four dollar ($704.00) cap for 2011 of seven hundred and four, ninety-two ($704.92). Our position is -- is -- is the cap most closely

approximates the amount that a Claimant would have been making in the future, which is what we're -- the case law says we're supposed to look forward to earnings in the future, not the past. Now, there is a sixty dollar and forty cents ($60.40) difference between this actual amount, seven hundred and thirty-two dollars ($732.00), and the -- the amount that Commissioner Lyndon gave of six hundred and seventy-one dollars ($671.00). Our position is that the comp rate -- the -- the amount that mostly clearly approximates --

Commissioner Wilkerson: That's not sixty dollars ($60.00).

Mr. Calhoun: -- sir?

Commissioner Wilkerson: That's not sixty dollars ($60.00).

Mr. Calhoun: It's -- I -- I have --

Commissioner Wilkerson: Is it?

Mr. Calhoun: -- sixty dollars and forty-six cents ($60.46) --

Commissioner Wilkerson: Okay.

Mr. Calhoun: -- between the six --

Commissioner Wilkerson: Six seventy-one ($671.00) --

Mr. Calhoun: -- seventy-one ($671.00) and --

Commissioner Wilkerson: -- and seven oh four ($704.00) --

Mr. Calhoun: -- the seven thirty-two ($732.00).

Commissioner Wilkerson: -- is not sixty dollars ($60.00).

Mr. Calhoun: Sir?

Commissioner Wilkerson: Six seventy-one, fifty-eight ($671.58) and seven oh four ($704.00) is not sixty dollars ($60.00).

Mr. Calhoun: Yes, sir. I'm saying the six seventy-one ($671.00) and the seven thirty-two ($732.00) --

Commissioner Wilkerson: Okay.

Mr. Calhoun: -- would be -- would be sixty dollars ($60.00). Okay. That -- that most clearly approximates what the Claimant would have made. During those three (3) months the wage records show and her testimony was that they were understaffed and the wage records show that she was working overtime. Now, that -- that's an exceptional circumstance that was used in the Booth case that working overtime is an exceptional circumstance during those three (3) months in the year 2011, and so since seven oh four ($704.00)

most closely approximates what the Claimant would have made in the future.

Commissioner Beck: All right. Thank you, sir.

Commissioner Wilkerson: Okay. Thank you.

Mr. Calhoun: Thank you.

Commissioner Beck: That will conclude this proceeding.

(THERE BEING NO FURTHER DISCUSSION, THE HEARING CONCLUDED AT 9:23 A.M.)

STATE OF SOUTH CAROLINA)
) CERTIFICATE
COUNTY OF RICHLAND)

Be it known that I took the foregoing South Carolina Workers' Compensation Commission Hearing of Gayla Ramey, vs. Unihealth Post-Acute Care Tanglewood;

That I was then and there a Notary Public in and for the State of South Carolina-At-Large;

That by virtue thereof I was duly authorized to administer an oath;

That the witness was first duly sworn to testify the truth, the whole truth, and nothing but the truth, concerning the matter in controversy aforesaid;

The foregoing transcript of 31 typewritten pages represents a true, accurate and complete transcription of the testimony so given at the time and place aforesaid to the best of my skill and ability;

That I am not related to nor an employee of any of the parties hereto, nor a relative or employee of any attorney or counsel employed by the parties hereto, nor interested in the outcome of this action;

Witness my hand and seal this 6th Day of July, 2012.

Gloria Davis
Notary Public for South Carolina
My Commission Expires 12/21/21

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SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE #1103442

GAYLA RAMEY, CLAIMANT, VS. UNIHEALTH POST-ACUTE CARE TANGLEWOOD EMPLOYER AND ZURICH AMERICAN INS CARRIER,	SC WORKERS' COMPENSATION COMMISSION HEARING OF GAYLA RAMEY VS UNIHEALTH POST-ACUTE CARE TANGLEWOOD

This is the Transcript of the South Carolina Workers' Compensation Hearing of Gayla Ramey versus Unihealth Post-Acute Care Tanglewood, taken before Gloria Davis, a Court Reporter and Notary Public in and for the State of South Carolina, commencing at the hour of 8:57 A.M., Tuesday, March 20, 2012, at South Carolina Workers' Compensation Commission, 1333 Main Street Columbia, South Carolina.

COPY

REPORTED

BY

GLORIA DAVIS

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COMMISSIONERS PRESENT:

T. Scott Beck, Chairman
Andrea Pope Roche
Avery Wilkerson

*Reporter's Note: -- Indicates incomplete thought or sentence, trailing off or interruption by speakers.

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STIPULATIONS

Commissioner Beck: All right, please call the case.

Court Reporter: Today is Tuesday, March 20th, 2012. This is South Carolina Workers' Compensation case number 1103442. This is the case of Gayla Ramey, Claimant versus Unihealth Post-Acute Care Tanglewood and Zurich American Insurance Company is the Carrier. This is a cross appeal. The First Appellant is the Defendant represented by R. Daniel Addison. The Second Appellant is the Claimant represented by Mark R. Calhoun. Each side is allowed eight (8) minutes for oral argument with two (2) minutes in reply. You are requested to argue the grounds of exception and stay within the record. The single hearing Commissioner was Commissioner was Commissioner Lyndon.

Commissioner Beck: Mr. Addison.

ARGUMENT FOR THE FIRST APPELLANT

By Mr. Addison:

May it please the Commission? Commissioners, I appealed several things but primarily the main thing that we have an appeal on is the finding that the Claimant was entitled to temporary total

disability benefits subsequent to her termination. I've cited quite a bit of stuff in my brief on that particular issue but I'm kind of -- kind of honing in on one (1) thing. If you look at the date, the -- the -- basically the current chronological order of what happened here. There was an injury; she had a slip and fall injury where she slipped and fell, indicated she had injured her low back and her right arm in -- in catching herself when she went down. And we sent her to the doctor; she went to Doctor's Care and was treating. She is an RN; she -- she has worked in this facility for some period of time. She actually got her RN through the facility; they actually helped pay for her to get her RN degree. She was working on the floor doing her regular -- this is a nursing home; it's a Medicare nursing home where she was working doing basic RN duties. She went to the doctor two (2) separate times to Doctor's Care. On the second time she told them that she was feeling a good bit better and that she felt like she could do her full duty job. She goes back to the facility and they give her her full duty job. In that next week she was working her full duty job and then some events occurred

that got her terminated. Quite frankly, I mean, we went through a lot of information at the hearing about that particular incidence. Commissioner Lyndon said that he didn't think that the -- that what she did rose to the level of being a terminable offense but he basically didn't speak that; he just said that he didn't think that it interfered with her employment such that it evoked 42-9-190 such that she was refusing suitable employment. Our position was that in essence it did; we said that she had falsified some records. The falsification was her turning in time sheets instead of -- they have a hand system where they put their hand up on some type of reading device and it reads that it's you; it basically reads your palm print and says its you and that's how they clock in and out of the facility. That particular week the clock mechanism was not working for her; when she put her hand on it it wouldn't register. She went to the doctor for one of the appointments with our position and they have all these no clock out policies when someone goes to the doctor. I don't -- I'm not going to stand here and tell you all that I think it's probably something that you all

wouldn't order us to pay for; however, what she did when she turned in time sheets that said that she was at work working when she was actually at the doctor. It was a very brief period of time but the employer at corporate said -- not the local facility but corporate said this is a violation of policy, we can't allow -- we can't kind of look the other way because somebody is on Workers' Comp, we've got to follow policy and she has to be terminated; so, the local facility terminated her for that reason. They -- there was testimony from someone from the facility that they do terminate people for those types of things. Ms. Burr, who testified, said basically if it was up to her she probably wouldn't have terminated her but she was told by corporate that she had to terminate her because that is policy. Mrs. Ramey is terminated by the facility. She then goes back to the doctor and her complaints become what -- and should be no surprise to anyone, considerably worse. She is saying that she's much worse off; she feels a whole lot worse and the doctor then puts her on some restricted duty at that point. That's what Commissioner Lyndon based his decision on why she should be on TT is because she had gone

back to the doctor and they had increased her restrictions and said that she was no longer on full duty. My argument to you all is that that was a self-serving statement by the Claimant to the physicians. She clearly told them on the visit prior to the termination --

Commissioner Wilkerson: Whose doctor was it?

Mr. Addison: -- it was ours.

Commissioner Wilkerson: Okay.

Mr. Addison: It was Doctor's Care is where she was going and the visit before, and I've put all of this in my brief, the visit before she told them that she was feeling a whole lot better and felt like she could do full duty without any problem and she wanted to return to full duty; basically begged them to return her to full duty. They put her back on full duty and then the termination occurs and when she goes back to the doctor after the termination all of a sudden it's a woe is me, I'm awful, I can't do anything statement to the doctor and the doctor is going -- did what any doctor is going to do in that situation, he says, okay, you feel worse; I'm going to write you out of work and that's where we have the TT statement from that point until now.

We are providing her additional medical; at the time of the hearing we agreed to provide her some additional medicals. We're continuing to pay medical for her --

Commissioner Wilkerson: But even your person at the facility said that if she had made the decision she would not have terminated her.

Mr. Addison: -- she alluded to that. She didn't say it specifically that way, Commissioner, I'm just -- I was kind of trying to be as honest as I could --

Commissioner Wilkerson: Okay.

Mr. Addison: -- about what Linda Burr said. She said basically she was told I have to fire this person to follow corporate policy; this is corporate policy, bam, bam, bam. And whether or not the decision itself was a good decision I think a -- a -- you know, clearly the policy was there, everybody, you know, there was no contrary evidence that there wasn't a policy of the facility -- of the Employer. This is a fifteen thousand (15,000) employee nursing home company; they have a hundred and twenty-five (125) facilities all over the southeast. So, it's not a small company and they are following what they --

you know, what was corporate policy. If some -- if somebody false -- turns in falsified records regarding any kind of time sheet it's an automatic terminable offense; it's just a, bam, you've got to do it. And that's what they turned -- and that's what they told the facility; you can't -- you know, we can't make an exception. I think the bigger issue is really just her -- her own statements. I asked her at the hearing, I said, you know, you went to the doctor and told him you felt a lot better -- excuse me; I've got a giant frog in my throat this morning. You told them you felt a whole lot better before you got fired and told them you wanted to work full duty. Her statements at the hearing were, I never told them any of that; that that's all made up. You all know how we do that in hearings all the time with the Claimants; we always cross them with medical records and if the medical records aren't lining up the only person that has a self-serving interest is the Claimant, not the physician. It wasn't like the physician got a call from the facility that said gen up some records so that we can fight up a Workers' Comp claim down the road. We were providing her benefits at the time. There

wasn't really any issue until she got fired. And so, my position was -- at the hearing with Commissioner Lyndon was I thought that was the most important factor was she was able to work full duty and worked full duty for one (1) week before she got fired and then when she --

Commissioner Roche: Yes, but I think the fire -- I agree, I think the firing is a red herring; I don't think it has anything to do with anything.

Commissioner Wilkerson: Yes, I don't either.

Commissioner Roche: What you do have is you have somebody that's not working --

Mr. Addison: -- yes.

Commissioner Roche: -- who was on full duty, not working, gets written out to light duty.

Mr. Addison: No, she was working. She actually was working.

Commissioner Roche: -- I know. Well, then she was fired.

Mr. Addison: Right.

Commissioner Roche: She wasn't working after she was fired.

Mr. Addison: Right.

Commissioner Roche: So, there was a period

of time when she was on full duty and not working because she got fired. And then she got on light duty?

Mr. Addison: Right, for a couple of days --

Commissioner Roche: Right.

Mr. Addison: -- like three (3) or four (4) days.

Commissioner Roche: And then, the doctor wrote her out at light duty. Now, your whole point is, the only reason he wrote her out at light duty is because she's -- she's telling him she can't work and that's not true?

Mr. Addison: Correct.

Commissioner Roche: Now, Commissioner Lyndon found that she was credible.

Mr. Addison: Right.

Commissioner Roche: Now, you tell me what -- that's -- that's the error; if -- if there is an error that's the error and I think the firing really doesn't have anything to do with it.

Mr. Addison: I think the credibility because I -- again, it's back to the self-serving statements, Commissioner. If you look at the record I -- I crossed her on that particular issue about what the record said and she kept trying to

say I never told the doctors I felt better and -- when they put me on full duty. She was basically trying to assert I was never really on full duty or shouldn't have been on full duty. I never told the doctors any of the stuff that I told them before I got fired and -- and she clearly did. I mean, the medical records speak -- you know, as we all say, speak for themselves. The medical records state she came in before she was terminated and told them I feel a whole lot better; I want to work full duty. Would you please write me out to full duty? And the doctor did; he put her on full duty and she then worked full duty up until this termination occurred.

Commissioner Wilkerson: Was the hand scanner malfunctioning or that --

Mr. Addison: It was malfunctioning and we agreed to that.

Commissioner Wilkerson: -- okay.

Mr. Addison: All that was -- you know, was clearly was going on and the Claimant agreed that she had turned in these records; that she actually turned in records. She just -- her belief was -- is that she wasn't really violating anything by turning in her time at the doctor as being work

related time and, quite frankly, I agree, Commissioner Roche, it's somewhat of a red herring on that issue because the Claimant could have been confused on that particular issue but from an employment -- this is not employment law and it's not the employment law arena and they clearly were following policy at the corporate level. They had a policy that said if you turned in falsified documents it's an automatic terminable offense and they have terminated other people for that exact same infraction at this facility -- at this same facility they had done that in the past; Ms. Burr testified to that. So, you know, you've got a -- you've got a corporate policy kind of running a foul, somewhat if you want to call it that, of the Workers' Comp system but I think the most important --

Commissioner Wilkerson: Well, the -- the problem with that is they're so large they have to do that because they're threatened to be sued by other --

Mr. Addison: -- right.

Commissioner Wilkerson: -- outside entities. They take a position as a major employer that the cost to do that is less than the cost to what

we're facing here today.

Mr. Addison: Correct. And then they -- you're absolutely right. I mean, if they don't follow -- if they don't have a consistent policy --

Commissioner Wilkerson: Yes, they have --

Mr. Addison: -- and follow it --

Commissioner Wilkerson: -- exactly.

Mr. Addison: -- they open themselves up to big giant law suits.

Commissioner Wilkerson: Exactly.

Mr. Addison: And, you know, you set a policy, you have to follow the policy --

Commissioner Wilkerson: Yes, that's right and I'm fine with that.

Mr. Addison: -- and the unfortunate results such as Ms. Ramey.

Commissioner Wilkerson: Yes.

Mr. Addison: And, you know, I -- well, I'll -- I'll get into this later; it's a -- you all -- it's a long story. But anyway, I do want to talk to a -- briefly on the issue of the comp rate calculation. We turned in materials, we turned in a Form 20, we actually had testimony from Ms. Burr about what the earnings were. This was a first

quarter of the new year injury, it's in March -- the beginning of March; so, we used the prior four (4) quarters in calculating the average weekly wage per the Statute and the Regs and it produced a particular average weekly wage and compensation rate. The Claimant is alleging that the compensation rate should be higher because according to her, in her brief to the court, she had worked some additional overtime hours before -- in the month or two (2) before the injury, no evidence was produced that showed that; the Claimant didn't even testify to it nor was there any cross of the Defense witness as to that issue. So, the only anything that's in the record as to that particular issue is the Claimant's pre-hearing brief stating that she had worked additional hours. There was no time sheet, there was no nothing that went in that said here is all the stuff where she has worked all of this additional time and she would be entitled to some increased amount of -- of -- of compensation rate where its an exception to the rule. All we did was look at what the Statute specifically says we're supposed to do, we did it and it produced the average weekly wage and compensation rate that

Commissioner Lyndon found, which was per what the Form 20 showed. I don't think there is any exceptional reasons here; there's no --

Commissioner Wilkerson: Which is the max comp rate, right?

Mr. Addison: -- she is just below it.

Commissioner Wilkerson: Oh, below, okay.

Mr. Addison: She's about --

Commissioner Wilkerson: Seven (7) -- that's right, it's seventy-three (73).

Mr. Addison: -- she's about thirty dollars ($30.00) below what the max comp rate would be for the year. The Claimant's position is, is that she's entitled to the maximum compensation rate.

Commissioner Wilkerson: It can't be thirty ($30.00) because thirty ($30.00) would get you over seven hundred ($700.00) -- was it seven oh four ($704.00) for '11?

Mr. Addison: Right -- right in there.

Commissioner Wilkerson: Okay.

Mr. Addison: Yes, sir.

Commissioner Wilkerson: That's fine. Okay. I'm fine with that.

Mr. Addison: I mean, it may be twenty-eight ($28.00) or whatever it is --

Commissioner Wilkerson: Okay.

Mr. Addison: -- but, I mean, I -- quite frankly I don't -- I think it was six seventy-one ($671.00) that was what was found; if I remember correctly.

Commissioner Wilkerson: Yes, it is six seventy-one, fifty-eight ($671.58).

Mr. Addison: So, it --

Commissioner Wilkerson: This is '11; I'm sorry, I thought it was a '10 case. I apologize.

Mr. Addison: -- so, about thirty ($30.00) some odd dollars.

Commissioner Wilkerson: Okay.

Mr. Addison: But -- so, you know, our position is basically that the compensation rate was accurately determined by the --

Commissioner Wilkerson: Yes.

Mr. Addison: -- Single Commissioner.

Commissioner Wilkerson: Okay. Thanks.

Mr. Addison: Thank you.

Commissioner Beck: Mr. Calhoun.

ARGUMENT FOR THE SECOND APPELLANT

By Mr. Calhoun:

Let me ask the Court, do I give my rebuttal next before I argue my appeal; is that correct?

Commissioner Beck: You'll -- you'll get two (2) minutes in reply as well.

Mr. Calhoun: Okay.

Commissioner Roche: You can do it however you want to but you've got eight (8) minutes now and then two (2) minutes in reply.

Mr. Calhoun: Okay. All right. Then I'll do my rebuttal if that's -- pleases the Court. On the day that Ms. Ramey was injured, March the 11th, there -- there's a hand scanning device that they use to punch in and out. That hand scanning device was working that day and after she fell she was immediately taken to Doctor's Care, she did not punch out with the hand scanning device; she was paid her normal hours that day even though she did not punch out. She began treating with Doctor's Care and she testified that there were two (2) other women that had Workers' Comp claims and -- and her understanding was that one (1) of the women was going to be fired. She was scared of being fired for that reason and the fact that the floor was understaffed and that they had her working in violation of her work restrictions and these other two (2) ladies also and they weren't complaining about it, quite frankly, because they

wanted to keep their jobs. On the day that she -- March 18th, the day that she was fired for -- for requesting to miss time for the doctor's appointment, the hand scanning device was not working; so, she could not use it to punch in and out. When the -- when the hand scanning device was not working the procedure was that you filled in a request for missed time form where you write in the time that you -- you arrived that day and left and you give it to your supervisor working that day, she reviews it and approves it. The glaring error that I feel that the Employer fails to address in -- in his brief is that Ms. Ramey's supervisor was there that day, she knew she had the doctor's appointment, as did Ms. Burr who testified for the Employer, she was the Human Resources Manager; they both knew she had a doctor's appointment that day. Ms. Sheppard, the supervisor working, approved the missed time form; the supervisor approved the missed time from work that Ms. Ramey was fired for, quite frankly. Ms. Ramey also testified that the day that she was fired -- her understanding that the reason she was fired was because she requested to be paid for a missed hour from work to get medical treatment on

a Workers' Comp case; that her Employer told her that -- that you can't do that and Ms. Burr, when her deposition was taken, confirmed that. She said she was fired because she requested to be paid for that hour and we can't -- we don't pay employees for missed time on Workers' Comp cases. Now, Ms. Burr changed her testimony at the hearing and she said that the reason she terminated Ms. Ramey was for falsifying documents and I believe that's where the Court needs to take into consideration that Ms. Ramey was found credible; Ms. Burr was not. But the bottom line is it -- and Commissioner Lyndon stated this, it would be professional suicide for an employee working nine (9) years, who has never had a Workers' Comp case before; who all the --

Commissioner Roche: And, Mr. Calhoun, I really don't think any of this matters to this case.

Commissioner Wilkerson: No.

Commissioner Roche: Whether she was fired correctly or not, what she was -- when she was fired she was on fully duty. So, it doesn't -- none of that really matters whether or not they properly terminated her, should have terminated

her, shouldn't terminate her. You -- I want you to speak to the fact that you've got somebody whose -- whose been written out at light duty and they've not offered employment; I think that's the issue. Now, what -- and Mr. Addison is saying well she wasn't credible in her complaints to the doctor that she -- that -- that for -- that made the doctor write her out for light duty. So, tell me what makes her credible. Commissioner Lyndon found her credible. Tell me what makes her credible and why she should -- she should be on -- I think it's a slam dunk if she's written out on light duty and they're not offering her any work. Right now it doesn't really matter whether she got fired because she was on full duty when she got fired. Do you see?

Mr. Calhoun: -- yes.

Commissioner Roche: Okay. Speak to --

Mr. Calhoun: But --

Commissioner Roche: -- speak to that.

Mr. Calhoun: -- but one issue I was working at, Commissioner, is that this fear of being fired that I think all of the employees had because they were understaffed is she was using special care not to do anything to give her Employer any reason

to fire her. When she went to the doctor's appointment on the 18th, which was the day that she -- she was just fired, she told the doctor -- her testimony was that she told the doctor I want -- you need to put me back on full duty; I'm worried about losing my job. The medical records from March the 18th indicate that she requested to be -- she requested, not the doctor, she requested to be put back on full duty and that's what she testified. She wanted to work full duty because she was in fear of losing her job; she was scared of losing her job and that's why she went back on full duty. She didn't want to; it wasn't the doctor's decision at Doctor's Care. The doctor at Doctor's Care had recommended that she go see an orthopedic doctor; that's what he wanted her to go do, which -- which didn't happen. So, at any rate, that's why she requested to be placed on full duty. And so, three (3) days later, on March the 21st, after she was fired and she had her follow up appointment at the Doctor's Care, you know, of course she -- she's not going to go back in there after she'd been fired and say, yeah, I want to keep working full duty; she didn't have a job at that point but that is the reason -- you

know, that was the reasoning for her doing what she did. But whether she was fired for requesting to be paid for one (1) missed hour at a doctor's appointment or falsifying documents, the supervisor approved her form. If she was falsifying documents, which is not what Ms. Burr says the reason -- was reason for her termination but even if that was the reason then the supervisor was a part of that and the supervisor wasn't fired. Ms. Ramey was paid on March the 11th for -- when she didn't clock out; that lead her to believe -- her testimony was that my understanding I was to be paid for time that I was at the doctor on my Workers' Comp case and that is corroborated by the fact that she was paid on the day that she was injured even though she didn't clock out. So, it would -- would be professional suicide; it would be throwing nine (9) years away for her to try to get paid for one (1) hour when everything that the Employer did, everything that the Employer told her up to that point, ever action that the Employer performed corroborated that her belief was that she was to be paid if she was at the doctor. And her supervisors working that day approved it; they okayed it. Ms. Burr

knew she was at the doctor – the lady who fired her knew that she was at the doctor that day; she approved it. Commissioner Lyndon simply said that he did not find it plausible that she would put nine (9) years on the line to get paid for one (1) hour at the doctor and Ms. Burr also, in her testimony, stated that all the other employees that we've fired in the past were falsifying documents. They were employees that requested to be paid for full shifts, nine (9) to twelve (12) hour shifts, that they did not work. They were not testified – I mean, terminated for requesting to be paid for one (1) hour that Ms. Ramey was at the doctor. That's all I have on that issue.

Commissioner Beck: All right. Thank you, sir. Mr. Addison, you have two (2) minutes.

Mr. Addison: Thank you, sir.

REPLY FOR THE FIRST APPELLANT

By Mr. Addison:

Very quickly, Commissioners, I -- I do not object typically at appeal hearings and that's why I did not. There was a lot of discussion there by Mr. Calhoun about what was said by anyone. Ms. Sheppard was not at this hearing. When he says Ms. Sheppard said something he's basing that on

testimony the Claimant alleged at the time of the hearing, which, again, I believe are self-serving statements. There is no corroborating the evidence that the Claimant was working outside of her restrictions; we also put that in our brief. There is a finding in the order, I don't really know that Commissioner Lyndon found that in his notes or order but it was in the order that was signed by Commissioner Lyndon. The only evidence on that was the Claimant saying that she was doing that. There was no other employee that was brought in by the Claimant to corroborate any of this. There was no other Claimant that was brought in by the Claimant to corroborate that anybody at the facility was scared to lose their job. Every one of you all sitting on this panel has had a hearing with this particular employer; this is UHS Pruitt. This is my client where I bring -- and he is going to kill me for saying this but the little guy that comes with me to all the hearings. You all know them; they are tough but they're fair. They have a lot of people that are on light duty all over this state. There are thirty (30) plus facilities in South Carolina and they have a bunch of people on light duty all the

time; it is something they do routinely. They don't fire people just because they're on light duty or have Workers' Comp claims. They are tough on people when they're on Workers' Comp claims, they don't let them just live outside the rules; if somebody violates the rules they go ahead and fire them. But if they work like they're supposed to and do what they're supposed to do they get back to work and they do their job. I mean, it's a tough but fair Employer. There was a statement that seemed to indicate that Ms. Burr was not found credible; there is no statement by Commissioner Lyndon that he didn't find her credible. He just took her testimony and didn't write anything on his notes for her. He specifically did not find her to be not credible, which is the requirement to state that she was somehow not credible before this panel. As for the issues of the Claimant's inability to do any work, I would just state that she's an RN. The injuries, you can see what's on the medicals to suggest what's wrong with her; there's nothing that seems to indicate that she's not capable of doing the work as an RN somewhere.

Commissioner Beck: Thank you, sir.

Mr. Addison: Thank you.

Commissioner Beck: Mr. Calhoun.

REPLY FROM THE SECOND APPELLANT

By Mr. Calhoun:

Very briefly, the supervisor, Sheppard, signed the missed time form; she signed it on March the 18th of that year. On the average weekly wage issue, very simply our position is that under 42-40 in the Hinson and Breland cases we're contending that the average weekly wage should be based on the fifty-two (52) weeks previous to the date of injury; not on the four (4) quarter – fifty-two (52) weeks prior to the date of injury, not the four (4) quarters that are on the Form 20 that the Employer uses; the last quarter being December 11th of 2010, which is three (3) months before the date of accident. Now, if you use – hear me out please – if – if you use those fifty-two (52) weeks it gives you an actual compensation rate of seven hundred and thirty-two dollars and four cents ($732.04), which of course is above the cap, the seven hundred and four dollar ($704.00) cap for 2011 of seven hundred and four, ninety-two ($704.92). Our position is – is – is the cap most closely

approximates the amount that a Claimant would have been making in the future, which is what we're -- the case law says we're supposed to look forward to earnings in the future, not the past. Now, there is a sixty dollar and forty cents ($60.40) difference between this actual amount, seven hundred and thirty-two dollars ($732.00), and the -- the amount that Commissioner Lyndon gave of six hundred and seventy-one dollars ($671.00). Our position is that the comp rate -- the -- the amount that mostly clearly approximates --

Commissioner Wilkerson: That's not sixty dollars ($60.00).

Mr. Calhoun: -- sir?

Commissioner Wilkerson: That's not sixty dollars ($60.00).

Mr. Calhoun: It's -- I -- I have --

Commissioner Wilkerson: Is it?

Mr. Calhoun: -- sixty dollars and forty-six cents ($60.46) --

Commissioner Wilkerson: Okay.

Mr. Calhoun: -- between the six --

Commissioner Wilkerson: Six seventy-one ($671.00) --

Mr. Calhoun: -- seventy-one ($671.00) and --

Commissioner Wilkerson: -- and seven oh four ($704.00) --

Mr. Calhoun: -- the seven thirty-two ($732.00).

Commissioner Wilkerson: -- is not sixty dollars ($60.00).

Mr. Calhoun: Sir?

Commissioner Wilkerson: Six seventy-one, fifty-eight ($671.58) and seven oh four ($704.00) is not sixty dollars ($60.00).

Mr. Calhoun: Yes, sir. I'm saying the six seventy-one ($671.00) and the seven thirty-two ($732.00) --

Commissioner Wilkerson: Okay.

Mr. Calhoun: -- would be -- would be sixty dollars ($60.00). Okay. That -- that most clearly approximates what the Claimant would have made. During those three (3) months the wage records show and her testimony was that they were understaffed and the wage records show that she was working overtime. Now, that -- that's an exceptional circumstance that was used in the Booth case that working overtime is an exceptional circumstance during those three (3) months in the year 2011, and so since seven oh four ($704.00)

most closely approximates what the Claimant would have made in the future.

Commissioner Beck: All right. Thank you, sir.

Commissioner Wilkerson: Okay. Thank you.

Mr. Calhoun: Thank you.

Commissioner Beck: That will conclude this proceeding.

(THERE BEING NO FURTHER DISCUSSION, THE HEARING CONCLUDED AT 9:23 A.M.)

STATE OF SOUTH CAROLINA)
COUNTY OF RICHLAND) CERTIFICATE

Be it known that I took the foregoing South Carolina Workers' Compensation Commission Hearing of Gayla Ramey, vs. Unihealth Post-Acute Care Tanglewood;

That I was then and there a Notary Public in and for the State of South Carolina-At-Large;

That by virtue thereof I was duly authorized to administer an oath;

That the witness was first duly sworn to testify the truth, the whole truth, and nothing but the truth, concerning the matter in controversy aforesaid;

The foregoing transcript of 31 typewritten pages represents a true, accurate and complete transcription of the testimony so given at the time and place aforesaid to the best of my skill and ability;

That I am not related to nor an employee of any of the parties hereto, nor a relative or employee of any attorney or counsel employed by the parties hereto, nor interested in the outcome of this action;

Witness my hand and seal this 6th Day of July, 2012.

Gloria Davis
Notary Public for South Carolina
My Commission Expires 12/21/21

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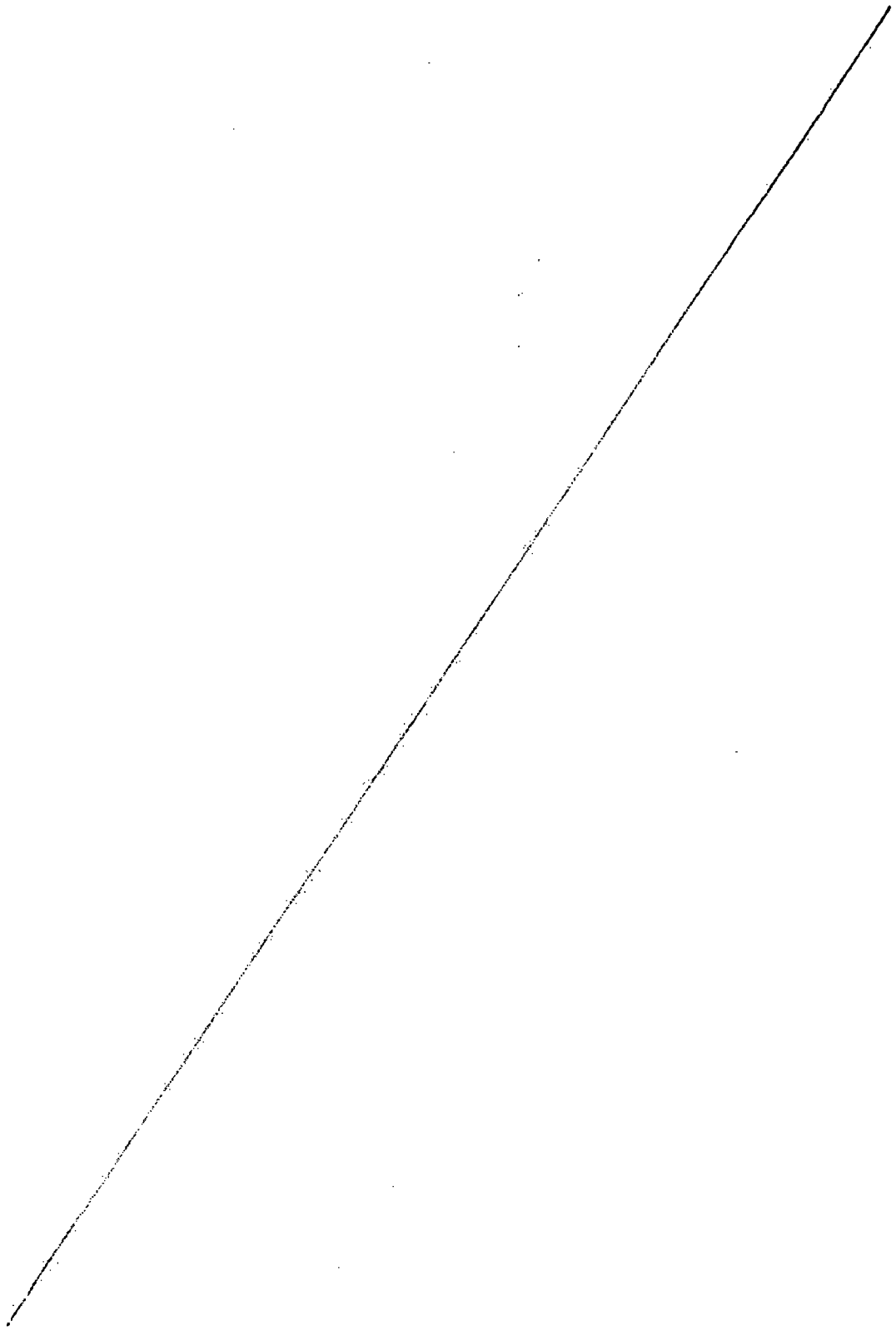

Gayla Ramey
WCC File No: 1103442
Date of Accident: 03/11/2011

1) Alice J. Brooks M.D., p.a

2) Doctors Care

3) Camden Open MRI

4) Palmetto Spine & Sports Medicine, p.a.

ALICE J. BROOKS M.D., p.a

LABORATORY REPORT

7200682 AREA/ROUTE/L JP: 0005400
KERSHAW COUNTY-EMPLOYEE HEALTH
ATTN: MARY LIBBY BYARS
1315 ROBERTS ST
CAMDEN, SC 29020-3737

SmithKline Beecham
Clinical Laboratories

PATIENT NAME	PATIENT ID	ROOM NO.	AGE	SEX	PHYSICIAN
RAMEY, GAYLA			39	F	NORRIS, THOMAS W

RE	REQUISITION NO.	ACCESSION NO.	LAB REF. #	COLLECTION DATE & TIME	LOG-IN DATE	REPORT DATE	& TIME
2	6841964	AT660573N		07122000 1510 PM	07132000	07142000	3:12PM

EASTERN TIME

REMARKS

SS#: [redacted]

REPORT STATUS	TEST	RESULT IN RANGE	RESULT OUT OF RANGE	UNITS	REFERENCE RANGE	SITE CODE
FINAL						
	Date of Birth: [redacted]					AT
	RUBEOLA VIRUS IGG AB	2.90		EIA VALUE		

EIA VALUE	EXPLANATION OF TEST RESULTS
(OR = 0.90	NEGATIVE - NO RUBEOLA (MEASLES) IGG ANTIBODY DETECTED
0.91 - 1.09	EQUIVOCAL
) OR = 1.10	POSITIVE - RUBEOLA (MEASLES) IGG ANTIBODY DETECTED

THE PRESENCE OF RUBEOLA (MEASLES) IGG ANTIBODY SUGGESTS A CURRENT OR PAST INFECTION OR IMMUNIZATION WITH THE MEASLES VIRUS. IN THE ABSENCE OF A CURRENT OR RECENT INFECTION, A RUBEOLA IGG VALUE OF EQUAL TO OR GREATER THAN 1.10 IS CONSISTENT WITH IMMUNITY. SERA COLLECTED EARLY IN THE COURSE OF INFECTION MAY NOT HAVE DETECTABLE ANTIBODY.

IF A CURRENT OR RECENT INFECTION IS SUSPECTED, PERFORMING A RUBEOLA IGM TEST ON A SINGLE SERUM OR A RUBEOLA IGG TEST ON ACUTE AND CONVALESCENT SERA SUBMITTED AT THE SAME TIME MAY YIELD CLINICALLY USEFUL INFORMATION.

)) REPORT CONTINUED ON NEXT PAGE - RAMEY,GAYLA AT660573N ((

INDICATES TESTING SITE SEE REVERSE SIDE

LABORATORY REPORT

7200682 AREA/ROUTE/[illegible] UP: 0005400
KERSHAW COUNTY-EMPLOYEE HEALTH
ATTN: MARY LIBBY BYARS
1315 ROBERTS ST
CAMDEN, SC 29020-3737

SmithKline Beecham
Clinical Laboratories

PATIENT NAME	PATIENT ID	ROOM NO.	AGE	SEX	PHYSICIAN
RAMEY, GAYLA			39	F	NORRIS, THOMAS W

SE	REQUISITION NO.	ACCESSION NO.	LAB REF. #	COLLECTION DATE & TIME	LOG-IN DATE	REPORT DATE	TIME
1	6841964	AT660573N		07122000 1510 PM	07132000	07142000	3:12PM

REMARKS

EASTERN TIME

SS#: [redacted]

REPORT STATUS	TEST	RESULT IN RANGE	RESULT OUT OF RANGE	UNITS	REFERENCE RANGE	SITE CODE
FINAL						

Date of Birth: 01/02/1961 [redacted] AT
RUBELLA VIRUS IGG AB
BY EIA 2.00 EIA VALUE

EIA VALUE	EXPLANATION OF TEST RESULTS
(OR = 0.90	NEGATIVE - NO RUBELLA IGG ANTIBODY DETECTED.
0.91 - 1.09	EQUIVOCAL
) OR = 1.10	POSITIVE - RUBELLA IGG ANTIBODY DETECTED.

THE PRESENCE OF RUBELLA IGG ANTIBODY SUGGESTS A CURRENT OR PAST INFECTION OR IMMUNIZATION WITH RUBELLA VIRUS. IN THE ABSENCE OF A CURRENT OR RECENT INFECTION, A RUBELLA IGG EIA VALUE OF EQUAL TO OR GREATER THAN 1.10 IS CONSISTENT WITH IMMUNITY TO RUBELLA. SERA COLLECTED EARLY IN THE COURSE OF INFECTION MAY NOT HAVE DETECTABLE LEVELS OF IGG ANTIBODY.

IF A CURRENT OR RECENT INFECTION IS SUSPECTED, PERFORMING A RUBELLA IGM TEST ON A SINGLE SERUM OR RUBELLA IGG TEST ON ACUTE AND CONVALESCENT SERA SUBMITTED AT THE SAME TIME MAY YIELD CLINICALLY USEFUL INFORMATION.

)) REPORT CONTINUED ON NEXT PAGE - RAMEY,GAYLA AT660573N ((

INDICATES TESTING SITE SEE REVERSE SIDE

2

AMENDED REPORT

7200682 AREA/ROUTE/L JR: 0005400
KERSHAW COUNTY-EMPLOYEE HEALTH
ATTN: MARY LIBBY BYARS
1315 ROBERTS ST
CAMDEN, SC 29020-3737

SmithKline Beecham Clinical Laboratories

[redacted]

PATIENT NAME	PATIENT ID	ROOM NO.	AGE	SEX	PHYSICIAN
RAMEY, GAYLA			39	F	NORRIS, THOMAS W

AGE	REQUISITION NO.	ACCESSION NO.	LAB REF. #	COLLECTION DATE & TIME	LOG-IN DATE	REPORT DATE	& TIME
3	6841964	AT660573N		07122000 1510 PM	07132000	07142000	3:12PM

EASTERN TIME

REMARKS

SS#: [redacted]

REPORT STATUS	TEST	RESULT IN RANGE	RESULT OUT OF RANGE	UNITS	REFERENCE RANGE	SITE CODE
FINAL						AT

Date of Birth: 01/02/1961

MUMPS VIRUS IGG AB BY EIA, SERUM 3.66 EIA VALUE

EIA VALUE	EXPLANATION OF TEST RESULTS
< OR = 0.90	NEGATIVE - NO MUMPS IGG ANTIBODY DETECTED
0.91 - 1.09	EQUIVOCAL
> OR = 1.10	POSITIVE - MUMPS IGG ANTIBODY DETECTED

THE PRESENCE OF MUMPS IGG ANTIBODY SUGGESTS A CURRENT OR PAST INFECTION OR IMMUNIZATION WITH MUMPS VIRUS. IN THE ABSENCE OF A CURRENT OR RECENT INFECTION, A MUMPS IGG EIA VALUE OF EQUAL TO OR GREATER THAN 1.10 IS CONSISTENT WITH IMMUNITY TO MUMPS. SERA COLLECTED EARLY IN THE COURSE OF INFECTION MAY NOT HAVE DETECTABLE LEVELS OF IGG ANTIBODY.

IF A CURRENT OR RECENT INFECTION IS SUSPECTED, PERFORMING A MUMPS IGM TEST ON A SINGLE SERUM OR MUMPS IGG TEST ON ACUTE AND CONVALESCENT SERA SUBMITTED AT THE SAME TIME MAY YIELD CLINICALLY USEFUL INFORMATION.

)) END OF REPORT - RAMEY,GAYLA AT660573N ((

INDICATES TESTING SITE SEE REVERSE SIDE

3

Kershaw County Medical Center
Occupational Health Services

Dept: West / Nurse Tech

Annual Health Review

Name RANEY GAY/A D.O.B 01/02/1961 Anniversary Date 7/17/2000
Social Security [redacted]

Preplacement Health Review AHR AHR AHR AHR

Date	7-12-00	06/25/01			
Height/Weight	5'7½" 108½	5'7½" 166½			
Temp/Pulse/Resp.	98.1 72 18	Defered			
Blood Pressure	112/78 LA	120/88 LA			
CBC/H&H/ Chem 12/UA	7-12-00 See doc.	—	—	—	—
Rubella/Rubeola/ Varicella/Mumps Titer	Varicella by History Mumps — Immune Rubella — Immune Rubeola — Immune		—	—	—
HBSAB titer		9/26/01 Immune			
Pre-placement drug screen	7/12/00 negative	—			
Chest X-ray	7/12/00 normal & on	—	—		
2 Step PPD:	—	—			
#1 PPD placed	Past Positive	Past PPD.			
Read	PPD.	1967			
Results	1967 -	no			
Lot #	/	negative			
#2 PPD placed	/	symptoms			
Read	/				
Results	/				
Lot #	/				
Prophylactic Tr. for positive PPD Y/N/NA	INH X 1 year age: 6	INH X 1 year age: 6 -			

(X) To get Documentation of Positive PPD
M Bryan, RN

Attempted to get documentation from Health Dept
M Bryan RN

4

KERSHAW COUNTY MEDICAL CENTER
Radiology Department
Haile and Roberts Streets
Camden, South Carolina 29020
(803)713-6531

Patient: RAMEY,GAYLA [redacted]

Age: 42 Sex: F

DOB: 01/02/1961

MRN: M000209492
Acct #: K10000016268
Req #: 03-0006753

Serv Dt/Tm: 11/27/03 / 2046
Loc: MED2IP
Status: ADM IN

Ord Dr: DIERINGER, CINDY MD

Rm/Bed: MED2 0315-2

HIGH,PATRICE DO
116 STANDARD WAREHOUSE RD
LUGOFF, SC 29078

REASON FOR EXAM: DYSPNEA.

CHEST 11/27/03:

Comparison is made with 3/13/01 and reveals no significant interval change. No acute infiltrates are seen. The heart is normal in size. The pulmonary vascularity is normal.

IMPRESSION: NO CHANGE SINCE THE PRIOR STUDY.

Read by:DONALD J COPLEY MD

Trans by: TKR
Trans date/time: 11/28/03 1119

5

Admitting Physician's copy

Signed
cc:DIERINGER,CINDY MD; HIGH,PATRICE DO
Report #1128-0021

KERSHAW COUNTY MEDICAL CENTER
CAMDEN, S.C. 29020

PATIENT: RAMEY, GAYLA
DOCTOR: Patrice L. High, DO
ADM DATE: 11/28/2003

RM#: MED2 0315-2
MR#: 0000209492
PT#: 0100000162[redacted]

Ms. Ramey is a 42 year old white female who is assigned to me who presents to the Emergency Department with worsening of shortness of breath, wheezing, tightness in her chest and cough over the last five days. The patient was seen six days ago at Doctor's Care with a dry hacking cough with temperature of 102 to 103. She was placed on Biaxin for five days. Three days prior to admission, she noted worsening of chest tightness, shortness of breath with exertion. The patient denies any history of asthma but noted several years ago she had a history of bronchitis with similar symptoms as above. She was also noted some chills and slight nausea but no vomiting and diarrhea has since resolved. She was further treated for some flu like symptoms as well as the above illness.

PAST MEDICAL HISTORY:
None.

PAST SURGICAL HISTORY:
In 1994 she had uterine polyps removed. She has had four vaginal deliveries.

MEDICATIONS:
Sudal and Biaxin. These have been stopped since her hospitalization.

ALLERGIES:
None known.

FAMILY HISTORY:
Mom had a history of chronic obstructive pulmonary disease, emphysema and osteoporosis. Father history unknown. PGM DM MGF Suicide PGF Stroke MGMOsteoarthritis Cervical CA @ 39

SOCIAL HISTORY:
Negative for alcohol and drug use but she is a 1.5 pack a day smoker times 30+ years but patient no smoking in the last week. Married 4 Kids - youngest 16.

Level 3

REVIEW OF SYSTEMS:
Negative.

PATIENT: RAMEY, GAYLA
DOCTOR: Patrice L. High, DO
ADM DATE: 11/28/2003

RM#: -
MR#: 0000209492
PT#: 010000016268

PHYSICAL EXAMINATION:
Blood pressure 107/66, respirations 22, temperature of 96.5°, pulse is 110. O2 sat of 95%.
GENERAL: She is alert and oriented times three in no acute distress. She answers appropriately and has no conversational dyspnea.
HENT: Head is normocephalic. Extraocular movements intact, pupils equal, round, reactive to light and accommodation. Her tympanic membranes are clear bilaterally. She has no adenopathy. She has dry mucous membranes. No posterior pharyngeal exudate.
HEART: Tachycardiac but regular with no murmurs or rubs.
LUNGS: Loud inspiratory and expiratory wheezes with occasional rhonchi, no rales.
ABDOMEN: Soft, nontender and no guarding or rebound. Positive bowel sounds.
EXTREMITIES: No edema, cyanosis or clubbing. She has good pulses bilateral pedal.
NEUROLOGICAL: Cranial nerves 2-12 grossly intact.

LABS:
From the Emergency Room, white count of 13.3 and her H&H 12.4 and 35.5. Platelets 362. Sodium was 138, potassium was low at 2.8. Her chloride was 101, CO2 25, BUN and creatinine 7 and 0.9 respectively. Her glucose was 108. Calcium was 9.7.

Chest x-ray unfortunately is not on the chart at this time. We will await those results.

ASSESSMENT:
Assessment of this patient, reactive airway disease, chronic obstructive pulmonary disease due to chronic smoking versus exacerbation of asthma. Hypokalemia questionable etiology.

PLAN:
To replace her potassium. She will on Solu-Medrol and await her

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PATIENT: RAMEY, GAYLA
DOCTOR: Patrice L. High, DO
ADM DATE: 11/28/2003

RM#: -
MR#: 0000209492
PT#: 010000016268

pending tests and x-rays.

Patrice L. High, DO

PH/lwk
D: 11/28/2003 8:20 A
T: 11/28/2003 8:42 A

cc: Patrice L. High, DO

KERSHAW COUNTY MEDICAL CENTER
CAMDEN, S.C. 29020

PATIENT: RAMEY, GAYLA
DOCTOR: Patrice L. High, DO
ADM DATE: 11/28/2003
DSC DATE: 12/02/2003

RM#: MED2 0315-2
MR#: 0000209492
PT#: 010000016268

DISCHARGE DIAGNOSES:
1. Asthma exacerbation, new onset.
2. Hypokalemia, resolved.

DISCHARGE MEDICATIONS:
1. Advair 500 per 51 one puff p.o. b.i.d.
2. ____ valve to be utilized t.i.d. 7
3. Tobacco cessation.

HOSPITAL COURSE:
Ms. Ramey is an unassigned patient to me who is 42 years of age. She came to the Emergency Department with worsening shortness of breath, wheezing, tightness in her chest and cough over the last five days. She had been at Doctor's Care approximately five days prior to admission with dry hacking cough and temperature of 102 to 103° and was subsequently placed on Biaxin for five days. She noted worsening of her symptoms and thus came into the Emergency Department. She subsequently was admitted for reactive airway disease. Probable asthma exacerbation. She was placed on Solu-Medrol and had Xopenex and Atrovent nebs q-4 as she progressed well during her treatment her nebs were cut back to q-6 and then subsequently to q-shift. Solu-Medrol was stopped therefore the patient was stable for discharge on 12-2-03 with no wheezing and clear lungs. She was ambulating well with a pulse oxygen of 97% post ambulation.

She had a chest x-ray while she was here done on 11-27 which showed no acute infiltrate and her heart was normal size and pulmonary vascularity was normal. Her initial labs showed white count of 13.3, Hemoglobin of 12.4, hematocrit of 35.5 and platelet count of 362. This subsequently doubled on November 29th to 33.1, H&H of 10.6 and 30.8 as well as platelets of 345. It started to decrease again on November 30th at 29.2, and her Solu-Medrol was subsequently decreased. Her hemoglobin and hematocrit were back up to 11.1 and 31.8. Platelets remained stable At 363.

She also was noted to have some increases in her sugars on the Solu-Medrol but also subsequently dropped as she was tapered off. The patient was noted to be stable. Clinical presentation on 12-2 with blood pressure of 123/79, pulse of 79, temperature of 98.4° and O2 sats

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KERSHAW COUNTY MEDICAL CENTER
CAMDEN, S.C. 29020

PATIENT: RAMEY, GAYLA
DOCTOR: Patrice L. High, DO
ADM DATE: 11/28/2003
DSC DATE: 12/02/2003

RM#: -
MR#: 0000209492
PT#: 010000016268

as stated above respirations 18. It was felt that despite her abnormal labs, it was safe for her to go home and to be followed up in ten days. She will placed on Advair inhaler as stated above. She will follow-up in my office in seven to ten days. The patient has been told that smoking is probably what caused her lung status and she needs to stop. After her lungs were clear, she will not be placed on any prednisone or anything like that. The number to my office has been given to her. She will call the office if she needs me in the interim.

Patrice L. High, DO

PH/lwk
D: 12/02/2003 8:40 A
T: 12/09/2003 10:13 A

cc: Patrice L. High, DO

0488701 Ramey, Gayla R
.6 Duke Drive

ugoff, SC 29078

DATE Dr. Notes

Date Created:

3/24/2004 02 Chart Number: 0488701
03/24/2004
Patient Name: Ramey, Gayla
DOB: 01/02/1961 Age: 43 Sex: Female
Ethnic Origin: WHITE, NON-HISPANIC
Doctor: ALICE J. BROOKS M.D.
**********CHIEF COMPLAINT**********
EXTENDED OV, PAP SMEAR AND CLINICAL BREAST EXAM
**********REVIEW OF SYSTEMS**********
THIS PATIENT DENIES FEVER, HA, PND, ALLERGIES, ST, COUGH, FATIGUE, SOB, CHEST PAIN, N/V/C/D, URINARY SYMPTOMS, SWELLING OR NEUROLOGIC CHANGES. ALL OTHER SYSTEMS NEGATIVE.
**********PATIENT HISTORY**********
ALLERGIES:NKDA
CHILDHOOD ILLNESSES:HEALTHY
ADULT ILLNESSES:COPD
INJURIES/FX'S:FX PINKY
SURGERIES:UTERINE POLYP REMOVED IN 1994
HOSPITALIZATIONS:FOR ABOVE AND CHILDBIRTH
CURRENT MEDICATIONS:
LMP:3-18-04
LAST PAP SMEAR:1994
LAST MAMMOGRAM:2 YRS AGO
HX OF ABNORMAL PAP SMEARS:NO
HX OF ABNORMAL MAMMOGRAMS:NO
G 5 P 4 A 1 L 4 MISCARRIAGE
PREGNANCY HISTORY:
FULL TERM: 4
SVD: 4
COMPLICATIONS WITH PREGNANCY:NO
AGE AT FIRST PREGNANCY:16
BREAST FEED:NO
BIRTH CONTROL METHOD:VASECTOMY
H/O STD'S:NO
IMMUNIZATIONS:
YEARLY FLU VACCINE:YES
PNEUMOVAX:NO
HEP B SERIES:YES
LAST TETANUS INJ (WITHIN 10 YEARS):UNSURE
LAST EYE EXAM:NEEDS TO HAVE ONE
LAST DENTAL EXAM:NEEDS TO HAVE ONE
BONE DENSITY SCAN:NO

SIGMOIDOSCOPY:NO
COLONOSCOPY:NO
PROBLEMS WITH VOIDING:
**********FAMILY HISTORY**********
HX OF FEMALE RELATED CANCER:
FAMILY HX OF OSTEOPOROSIS:
MOTHER:UTERINE OR CERVICAL CA AT 29. COPD/HTN/CHF
FATHER:UNSURE
SIBLINGS:HEALTHY
MGM:OSTEOARTHRITIS
MGF:UNSURE
PGM:DM
PGF:UNSURE
**********SOCIAL HISTORY**********
TOBACCO USE:3/4 PPD X 25 YRS
ETOH:NO
RECREATIONAL DRUG USE:NO TYPE:
CAFFEINE INTAKE:ALOT
EXERCISE:NO
EMPLOYED:NURSE AT REHAB CENTER
MARITAL STATUS:MARRIED
LIVING ARRANGEMENTS:LIVES WITH HUSBAND AND YOUNGEST CHILD
**********PHYSICAL**********
NEURO: THE PATIENT IS WELL DEVELOPED. A&O X3, PLEASANT AFFECT. CRANIAL NERVE II-XII INTACT TO INCLUDE DTR'S AND SENSATION. SENSE OF TASTE NOT TESTED.
HEAD: HEAD IS ATRAUMATIC AND NORMOCEPHALIC, HELD MIDLINE & ERECT WITH FEATURES SYMMETRIC. SCALP MOVES FREELY UNDER EXAMINING FINGERS. NO TENDERNESS NOTED. TEMPORAL ARTERIES PALPABLE BUT NOT THICKENED. NO DEFECTS OR DEFORMITIES NOTED.
EYES: PATIENT DENIES PAIN, DISCOMFORT, ITCHING, BLURRED VISION, OR DOUBLE VISION. THE PATIENT'S VISION WAS 20/20 BILATERALLY. PUPILS ARE EQUAL, ROUND & REACTIVE TO LIGHT AND ACCOMODATION. EXTRA OCULAR MOVEMENTS INTACT. PERIPHERAL VISION INTACT AT 75 DEGREES BILATERALLY. INSPECTION OF LIDS AND CONJUNCTIVAE WITHIN NORMAL LIMITS.
EARS: AURICLE IN ALIGNMENT, NO MASSES, LESIONS, SCARS OR TENDERNESS NOTED. EXTERNAL AUDITORY CANALS UNOBSTRUCTED. TYMPANIC MEMBRANES ARE TRANSLUCENT PEARLY GREY IN COLOR, INTACT, MOBILE, GOOD LIGHT REFLEX AND BONY LANDMARKS PRESENT.
NOSE: NO DISCHARGE OR POLYPS, MUCOSA PINK AND MOIST, SEPTUM MIDLINE AND PATENT BILATERALLY, TURBINATES CLEAR. NO ERYTHEMA OR PURULENCE WAS NOTED. NO FRONTAL OR MAXILLARY TENDERNESS ON PALPATION OR PERCUSSION.
MOUTH: LIPS ARE SYMMETRICAL, COLOR PINK, WITHOUT EDEMA OR SURFACE ABNORMALITIES. BUCCAL MUCOSA PINK AND MOIST WITHOUT LESIONS, GINGIVAE RED AND BOGGY; TONGUE MIDLINE; NO LESIONS OR TREMORS. TEETH IN GOOD REPAIR. HARD AND SOFT PALATE INSPECTED NO OBVIOUS ABNORMALITIES NOTED.
THROAT: GAG REFLEX INTACT, UVULA RISES EVENLY, OROPHARYNX PINK

AND MOIST WITHOUT EXUDATE OR ERYTHEMA, NO HOARSENESS. ENUCIATES WORDS CLEARLY.
NECK: TRACHEA MIDLINE. THE NECK IS SUPPLE, NON-TENDER, WITHOUT JVD OR BRUITS. FULL RANGE OF MOTION. THERE IS NO ADENOPATHY OR THYROMEGALY PRESENT. THYROID IS SMOOTH, SOFT, NON-TENDER, & MOVES FREELY WHEN PATIENT SWALLOWS.
LUNGS: CLEAR TO AUSCULTATION AND PERCUSSION. NO RALES, RHONCHI, OR WHEEZES WERE HEARD. VESICULAR BREATH SOUNDS OVER PERIPHERAL LUNG TISSUE. NON LABORED AND EVEN EFFORT. NO INCREASED OR DIMINISHED TACTILE FREMITUS NOTED.
HEART: NORMAL S1,S2 REGULAR RATE AND RHYTHM WITHOUT CLICKS GALLOPS, RUBS, OR MURMURS. PMI IS AT THE LMC LINE.
VASCULAR: PULSES IN ALL FOUR EXTREMITIES +3, NO JUGULAR VEIN DISTENTION NOTED, CAPILLARY REFILL 1-2 SECONDS, NO PITTING EDEMA OR SWELLING OF EXTREMITIES NOTED. NO BRUITS AUDIBLE.
BREASTS: PALPATION WITHOUT MASSES, DIMPLES OR AXILLARY ADENOPATHY. SYMMETRICAL SHAPE AND SIZE. NO DISCHARGE FROM NIPPLES.
ABDOMEN: VISUAL INSPECTION OF ABDOMEN WITHOUT MASSES OR LESIONS NOTED. NORMAL BOWEL SOUNDS, NO HEPATO-SPLEENMEGALY NOTED. NO TENDERNESS TO PALPATION. NO GUARDING OR REBOUND. NORMAL TO PERCUSSION. THE PATIENT WAS EVALUATED AND NO HERNIAS PRESENT.
GENITOURINARY: HAIR DISTRIBUTION IS WITHIN NORMAL LIMITS. BLADDER IS WITHOUT FULLNESS, MASSES OR TENDERNESS. THE ORIFICE OF THE URETHRA IS WITHOUT MASSES, TENDERNESS OR SCARING. THE VAGINA IS NORMAL IN COLOR AND RUGGAE. NO LESIONS OR MASSES ARE SEEN. THE UTERUS IS NORMAL IN SIZE, SHAPE AND CONSISTENCY. THERE IS NO CERVICAL MOTION TENDERNESS. THE CERVICAL OS IS WITHOUT LESIONS OR MASSES. NO ADNEXAL TENDERNESS TO PALPATION. NO RECTOCELE OR CYSTOCELE PRESENT.
RECTUM: MANUALLY EVALUATED AND FOUND TO HAVE NORMAL TONE AND NO MASSES. THE PATIENT'S STOOL WAS GAUIAC NEGATIVE. NO HEMORRHOID NOTED.
MUSCULOSKELETAL: NORMAL GAIT NOTED. POSTURE STRAIGHT, WITHOUT SCOLIOSIS. MUSCLES & EXTREMITIES SYMMETRIC. MUSCLE STRENGTH APPROPRIATE AND EQUAL BILATERALLY. ACTIVE RANGE OF MOTION.
JOINTS: NORMAL SIZE AND CONTOUR, FULL RANGE OF MOTION, NO REDNESS OR SWELLING. NO EVIDENCE OF INJURY. NO CLICKS, LOCKING, OR LIMITED EXTENSION NOTED.
SKIN: APPROPRIATE COLOR FOR RACE. WARM & DRY W/O LESIONS OR DEFORMITIES.
DX: COPD/TOBACCO DEPENDENCE/EOV WITH PAP, CLINICAL BREAST EXAM
PLAN: SCHEDULE MAMMOGRAM, PT TO CHECK WITH INSURANCE ABOUT
LABS:CBC W/DIFF, TSH, CMP, HGB A1C AND LIPID PANEL. PT AWARE OF MESSAGE CENTER FOR X-RAY/LAB RESULTS OR SCHEDULED APPOINTMENTS.
DS

13

)488701 Ramey, Gayla R
16 Duke Drive

Lugoff, SC 29078

DATE	Dr. Notes	Date Created:
3/25/2004 07	Chart Number: 0488701 03/25/2004 Patient Name: Ramey, Gayla R DOB: 01/02/1961 Age: 43 Sex: Female Ethnic Origin: WHITE, NON-HISPANIC Doctor: ALICE J. BROOKS M.D. LABS DRAWN IN OFFICE ON 3-25-04//MAT	

14

LabCorp®

Type	Primary Lab	Report Status	
S	GF	Final	Pg 1

)5-C99-0040-0
ime 0901

CD- 910856102360

Sex	Age (Yrs/Mos)
F	043/02

AMEY, GAYLA

Date Collected	Date Entered	Date Reported	
3/24/04	03/25/04	03/31/04	1597

YI N
DOB: 01/02/61

Physician ID	Patient ID
SHUMPERT, E	401987482

Account: ALICE J BROOKS MD CLINCIAL 39432640

116 STANDARD WAREHOUSE ROAD
LUGOFF, SC 29078
803-438-6023
UPIN: S99428

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB

CYTOLOGY INFORMATION:
SOURCE.....CERVICAL
COLLECTION.....CX BROOM ONLY
LMP / PREV TREAT...NONE
PREV CYTOLOGY.....NEGATIVE

GF

iquid Pap w/HPV Rfx on ASC-U

Test ordered:
192047 Liquid Pap with HPV Reflex on ASCU
Number of Slides = 1

GF

Clinical history:
V76.2 ; Screening for malignant neoplasm of the cervix

GF

****

GF

Diagnosis:
NEGATIVE FOR INTRAEPITHELIAL LESION AND MALIGNANCY.

Specimen adequacy:
Satisfactory for evaluation. Endocervical and/or squamous metaplastic cells (endocervical component) are present.

GF

****

Performed by:
Deena D Currie,
Cytotechnologist (ASCP)

GF
GF

The Pap smear is a screening test designed to aid in the detection of premalignant and malignant conditions of the uterine cervix. It is not a diagnostic procedure and should not be used as the sole means of detecting cervical cancer. Both false-positive and false-negative reports do occur.

GF

Comment: HPV DNA TESTING WAS NOT INDICATED FOR THIS SPECIMEN.

Director: Sandra Bigner, MD

LAB: GF LabCorp Burlington
2039 Willow Springs Lane Burlington, NC 27215-0000

For inquiries the physician may contact: Branch: 800-327-0997 Lab: 336-584-5171

Last Page of Report

401-98-7482

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Specimen #	Type	Primary Lab	Report Status	
085-002-0163-0	S	BN	Final	Pg 1

Additional Information: Time 1022

CD- 91085610269

XI N

Clinical Information: DOB: 01/02/61 Fasting: Y

Physician ID	Patient ID
SHUMPERT, E	401987482

Account: ALICE J BROOKS MD CLINCIAL 394326 08 14

116 STANDARD WAREHOUSE ROAD
LUGOFF, SC 29078
803-438-6023
UPIN: B99492

Patient Name: RAMEY, GAYLA R [redacted]

Sex: F

Age (Yr/Mo): 043/02

Patient Address: [redacted]

Date Collected	Date Entered	Date Reported	
03/25/04	03/25/04	03/29/04	1494

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
CMP14+LP+CBC/D/Plt+TSH+Hb A...					
Chemistries					
Glucose, Serum	95		mg/dL	65 - 99	
A1c	5.3		%	4.5 - 5.7	

draft approved

Current guidelines recommend a treatment goal of <7% for diabetic patients. A1c may be overestimated in diabetic patients exhibiting poor control and who are also heterozygous or homozygous for HgbS or HgbC. Total glycohemoglobin is a better indicator of diabetic control in patients with these hemoglobin variants.

Mean Bld Glu Estim.	90		mg/dL	5 - 26
BUN	10		mg/dL	6 - 20
Creatinine, Serum	0.7		mg/dL	0.6 - 1.5
BUN/Creatinine Ratio	14			6 - 27
Sodium, Serum	140		mmol/L	135 - 146
Potassium, Serum	4.7		mmol/L	3.5 - 5.5
Chloride, Serum	107		mmol/L	96 - 109
Carbon Dioxide, Total	22		mmol/L	20 - 32
Calcium, Serum	9.3		mg/dL	8.5 - 10.6
Protein, Total, Serum	6.5		g/dL	6.0 - 8.5
Albumin, Serum	4.1		g/dL	3.5 - 5.5
Globulin, Total	2.4		g/dL	1.5 - 4.5
A/G Ratio	1.7			1.1 - 2.5
Bilirubin, Total	0.3		mg/dL	0.1 - 1.2
Alkaline Phosphatase, Serum	64		IU/L	25 - 150
AST (SGOT)	17		IU/L	0 - 40
ALT (SGPT)	15		IU/L	0 - 40
Lipids				
Cholesterol, Total		212	H mg/dL	100 - 199
Triglycerides	102		mg/dL	0 - 149
HDL Cholesterol	41		mg/dL	40 - 59
VLDL Cholesterol Cal	20		mg/dL	5 - 40
LDL Cholesterol Calc		151	H mg/dL	0 - 99

Comment

IF initial LDL-cholesterol result is >100 mg/dL, assess for risk factors and refer to the ATP-III table below.

DS

Risk Category	LDL Goal mg/dL	LDL Level (mg/dL) at which to initiate Therapeutic Lifestyle Changes (TLC)	LDL Level (mg/dL) at which to consider Drug Therapy
CHD	<100	>100	>or=130
2+ Risk Factors	<130	>or=130	>or=130

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LDL - 99 - 7000

LabCorp®

Specimen #	Type	Primary Lab	Report Status	Pg
085-002-0163-0	S	BN	Final	2

Time 1022 — Additional Information

CD- 9108561026?

Patient Name: RAMEY, GAYLA R [redacted] | Sex: F | Age (Yr/Mo): 043/02

Patient Address: [redacted]

Date Collected	Date Entered	Date Reported	
03/25/04	03/25/04	03/29/04	1494

XI N

Clinical Information: DOB: 01/02/61 Fasting: Y

Physician ID: SHUMPERT, E | Patient ID: 401987462

Account: ALICE J BROOKS MD CLINCIAL 39432
08
14

116 STANDARD WAREHOUSE ROAD
LUGOFF, SC 29078
803-438-6023
UPIN: S99492

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LA
				>or=190	
0-1 Risk Factors <160	>or=160		H ratio units	0.0 - 4.4	
T. Chol/HDL Ratio	5.2		H ratio units	0.0 - 3.2	
LDL/HDL Ratio	3.7				

	LDL/HDL Men	Women
1/2 Avg.Risk	1.0	1.5
Avg.Risk	3.6	3.2
2X Avg.Risk	6.3	5.0
3X Avg.Risk	8.0	6.1

Lab omad

Thyroid TSH	0.646	uIU/mL	0.350 - 5.500
CBC, Platelet Ct, and Diff	7.3	X 10-3/uL	4.0 - 10.5
White Blood Cell (WBC) Count	4.69	X 10-6/uL	3.80 - 5.10
Red Blood Cell (RBC) Count	13.7	g/dL	11.5 - 15.0
Hemoglobin	41.4	%	34.0 - 44.0
Hematocrit	88	fL	80 - 98
MCV	29.2	pg	27.0 - 34.0
MCH	33.1	g/dL	32.0 - 36.0
MCHC	14.9	%	11.7 - 15.0
RDW	236	X 10-3/uL	140 - 415
Platelets	58	%	40 - 74
Polys	34	%	14 - 46
Lymphs	5	%	4 - 13
Monocytes	3	%	0 - 7
Eos	0	%	0 - 3
Basos	4.2	X 10-3/uL	1.8 - 7.8
Polys (Absolute)	2.6	X 10-3/uL	0.7 - 4.5
Lymphs (Absolute)	0.4	X 10-3/uL	0.1 - 1.0
Monocytes(Absolute)	0.2	X 10-3/uL	0.0 - 0.4
Eos (Absolute Value)	0.0	X 10-3/uL	0.0 - 0.2
Baso(Absolute)			

DD

Director: Frank Hancock, MD

LAB: BN LabCorp Burlington
1447 York Court Burlington, NC 27215-2230

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For inquiries the physician may contact: Branch: 800-327-0997 Lab: 888-200-54

Last Page of Report

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West Wateree Medical Complex

Suite 300 • 1165 Highway One South • Lugoff, SC 29078 • Phone: (803) 438-0869 • Fax: (803) 438-0332

[redacted]
MRN: M000209492
[redacted]

Patient: Gayla Ramey
DOB: January 2, 1961 Age: 43
Phone: (803)

April 1, 2004

Procedure Report

TO: EVELYNNE SHUMPERT(BROOKS, NP
116 STANDARD WAREHOUSE RD
LUGOFF SC 29078

Patient History

Last mammogram was performed 3 years and 1 month ago.

Reason for exam: screening.

Screening Mammogram: March 31, 2004 - Account #: K10000047521
Bilateral CC and MLO.

Prior study comparison: March 6, 2001, bilateral screening mammogram.

Views of the breasts demonstrate no change in their appearance since the prior study. No signs suggestive of neoplastic disease are identified.

ASSESSMENT: BENIGN Bi-rads2

Recommendation
Routine screening mammogram in 1 year.

Donald J. Copley, M.D.
DJC/js
West Wateree Medical Complex

401-98-7482

APR 01 2004

18

250 Lab

)488701 Ramey, Gayla R
(6 Duke Drive

Lugoff, SC 29078

DATE Dr. Notes Date Created:

2/28/2004 17 Chart Number: 0488701
12/28/2004
Patient Name: Ramey, Gayla R
DOB: 01/02/1961 Age: 43 Sex: Female
Ethnic Origin: WHITE, NON-HISPANIC
Doctor: ALICE J. BROOKS M.D.
**********CC**********
UTI SYMPTOMS
**********HPI**********
PT CO FREQUENCY, BURNING, URGENCY,
DID HAVE ONE DAY VAGINAL DISCHARGE,WITH SOME ODD ODOR, BUT THAT RESOLVED.
FOR 7 DAYS WITH THE FREQUENCY, DYSURIA, FREQ SINCE YESTERDAY.
**********ROS**********
PT DENIES FEVER, ABDOMINAL PAIN, BACK PAIN, NAUSEA , VOMITING,
AND REPORTS THESE SX AS SIMILAR TO PREVIOUS UTIS.
LMP ENDED MID DECEMBER
AND PERIODS ARE NOT NORMAL AND NO ACTIVE MENSES NOW.
REST OF ROS IS NEGATIVE EXCEPT AS ABOVE, AND FAMILY, PAST MEDICAL
AND SOCIAL HISTORY ARE UNCHANGED FROM LAST VISIT AND EXAM.
**********PE**********
ABDOMEN: SOFT, NONTENDER, NO HSM, NO GUARD OR REBOUND
BACK: NO CVA TENDERNESS
MILD SUPRAPUBIC TENDERNESS TO DEEP PALPATION WITH SENSATION OF URGE TO VOID.
PELVIC EXAM: DEFERRED AT THIS TIME
UA: SML LEUKO, MICRO SCANT EPI, FEW WBC, SOME "TRASH"
ASSESSMENT: UTI
POSSIBLE BV
PLAN: RX SEPTRA DS 3 DAYS
ALSO RX FOR FLAGYL 250 TID 7 DAYS IF NON-ITCHY VAG D/C
RECURRS. OW MAY TRY OTC MONISTAT FOR ITCHY D/C
PT AWARE OF PHONE MESSAGE CENTER FOR RESULTS AND APPTS AND WILL CALL IF SX WORSEN OR CHANGE.
RES

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0488701 Ramey, Gayla R
16 Duke Drive

Lugoff, SC 29078

DATE Dr. Notes

Date Created:

2/29/2005 01 Chart Number: 0488701
12/29/2005
Patient Name: Ramey, Gayla R
DOB: 01/02/1961 Age: 44 Sex: Female
Ethnic Origin: WHITE, NON-HISPANIC
Doctor: ALICE J. BROOKS M.D.
**********CHIEF COMPLAINT**********
PT C/O SINUS INFECTION
2 WEEKS OF SXMS
GREEN DRAINAGE
THICK
FELT LIKE EYES WERE GOING TO POP
NOW COUGHING
GREEN SPUTUM
CONGESTION
TIRED
NOW PAIN BETWEEN THE SHOULDER BLADES
TODAY SHE HAS ALSO NOTED NERVOUSNESS???ETIOLOGY SHE DOES DRINK COFFEE BUT NEVER LIKE THIS BEFORE
PT TO RETURN FOR EARLY SATIETY AND EPIGASTRIC PAIN
**********ROS**********
THE PATIENT DENIES HA, VISUAL CHANGES, NECK PAIN, FEVER, CHILLS, WEIGHT CHANGE, CHEST PAIN, SOB, NAUSEA, VOMITING, URINARY SYMPTOMS, ABDOMINAL PAIN, NUMBNESS OR TINGLING. ALSO THE PATIENT DENIES ANY MENTAL STATUS CHANGES.
****
**********SOCIAL HISTORY**********
THE PATIENT DOES NOT DRINK ALCOHOL.
THE PATIENT HAS NO HISTORY OF SUBSTANCE ABUSE.
THE PATIENT IS A SMOKER.
FAMILY STATUS:MARRIED
EMPLOYMENT=FULL TIME
**********FAMILY HISTORY**********
THE PATIENT'S FATHER HAS A HISTORY OF HYPERTENSION.
THE PATIENT'S MOTHER HAS A HISTORY OF HYPERTENSION.
THE PATIENT'S MOTHER HAS A HISTORY OF COPD.
MOTHER:CARDIAC PATIENT AND CHF
**********PHYSICAL**********
EARS: Auricle in alignment, no masses, lesions, or tenderness. Canals unobstructed with small amount of brown cerumen. Tympanic membranes of translucent pearly grey in color, intact, mobile, good light reflex and bony landmarks present.

THROAT: Gag reflex intact, uvula rises evenly, pharynx pink and moist without exudate or erythema, no hoarseness.
THE LUNGS HAD RHONCHI THROUGHOUT. NON LABORED AND EVEN EFFORT. Inspiratory and expiratory wheezing is noted.
NORMAL S1 S2 REGULAR RATE & RHYTHM WITHOUT CLICKS, RUBS, GALLOPS OR MURMURS.
DX: BRONCHITIS
TX: PT HAS NEBULIZER AND MED COMBIVENT TO GO IN IT FROM HER MOTHER
ANTIBIOTIC
AB

)488701 Ramey, Gayla R
:6 Duke Drive

Lugoff, SC 29078

DATE Dr. Notes

Date Created:

7/27/2006 Chart Number: 0488701
07/27/2006
Patient Name: Ramey, Gayla R
DOB: 01/02/1961 Age: 45 Sex: Female
Ethnic Origin: WHITE, NON-HISPANIC
Doctor: ALICE J. BROOKS M.D.
**********CHIEF COMPLAINT**********
PT FEELS DRAINED.
SOME BETTER TODAY
LOTS OF STRESS...MOTHER DIED IN MARCH
HEAVY MENSES
ON CYCLE NOW
HAS NOT BEEN SEEN SINCE 2004
NOT SLEEPING WELL
INTERRUPTED SLEEP
TROUBLE FALLING ASLEEP
PT HAS NOT YET TRIED TYLENOL PM
PT ALSO RELATES SOME DEPRESSION
**********ROS**********
THE PATIENT DENIES HA, VISUAL CHANGES, NECK PAIN, FEVER, CHILLS, WEIGHT CHANGE, CHEST PAIN, SOB, NAUSEA, VOMITING, URINARY SYMPTOMS, ABDOMINAL PAIN, NUMBNESS OR TINGLING. ALSO THE PATIENT DENIES ANY MENTAL STATUS CHANGES.
****
THE PAST MEDICAL HISTORY WAS REVIEWED AND FOUND TO BE UNCHANGED.
THE PRIOR SOCIAL HISTORY WAS REVIEWED AND UNCHANGED FROM PRIOR VISITS.
THERE IS NO NEW FAMILY HISTORY AT THIS OFFICE VISIT.
**********PHYSICAL**********
VITAL SIGNS:
Blood Pressure.: 122 (Systolic) How Taken CUFF Arm
80 (Diastolic)
Weight.....: 174.5 lbs. Height 0 ft 0.0 inches
Inspiratory and expiratory wheezing is noted.
NORMAL S1 S2 REGULAR RATE & RHYTHM WITHOUT CLICKS, RUBS, GALLOPS OR MURMURS.
DX: MENORRHAGIA; HYPERLIPIDEMIA; WEAKNESS AND FATIGUE; INSOMNIA; DEPRESSION
TX: STTART ZOLOFT; GET FEMALE PANEL; SCHEDULE EOV
AB

22

KERSHAW COUNTY MEDICAL CENTER
Radiology Department
Haile and Roberts Streets
Camden, South Carolina 29020
(803)713-6531

Patient: RAMEY,GAYLA
[redacted]

Age: 45 Sex: F

DOB: 01/02/1961

Ord Dr: BROOKS, ALICE MD

[redacted]
MRN: M000209492
Acct #: K10000279053
Req #: 06-0024162

Serv Dt/Tm: 07/27/06 /
Loc: WWRAD Rm/Bed:
Status: REG CLI

BROOKS,ALICE MD
116 STANDARD WAREHOUSE RD
LUGOFF, SC 29078

REASON FOR EXAM: COPD

CHEST 7-27-06

Frontal and lateral views demonstrate the lungs, heart, mediastinum and bony thorax to be within normal limits.

IMPRESSION: NORMAL EXAMINATION.

Electronically signed by:YASSEEN KUZBARY MD <<Signature on File>>

Trans by: LM
Trans date/time: 07/28/06 1349

401 98 1482

8/4/06
lab retrieve

23

Ordering Physician's copy

Signed
cc:BROOKS,ALICE MD
Report #0728-0101

KERSHAW COUNTY MEDICAL CENTER
Radiology Department
Haile and Roberts Streets
Camden, South Carolina 29020
(803)713-6531

0487

AB
AUG 24 2006
9-11-06

Patient: RAMEY,GAYLA
[redacted]

Age: 45 Sex: F

DOB: 01/02/1961

Ord Dr: BROOKS, ALICE MD

[redacted]
MRN: M000209492
Acct #: K10000279053
Req #: 06-0024162

Serv Dt/Tm: 07/27/06 /
Loc: WWRAD Rm/Bed:
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BROOKS,ALICE MD
116 STANDARD WAREHOUSE RD
LUGOFF, SC 29078

REASON FOR EXAM: COPD

CHEST 7-27-06

Frontal and lateral views demonstrate the lungs, heart, mediastinum and bony thorax to be within normal limits.

IMPRESSION: NORMAL EXAMINATION.

Electronically signed by:YASSEEN KUZBARY MD

Trans by: LM
Trans date/time: 07/28/06 1349

24

Ordering Physician's copy

Signed
cc:BROOKS,ALICE MD
Report #0728-0101

0488701 Ramey, Gayla R
[redacted]

[redacted]

DATE Dr. Notes Date Created:

7/28/2006 06 Chart Number: 0488701
07/28/2006
Patient Name: Ramey, Gayla R
DOB: 01/02/1961 Age: 45 Sex: Female
Ethnic Origin: WHITE, NON-HISPANIC
Doctor: ALICE J. BROOKS M.D.
LMTRC ABOUT MAMMOGRAM. SG

)488701 Ramey, Gayla R
16 Duke Drive

Lugoff, SC 29078

DATE Dr. Notes

Date Created:

8/31/2006 07 Chart Number: 0488701
08/31/2006
Patient Name: Ramey, Gayla R
DOB: 01/02/1961 Age: 45 Sex: Female
Ethnic Origin: WHITE, NON-HISPANIC
Doctor: ALICE J. BROOKS M.D.
LABS DRAWN IN OFFICE ON 8-31-2006/MAT

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REPORT STATUS Final

QUEST DIAGNOSTICS INCORPORATED
CLIENT SERVICE 770.934.9205

PATIENT INFORMATION
RAMEY,GAYLA R

DOB: 01/02/1961 Age: 45
GENDER: F Fasting: Y
SS: [redacted]
ID: 0488701
PHONE: [redacted]

ORDERING PHYSICIAN
BROOKS,ALICE J

CLIENT INFORMATION
7189992
ALICE J BROOKS, MD
116 STANDARD WAREHOUSE RD
LUGOFF, SC 29078-9670

SPECIMEN INFORMATION
SPECIMEN: AT431777R
REQUISITION: 7211329
LAB REF NO:

Room/Loc: LAB

COLLECTED:	08/31/2006	08:55
RECEIVED:	08/31/2006	09:37
REPORTED:	09/01/2006	03:47

3/0XL

COMMENTS: FASTING

Test Name	In Range	Out of Range	Reference Range	Lab
LIPID PANEL				AT
TRIGLYCERIDES	118	102	<150 mg/dL	AT
CHOLESTEROL, TOTAL		222 H 212	<200 mg/dL	AT
HDL CHOLESTEROL		38 L 41	> OR = 40 mg/dL	AT
LDL-CHOLESTEROL		160 H ~~150~~ 151	<130 mg/dL (calc)	AT
CHOL/HDLC RATIO		5.8 H 5.2	<4.4 (calc)	AT
COMPREHENSIVE METABOLIC PANEL				
GLUCOSE		100 H	65-99 mg/dL FASTING REFERENCE INTERVAL	
UREA NITROGEN (BUN)	10		7-25 mg/dL	
CREATININE	1.0		0.5-1.2 mg/dL	
BUN/CREATININE RATIO	10		6-25 (calc)	
SODIUM	143		135-146 mmol/L	
POTASSIUM	4.9		3.5-5.3 mmol/L	
CHLORIDE	108		98-110 mmol/L	
CARBON DIOXIDE	25		21-33 mmol/L	
CALCIUM	9.6		8.5-10.4 mg/dL	
PROTEIN, TOTAL	6.7		6.0-8.3 g/dL	
ALBUMIN	4.2		3.5-4.9 g/dL	
GLOBULIN	2.5		2.2-4.2 g/dL (calc)	
ALBUMIN/GLOBULIN RATIO	1.7		0.8-2.0 (calc)	
BILIRUBIN, TOTAL	0.4		0.2-1.3 mg/dL	
ALKALINE PHOSPHATASE	58		20-125 U/L	
AST	15		3-35 U/L	
ALT	13		3-40 U/L	
				AT
CBC (INCLUDES DIFF/PLT)				
WHITE BLOOD CELL COUNT	8.4		3.8-10.8 Thousand/uL	
RED BLOOD CELL COUNT	4.54		3.80-5.10 Million/uL	
HEMOGLOBIN	13.8		11.7-15.5 g/dL	
HEMATOCRIT	41.2		35.0-45.0 %	
MCV	90.8		80.0-100.0 fL	
MCH	30.4		27.0-33.0 pg	
MCHC	33.5		32.0-36.0 g/dL	
RDW	14.0		11.0-15.0 %	
PLATELET COUNT	290		140-400 Thousand/uL	
ABSOLUTE NEUTROPHILS	4847		1500-7800 cells/uL	
ABSOLUTE LYMPHOCYTES	2898		850-3900 cells/uL	
ABSOLUTE MONOCYTES	403		200-950 cells/uL	

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Page 1 - Continued on Page 2

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QUEST DIAGNOSTICS INCORPORATED

REPORTED: 09/01/2006 03:47

PATIENT INFORMATION
RAMEY,GAYLA R

DOB: 01/02/1961 Age: 45
GENDER: F Fasting: Y
ID: [redacted]

REPORT STATUS Final

ORDERING PHYSICIAN
BROOKS,ALICE J

Test Name	In Range / Out of Range	Reference Range	Lab
CBC (INCLUDES DIFF/PLT) (Continued)			
ABSOLUTE EOSINOPHILS	218	15-500 cells/uL	
ABSOLUTE BASOPHILS	34	0-200 cells/uL	
NEUTROPHILS	57.7	%	
LYMPHOCYTES	34.5	%	
MONOCYTES	4.8	%	
EOSINOPHILS	2.6	%	
BASOPHILS	0.4	%	
TSH	1.24	mIU/L > 20 YEARS: 0.40-5.50 FOR PREGNANT PATIENTS: FIRST TRIMESTER 0.30-4.50 SECOND TRIMESTER 0.50-4.60 THIRD TRIMESTER 0.80-5.20	AT
HEMOGLOBIN A1c	5.3 5.3	% of total Hgb NON-DIABETIC: <6.0%	AT

Performing Laboratory Information:

AT QUEST DIAGNOSTICS-ATLANTA 1777 MONTREAL CIRCLE TUCKER GA 30084 Laboratory Director: WILLIAM M MILLER, MD

Zoloft 50mg

28

AB

SEP 06 2006

9-11-06

West Wateree Medical Complex

Suite 300 • 1155 Highway One South • Lugoff, SC 29078 USA • Phone: (803) 438-0869 • Fax: (803) 438-0832

0487

Patient: Gayla Ramey
DOB: January 2, 1961 Age: 45
Phone: (803)

MRN: M000209492

September 6, 2006

Phone: (803) 438-6023

Procedure Report

TO: ALICE BROOKS, M.D.
116 STANDARD WAREHOUSE RD
LUGOFF SC 29078

Patient History

Last mammogram was performed 2 years and 5 months ago.

Reason for exam: screening.

Screening Mammogram: September 1, 2006 - Account #: K10000279084

Bilateral CC and MLO view(s) were taken.

Prior study comparison: March 31, 2004, bilateral screening mammogram.

Views of the breasts demonstrate no change in their appearance since the prior study. No signs suggestive of neoplastic disease are identified.

ASSESSMENT: BENIGN Bi-rads2

Recommendation
Routine screening mammogram in 1 year.

Donald J. Copley, M.D.
DJC/lm
West Wateree Medical Complex

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0488701 Ramey, Gayla R
16 Duke Drive

Lugoff, SC 29078

DATE Dr. Notes

9/11/2006 01 Date Created:

Chart Number: 0488701
09/11/2006
Patient Name: Ramey, Gayla R
DOB: 01/02/1961 Age: 45 Sex: Female
Ethnic Origin: WHITE, NON-HISPANIC
Doctor: ALICE J. BROOKS M.D.
**********CHIEF COMPLAINT**********
EXTENDED OV, PAP SMEAR AND CLINICAL BREAST EXAM
LABS -- DISCUSSED
**********REVIEW OF SYSTEMS**********
THIS PATIENT DENIES FEVER, HA, PND, ALLERGIES, ST, COUGH, FATIGUE, SOB, CHEST PAIN, N/V/C/D, URINARY SYMPTOMS, SWELLING OR NEUROLOGIC CHANGES. ALL OTHER SYSTEMS NEGATIVE.
**********PATIENT HISTORY**********
ALLERGIES: NKDA
CHILDHOOD ILLNESSES:ALL ROUTINE
ADULT ILLNESSES: MENORRHAGIA, HYPERLIPIDEMIA, INSOMNIA, DEPRESSION, COPD, HYPOKALEMIA-RESOLVED, TOBACCO DEPENDENCE
INJURIES/FX'S: FX PINKY
SURGERIES: UTERINE POLYP REMOVED 1994
HOSPITALIZATIONS: RESPIRATORY INFECTION AND CHILDBIRTH
CURRENT MEDICATIONS: ZOLOFT
LMP: 07-27-06 HEAVY AND CLOTS WITH PAIN
MENARCHE:11
LAST PAP SMEAR:03/24/04
LAST MAMMOGRAM: 09/01/06
HX OF ABNORMAL PAP SMEARS: NO
HX OF ABNORMAL MAMMOGRAMS: NO
G 5 P4 A1 MISCARRIAGE
PREGNANCY HISTORY:
FULL TERM: 4
SVD: 4
COMPLICATIONS WITH PREGNANCY: NO
AGE AT FIRST PREGNANCY: 16
BREAST FEED: NO
BIRTH CONTROL METHOD: VASECTOMY
H/O STD'S: NO
IMMUNIZATIONS:
YEARLY FLU VACCINE: YES
PNEUMOVAX:3 YRS AGO
HEP B SERIES: YES

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LAST TETANUS INJ (WITHIN 10 YEARS): 1994/5
LAST EYE EXAM: LONG TIME
LAST DENTAL EXAM: 1 YR
BONE DENSITY SCAN: NONE
COLONOSCOPY: NONE
PROBLEMS WITH VOIDING: NONE
**********FAMILY HISTORY**********
HX OF FEMALE RELATED CANCER:MOTHER UTERINE OR CERVICAL CANCER
FAMILY HX OF OSTEOPOROSIS: MOTHER AND MATERNAL GRANDMOTHER
MOTHER: DECEASED, HTN, COPD, CHF, CARDIAC, UTERINE OR CERVICAL CA AT AGE 29; OSTOPORSIS
FATHER: HTN
SIBLINGS: 1 BROTHER-HEALTHY; 2 SISTERS ONE HAD BREAST BIOPSY
MGM: OSTEOPOROSIS
MGF: UNSURE
PGM: DM
PGF: UNSURE
**********SOCIAL HISTORY**********
TOBACCO USE: YES 1-1.5 PPD 28 YRS
ETOH: NO TYPE:
RECREATIONAL DRUG USE: NO
CAFFEINE INTAKE: A LOT
EXERCISE: NO FORMAL ROUTINE
EMPLOYED: RIDGEWAY HEALTH AND REHAB
MARITAL STATUS: MARRIED
LIVING ARRANGEMENTS: LIVES WITH HUSBAND AND YOUNGEST CHILD 5 GRANDCHILDREN AND 2 MIDDLE DAUGHTERS

VITAL SIGNS:

Blood Pressure.:	122 (Systolic) 80 (Diastolic)	How Taken CUFF	Arm
Pulse.....:	72		
	0 Oximeter		
Respiration....:	21 Non Labored	0 Labored	0
Temperature....:	0 How Taken ORAL		
Hemoglobin AIC.:	5.3		
Weight.....:	178.0 lbs.	Height 5 ft 7.5 inches	
Body Mass Index:	28.0		

Cholesterol
222 Total Cholesterol
38 (HDL) High Density Lipoproteins
160 (LDL) Low Density Lipoproteins
118 Triglycerides

Arterial Blood Gases
PH 0.00 CO2 0
O2 0 HCO3 0

**********PHYSICAL**********
NEURO: THE PATIENT IS WELL DEVELOPED. A&O X3, PLEASANT AFFECT. CRANIAL NERVE II-XII INTACT TO INCLUDE DTR'S AND SENSATION. SENSE OF TASTE NOT TESTED.
HEAD: HEAD IS ATRAUMATIC AND NORMOCEPHALIC, HELD MIDLINE & ERECT WITH FEATURES SYMMETRIC. SCALP MOVES FREELY UNDER EXAMINING FINGERS. NO TENDERNESS NOTED. TEMPORAL ARTERIES PALPABLE BUT NOT THICKENED. NO DEFECTS OR DEFORMITIES NOTED.

EYES: PATIENT DENIES PAIN, DISCOMFORT, ITCHING, BLURRED VISION, OR DOUBLE VISION. THE PATIENT'S VISION WAS 20/20 BILATERALLY. PUPILS ARE EQUAL, ROUND & REACTIVE TO LIGHT AND ACCOMODATION. EXTRA OCULAR MOVEMENTS INTACT. PERIPHERAL VISION INTACT AT 75 DEGREES BILATERALLY. INSPECTION OF LIDS AND CONJUNCTIVAE WITHIN NORMAL LIMITS.
EARS: AURICLE IN ALIGNMENT, NO MASSES, LESIONS, SCARS OR TENDERNESS NOTED. EXTERNAL AUDITORY CANALS UNOBSTRUCTED. TYMPANIC MEMBRANES ARE TRANSLUCENT PEARLY GREY IN COLOR, INTACT, MOBILE, GOOD LIGHT REFLEX AND BONY LANDMARKS PRESENT. WHISPER TEST, WEBER AND RINNE WITHIN NORMAL LIMITS, MIDLINE, NONLATERALIZING AND AIR > BONE CONDUCTION.
NOSE: NO DISCHARGE OR POLYPS, MUCOSA PINK AND MOIST, SEPTUM MIDLINE AND PATENT BILATERALLY, TURBINATES CLEAR. NO ERYTHEMA OR PURULENCE WAS NOTED. NO FRONTAL OR MAXILLARY TENDERNESS ON PALPATION OR PERCUSSION.
MOUTH: LIPS ARE SYMMETRICAL, COLOR PINK, WITHOUT EDEMA OR SURFACE ABNORMALITIES. BUCCAL MUCOSA PINK AND MOIST WITHOUT LESIONS, GINGIVAE RED AND BOGGY; TONGUE MIDLINE; NO LESIONS OR TREMORS. TEETH IN GOOD REPAIR. HARD AND SOFT PALATE INSPECTED NO OBVIOUS ABNORMALITIES NOTED.
THROAT: GAG REFLEX INTACT, UVULA RISES EVENLY, OROPHARYNX PINK AND MOIST WITHOUT EXUDATE OR ERYTHEMA, NO HOARSENESS. ENUCIATES WORDS CLEARLY.
NECK: TRACHEA MIDLINE. THE NECK IS SUPPLE, NON-TENDER, WITHOUT JVD OR BRUITS. FULL RANGE OF MOTION. THERE IS NO ADENOPATHY OR THYROMEGALY PRESENT. THYROID IS SMOOTH, SOFT, NON-TENDER, & MOVES FREELY WHEN PATIENT SWALLOWS.
LUNGS: CLEAR TO AUSCULTATION AND PERCUSSION. NO RALES, RHONCHI, OR WHEEZES WERE HEARD. VESICULAR BREATH SOUNDS OVER PERIPHERAL LUNG TISSUE. NON LABORED AND EVEN EFFORT. NO INCREASED OR DIMINISHED TACTILE FREMITUS NOTED.
HEART: NORMAL S1,S2 REGULAR RATE AND RHYTHM WITHOUT CLICKS GALLOPS, RUBS, OR MURMURS. PMI IS AT THE LMC LINE.
VASCULAR: PULSES IN ALL FOUR EXTREMITIES +3, NO JUGULAR VEIN DISTENTION NOTED, CAPILLARY REFILL 1-2 SECONDS, NO PITTING EDEMA OR SWELLING OF EXTREMITIES NOTED. NO BRUITS AUDIBLE.
BREASTS: PALPATION WITHOUT MASSES, DIMPLES OR AXILLARY ADENOPATHY. SYMMETRICAL SHAPE AND SIZE. NO DISCHARGE FROM NIPPLES.
ABDOMEN: VISUAL INSPECTION OF ABDOMEN WITHOUT MASSES OR LESIONS NOTED. NORMAL BOWEL SOUNDS, NO HEPATO-SPLEENMEGALY NOTED. NO TENDERNESS TO PALPATION. NO GUARDING OR REBOUND. NORMAL TO PERCUSSION. THE PATIENT WAS EVALUATED AND NO HERNIAS PRESENT.
GENITOURINARY: HAIR DISTRIBUTION IS WITHIN NORMAL LIMITS. BLADDER IS WITHOUT FULLNESS, MASSES OR TENDERNESS. THE ORIFICE OF THE URETHRA IS WITHOUT MASSES, TENDERNESS OR SCARING. THE VAGINA IS NORMAL IN COLOR AND RUGGAE. NO LESIONS OR MASSES ARE SEEN. THE UTERUS IS NORMAL IN SIZE, SHAPE AND CONSISTENCY. THERE IS NO CERVICAL MOTION TENDERNESS. THE CERVICAL OS IS WITHOUT

LESIONS OR MASSES. NO ADNEXAL TENDERNESS TO PALPATION. NO RECTOCELE OR CYSTOCELE PRESENT.
RECTUM: MANUALLY EVALUATED AND FOUND TO HAVE NORMAL TONE AND NO MASSES. THE PATIENT'S STOOL WAS GAUIAC NEGATIVE. NO HEMORRHOID NOTED.
MUSCULOSKELETAL: NORMAL GAIT NOTED. POSTURE STRAIGHT, WITHOUT SCOLIOSIS. MUSCLES & EXTREMITIES SYMMETRIC. MUSCLE STRENGTH APPROPRIATE AND EQUAL BILATERALLY. ACTIVE RANGE OF MOTION.
JOINTS: NORMAL SIZE AND CONTOUR, FULL RANGE OF MOTION, NO REDNESS OR SWELLING. NO EVIDENCE OF INJURY. NO CLICKS, LOCKING, OR LIMITED EXTENSION NOTED.
SKIN: APPROPRIATE COLOR FOR RACE. WARM & DRY W/O LESIONS OR DEFORMITIES.
MONOFILAMENT EXAM NORMAL
DX: MENORRHAGIA, HYPERLIPIDEMIA, INSOMNIA, DEPRESSION, COPD, HYPOKALEMIA-RESOLVED, TOBACCO DEPENDENCE EOV WITH PAP, CLINICAL BREAST EXAM
PLAN:
1) SCHEDULE MAMMOGRAM
2) LABS:3 MOS
3) START LOVASTATIN 40MG
PT AWARE OF MESSAGE CENTER FOR X-RAY/LAB RESULTS OR SCHEDULED APPOINTMENTS

Quest on Demand™

Quest Diagnostics

QUEST DIAGNOSTICS INCORPORATED
CLIENT SERVICE 770.934.9205

SPECIMEN INFORMATION
SPECIMEN: AT643536R
REQUISITION: 7211551
LAB REF NO:

COLLECTED: 09/11/2006 00:00
RECEIVED: 09/11/2006 18:10
REPORTED: 09/13/2006 08:51

PATIENT INFORMATION
RAMEY,GAYLA R
401 98 7482
DOB: 01/02/1961 Age: 45
GENDER: F

ID: 0488701
PHONE: [redacted]

REPORT STATUS Final

ORDERING PHYSICIAN
BROOKS,ALICE J

CLIENT INFORMATION
7189992
ALICE J BROOKS, MD
116 STANDARD WAREHOUSE RD
LUGOFF, SC 29078-9670

Test Name	PATHOLOGY REPORT	Lab AT
SUREPATH REX HPV REPORT STATUS:	FINAL	
CLINICAL INFORMATION:	Normal exam	
LMP:	7/27/06	
PREV. PAP:	3/24/04	
PREV. BX:	NONE GIVEN	
SOURCE:	CERVICAL	
STATEMENT OF ADEQUACY:	Satisfactory for evaluation. Endocervical/transformation zone component present.	
INTERPRETATION/RESULT:	Negative for intraepithelial lesion or malignancy.	
COMMENT:	Based on the cytology result, reflex High/Int Risk HPV DNA Probe testing is not performed.	
CYTOTECHNOLOGIST:	LKC CT(ASCP)	

GYNECOLOGICAL CYTOLOGY IS A SCREENING PROCEDURE SUBJECT TO BOTH FALSE NEGATIVE AND FALSE POSITIVE RESULTS. IT IS MOST RELIABLE WHEN A SATISFACTORY SAMPLE IS OBTAINED ON A REGULAR REPETITIVE BASIS. RESULTS MUST BE INTERPRETED IN THE CONTEXT OF HISTORIC AND CURRENT CLINICAL INFORMATION.

BW 12/14/06
12/19/06

Performing Laboratory Information:

AT QUEST DIAGNOSTICS-ATLANTA 1777 MONTREAL CIRCLE TUCKER GA 30084 Laboratory Director: WILLIAM M MILLER, MD

)488701 Ramey, Gayla R
16 Duke Drive

Lugoff, SC 29078

DATE Dr. Notes Date Created:

1/14/2006 18 Chart Number: 0488701
11/14/2006
Patient Name: Ramey, Gayla R
DOB: 01/02/1961 Age: 45 Sex: Female
Ethnic Origin: WHITE, NON-HISPANIC
Doctor: ALICE J. BROOKS M.D.
**********CHIEF COMPLAINT**********
EAR PAIN EARS ITCHING,STOPPED ZOLOFT AFTER 3 WKS,THINKS SHE SHOULD BE ABLE TO HANDLE THINGS HERSELF
**********PMHX**********
REVIEWED AND UNCHANGED
**********SOCIAL HISTORY**********
SMOKER:YES 1 PACK A DAY
ALCOHOL:
DIET:
RECREATIONAL DRUGS:
**********ROS**********
NEGATIVE EXCEPT AS DESCRIBED IN CC AND HPI
**********PE**********
EARS: TM'S CLEAR, GOOD LIGHT REFLEX.
THROAT: RED AND MOIST,COBBLESTONED
ANENOPATHY:NONE
HEART: RRR NORMAL S1 AND S2, NO MURMUR, GALLOP, CLICK OR RUB HEARD.
LUNGS: CLEAR TO AUSCULTATION
DX:PND,ALLERGIC RHINITIS,DEPRESSION
TX:OTC ALAVERT,MUCINEX ADVISED TO TAKE ZOLOFT
PT INFORMED OF MESSAGE CENTER FOR ANY LAB/X-RAY REPORTS OR SCHEUDLED APPOINTMENTS.
PDB
VITAL SIGNS:
Blood Pressure.: 120 (Systolic) How Taken CUFF Arm
70 (Diastolic)
Pulse.....: 0
0 Oximeter
Respiration....: 0 Non Labored 0 Labored 0
Temperature....: 96 How Taken ORAL
Weight.....: 177.0 lbs. Height 0 ft 0.0 inches

35

0488701 Ramey, Gayla R
[redacted]

[redacted]

DATE Dr. Notes

Date Created:

1/16/2006 01 Chart Number: 0488701
11/16/2006
Patient Name: Ramey, Gayla R
DOB: 01/02/1961 Age: 45 Sex: Female
Ethnic Origin: WHITE, NON-HISPANIC
Doctor: ALICE J. BROOKS M.D.
**********CHIEF COMPLAINT**********
PT COMPLAINS OF LEFT EAR PAIN FOR 1 WEEK ASSOCIATED WITH CONGESTION, RUNNY NOSE, SORE NECK, AND A "LUMP BELOW MY LEFT EAR" THAT IS HARD AND PAINFUL. PT DENIES FEVER, HEADACHE, SORE THROAT, SOB, OR DIFFICULTY BREATHING. PT STATES THAT SHE WAS SCRATCHING HER LEFT EAR AND LATER NOTICED SWELLING AND INCREASED PAIN IN HER EAR CANAL.
**********PMHX**********
REVIEWED AND UNCHANGED
**********SOCIAL HISTORY**********
SMOKER:YES 1 PACK A DAY
**********ROS**********
NEGATIVE EXCEPT AS DESCRIBED IN CC AND HPI
**********PE**********
EARS: TM'S CLEAR, GOOD LIGHT REFLEX.
THROAT: RED AND MOIST,COBBLESTONED
ANENOPATHY:NONE
HEART: RRR NORMAL S1 AND S2, NO MURMUR, GALLOP, CLICK OR RUB HEARD.
LUNGS: CLEAR TO AUSCULTATION
DX:OE, SINUSITIS
TX: 1) OMNICEF AND CORTISOPORIN OTIC DROPS
PT INFORMED OF MESSAGE CENTER FOR ANY LAB/X-RAY REPORTS OR SCHEUDLED APPOINTMENTS.
PT SEEN WITH BRANDON DRAFTS, MS-III
AB

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1488701 Ramey, Gayla R
[redacted]

DATE Dr. Notes Date Created:

2/14/2006 07 Chart Number: 0488701
12/14/2006
Patient Name: Ramey, Gayla R
DOB: 01/02/1961 Age: 45 Sex: Female
Ethnic Origin: WHITE, NON-HISPANIC
Doctor: ALICE J. BROOKS M.D.
LABS DRAWN IN OFFICE ON 12-14-2006/MAT

37

Quest Diagnostics

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QUEST DIAGNOSTICS INCORPORATED
CLIENT SERVICE 770.934.9205

SPECIMEN INFORMATION
SPECIMEN: AT668100T
REQUISITION: 7213475
LAB REF NO:

COLLECTED: 12/14/2006 08:30
RECEIVED: 12/14/2006 11:45
REPORTED: 12/15/2006 03:11

PATIENT INFORMATION
RAMEY,GAYLA R

DOB: 01/02/1961 Age: 45
GENDER: F Fasting: Y

ID: 0488701
PHONE: 803-438-5047

Room/Loc: LAB

REPORT STATUS Final

ORDERING PHYSICIAN
BROOKS,ALICE J

CLIENT INFORMATION
7189992
ALICE J BROOKS, MD [redacted]
116 STANDARD WAREHOUSE RD
LUGOFF, SC 29078-9670 [redacted]

8-31-06

COMMENTS: FASTING

Test Name	In Range	Out of Range	Reference Range	Lab
LIPID PANEL				
TRIGLYCERIDES	84	118	<150 mg/dL	AT
CHOLESTEROL, TOTAL	195	222	<200 mg/dL	AT
HDL CHOLESTEROL	45	38	> OR = 40 mg/dL	AT
LDL-CHOLESTEROL		133 H 160	<130 mg/dL (calc)	AT
	DESIRABLE RANGE <100 MG/DL FOR PATIENTS WITH CHD OR DIABETES AND <70 MG/DL FOR DIABETIC PATIENTS WITH KNOWN HEART DISEASE.			
CHOL/HDLC RATIO	4.3		<4.4 (calc)	AT
HEPATIC FUNCTION PANEL				AT
PROTEIN, TOTAL	7.2		6.0-8.3 g/dL	
ALBUMIN	4.6		3.5-4.9 g/dL	
GLOBULIN	2.6		2.2-4.2 g/dL (calc)	
ALBUMIN/GLOBULIN RATIO	1.8		0.8-2.0 (calc)	
BILIRUBIN, TOTAL	0.6		0.2-1.3 mg/dL	
BILIRUBIN, DIRECT	0.1		0.0-0.3 mg/dL	
BILIRUBIN, INDIRECT	0.5		0.0-1.3 mg/dL (calc)	
ALKALINE PHOSPHATASE	62		20-125 U/L	
AST	18		3-35 U/L	
ALT	14		3-40 U/L	

Performing Laboratory Information:

AT QUEST DIAGNOSTICS-ATLANTA 2777 MONTREAL CIRCLE TUCKER GA 30084 Laboratory Director: WILLIAM M MILLER, MD

Lovastatin
Zoloft 50

38 /OV
270 12/20

RAMEY,GAYLA R - AT668100T

Page 1 - End of Report

0488701 Ramey, Gayla R
[redacted]

DATE Dr. Notes Date Created:

2/20/2006 01 Chart Number: 0488701
12/20/2006
Patient Name: Ramey, Gayla R
DOB: 01/02/1961 Age: 45 Sex: Female
Ethnic Origin: WHITE, NON-HISPANIC
Doctor: ALICE J. BROOKS M.D.
**********CHIEF COMPLAINT**********
Follow-Up of LABS
ROUTINE FOLLOW-UP OF MEDICATIONS
PT ALSO C/O RIGHT NECK PAIN
MASSAGE HELPED THEN PAIN RETURNED
1 MONTH DURATION
PT HAS TWO SKIN LESIONS
**********ROS**********
THE PATIENT DENIES HA, VISUAL CHANGES, NECK PAIN, FEVER, CHILLS, WEIGHT CHANGE, CHEST PAIN, SOB, NAUSEA, VOMITING, URINARY SYMPTOMS, ABDOMINAL PAIN, NUMBNESS OR TINGLING. ALSO THE PATIENT DENIES ANY MENTAL STATUS CHANGES.
****
THE PAST MEDICAL HISTORY WAS REVIEWED AND FOUND TO BE UNCHANGED.
THE PRIOR SOCIAL HISTORY WAS REVIEWED AND UNCHANGED FROM PRIOR VISITS.
THERE IS NO NEW FAMILY HISTORY AT THIS OFFICE VISIT.
**********PHYSICAL**********
VITAL SIGNS:
Blood Pressure.: 130 (Systolic) How Taken CUFF Arm
70 (Diastolic)
Weight.....: 174.0 lbs. Height 0 ft 0.0 inches
The neck is tender over the trapezius muscles RIGHT. There is no tenderness midline. There are no defects or deformities. The lungs are clear to auscultation and percussion. No rales rhonchi or wheezes were heard. Vesicular breath sounds over peripheral lung tissue. NON-LABORED AND EVEN EFFORT. NORMAL S1 S2 REGULAR RATE & RHYTHM WITHOUT CLICKS, RUBS, GALLOPS OR MURMURS.
LEFT POSTERIOR SHOULDER AT BRA STRAP LINE RED RAISED WITH DARK CENTER/SCAB
NEEDS REMOVAL
ALSO ONE RIGHT FLANK UNDER BRA LINE THAT IS MULTICOLORED
ALSO NEEDS REMOVAL
DX: SKIN LESION; HYPERLIPIDEMIA; TRAPEZIUS SPASM
TX: CONT CURRENT MEDS; RETURN FOR SKIN LESION REMOVAL; FLEXERIL

AND ALEVE FOR NECK
AB

)488701 Ramey, Gayla R
[redacted]

DATE Dr. Notes Date Created:

2/29/2006 [redacted]
Chart Number: 0488701
12/29/2006
Patient Name: Ramey, Gayla R
DOB: 01/02/1961 Age: 45 Sex: Female
Ethnic Origin: WHITE, NON-HISPANIC
Doctor: ALICE J. BROOKS M.D.
**********CHIEF COMPLAINT**********
PT PRESENTS FOR 4 LESION REMOVALS.
THE LESIONS HAS CHANGED IN COLOR,GROWN AND BECOME IRRITATED
DURATION:#1 RIGHT FLANK SEVERAL WEEKS IRRITATED RAISED AND AT
BRA LINE
0.25CM
#2 LEFT BACK, YRS BUT CHANGING AND IRRITATED 0.5CM AT THE BRA
STRAP LINE
#3 LEFT FOREARM, MONTHS BUT COLOR CHANGING AND GROWING 0.25 CM
MID LEFT FOREARM
#4 LEFT LOWER ABD GROWING CHANGING IN COLOR AND DEVELOPING A
SHADOW TO THE LEFT SIDE 0.5 X 1 CM SQUARE SHAPED
**********PROCEDURE**********L
ESION
LOCAL ANESTHESIA WAS INSTILLED USING 1% XYLOCAINE W/EPI AFTER
USUAL PREP WITH EYOH.
LESIONS X 4 REMOVED BY SHAVE BX AND SENT FOR PATHOLOGY.
HEMOSTASIS OBTAINED WITH DRYSOL. PT TOLERATED PROCEDURE WELL
WITHOUT INCIDENT.
DX: LESIONS X 4 SENT FOR PATH
TX: BX SITE DRESSED WITH NEOSPORIN OINTMENT AND BAND AID
COVERAGE. PT MAY REMOVE IN 24 HRS. PT TO RTO IF SIGNS OF
INFECTION SUCH AS ERYTHEMA/WARMTH/MALODOROUS DISCHARGE NOTED.
AB

41

AC
JAN 08 2007
3.21.07
04817

Pathology Service

Carolinas Dermatology Group, PA
1708 Saint Julian Place, Columbia, SC 29204 (803) 771-7506

*401987482-1

[redacted]

PATHOLOGY REPORT

Date Done:	12/29/2006	Patient:	RAMEY, GAYLA	MRN:	401987482
Date Received:	1/4/2007	DOB:	1/2/1961 Sex: F	SSN:	[redacted]
Date Processed:	1/5/2007	Referring Physician:	Brooks, Alice, MD		[redacted]

Final Diagnosis 1/5/2007

CZ07-00150	Seborrheic Keratosis, irritated. *Skin, left forearm, Biopsy*	702.11
CZ07-00151	Compound Melanocytic Nevus, irritated. *Skin, left back, Biopsy*	216.5
CZ07-00152	Intradermal Melanocytic Nevus, irritated *Skin, right side, Biopsy*	216.5
CZ07-00153	Junctional melanocytic nevus, irritated. *Skin, left abdomen, Biopsy*	216.5

Clinical

CZ07-00150	DYSPLASTIC NEVUS
CZ07-00151	DYSPLASTIC NEVUS
CZ07-00152	DYSPLASTIC NEVUS
CZ07-00153	DYSPLASTIC NEVUS

Specimen: CZ07-00150

Gross Description:

Received in formalin is a single piece of soft tan skin biopsy specimen measuring 5 mm in greatest dimension. Sectioned and entirely submitted.

Microscopic Description:

Skin with acanthosis, hyperkeratosis, horn pseudocysts and dermal inflammation

Specimen: CZ07-00151

Gross Description:

Received in formalin is a single piece of soft tan skin biopsy specimen measuring 5 mm in greatest dimension. Inked in black, sectioned and entirely submitted.

Microscopic Description:

Skin with melanocytes disposed as single cells and as nests at the dermo-epidermal junction and in the dermis. No significant cytological atypia is identified. Mild lymphocytic infiltrates are present around the nevus cells.

Specimen: CZ07-00152

42

1/17/07 Ptaway 80

Electronically signed by Zhang, Jing MD/PhD 1/5/2007

Pathology Service

Carolinas Dermatology Group, PA
1706 Saint Julian Place, Columbia, SC 29204 (803) 771-7506

*401987482-1

PATHOLOGY REPORT

Date Done:	12/29/2006	Patient:	RAMEY, GAYLA	MRN:	401987482
Date Received:	1/4/2007	DOB:	1/2/1961 Sex: F	SSN:	[redacted]
Date Processed:	1/5/2007	Referring Physician:	Brooks, Alice, MD		

Gross Description:
Received in formalin is a single piece of soft tan skin biopsy specimen measuring 5 mm in greatest dimension. Sectioned and entirely submitted.

Microscopic Description:
Skin with melanocytes disposed as single cells and as nests in the dermis. No significant cytological atypia seen. Mild lymphocytic infiltrates are present around the nevus cells.

Specimen: CZ07-00153

Gross Description:
Received in formalin is a single piece of soft tan skin biopsy specimen measuring 5 mm in greatest dimension. Inked in black, sectioned and entirely submitted.

Microscopic Description:
Skin with melanocytes disposed as single cells and as nests at the dermo-epidermal junction. No significant cytological atypia is identified. Mild lymphocytic infiltrates are seen in the papillary dermis.

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Electronically signed by Zhang, Jing MD/PhD 1/5/2007

275

)488701 Ramey, Gayla R
[redacted]

[redacted]78

DATE Dr. Notes

Date Created:

4/03/2007 07 [redacted]umber: 0488701
04/03/2007
Patient Name: Ramey, Gayla R
DOB: 01/02/1961 Age: 46 Sex: Female
Ethnic Origin: WHITE, NON-HISPANIC
Doctor: ALICE J. BROOKS M.D.

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Quest Diagnostics

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REPORT STATUS Final

QUEST DIAGNOSTICS INCORPORATED
CLIENT SERVICE 770.934.9205

PATIENT INFORMATION
RAMEY,GAYLA R

DOB: 01/02/1961 Age: 46
GENDER: F Fasting: Y

ID: 0488701
PHONE: [redacted]

ORDERING PHYSICIAN
BROOKS,ALICE J

CLIENT INFORMATION
7189992
ALICE J BROOKS, MD
116 STANDARD WAREHOUSE RD
LUGOFF, SC 29078-9670

SPECIMEN INFORMATION
SPECIMEN: AT803557V
REQUISITION: 7215683
LAB REF NO:

COLLECTED: 04/03/2007 08:30
RECEIVED: 04/03/2007 09:40
REPORTED: 04/04/2007 01:20

Room/Loc: LAB

12/04

COMMENTS: FASTING

Test Name	In Range	Out of Range	Reference Range	Lab
LIPID PANEL				AT
TRIGLYCERIDES	84	84	<150 mg/dL	AT
CHOLESTEROL, TOTAL	128	195	125-200 mg/dL	AT
HDL CHOLESTEROL		39 L 45	> OR = 40 mg/dL	AT
LDL-CHOLESTEROL	72	133	<130 mg/dL (calc)	AT
	DESIRABLE RANGE <100 MG/DL FOR PATIENTS WITH CHD OR DIABETES AND <70 MG/DL FOR DIABETIC PATIENTS WITH KNOWN HEART DISEASE.			
CHOL/HDLC RATIO	3.3	4.3	< OR = 5.0 (calc)	AT
HEPATIC FUNCTION PANEL				AT
PROTEIN, TOTAL	6.9		6.2-8.3 g/dL	
ALBUMIN	4.2		3.6-5.1 g/dL	
GLOBULIN	2.7		2.2-3.9 g/dL (calc)	
ALBUMIN/GLOBULIN RATIO	1.6		1.0-2.1 (calc)	
BILIRUBIN, TOTAL	0.3		0.2-1.2 mg/dL	
BILIRUBIN, DIRECT	0.1		< OR = 0.2 mg/dL	
BILIRUBIN, INDIRECT	0.2		0.2-1.2 mg/dL (calc)	
ALKALINE PHOSPHATASE	55		33-115 U/L	
AST	14		10-35 U/L	
ALT	11		6-40 U/L	

Performing Laboratory Information:

AT QUEST DIAGNOSTICS-ATLANTA 1777 MONTREAL CIRCLE TUCKER GA 30084 Laboratory Director: WILLIAM M MILLER, MD

[redacted]

Lovastatin
20 of +

appt 4/9/07

Page 1 - End of Report

RAMEY,GAYLA R - AT803557V

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Recd: 9/26/07
Scan

KERSHAW COUNTY MEDICAL CENTER
CAMDEN, S.C. 29020

PATIENT: RAMEY, GAYLA 004646
DOCTOR: A.J. Brooks, MD
ADM DAT 09/21/2007

RM#: MED1 0312-2
MR#: 0000209492
PT#: 010000396163
DOB: 01/02/1961

REPORT: NUCLEAR STRESS TEST EXAM DATE: 09/24/2007

46 year-old patient with recurring chest discomfort.

RESTING ELECTROCARDIOGRAM:
Resting electrocardiogram shows sinus rhythm and is normal.

EXERCISE:
The patient exercised a total of 8 minutes and 15 seconds, achieving a maximum recorded heart rate of 150, which is 86% of her maximum predicted heart rate. Peak systolic blood pressure recorded was 160. Exercise terminated secondary to an adequate heart rate being achieved.

ELECTROCARDIOGRAPHIC INTERPRETATION:
At peak exercise 1 mm of ST segment depression is seen in the inferior leads. No arrhythmias occurred.

NUCLEAR SCANNING:
Radioisotope uptake demonstrates a mild anterior wall defect which is actually worse on the rest scan. The gated SPECT shows normal thickening and contractility throughout with a well preserved ejection fraction of 65%.

IMPRESSION:
1. Normal SPECT Cardiolite scanning without any definite ischemia or scarring. Attenuation artifact is suspected.
2. Normal wall motion analysis.

CARDIOLOGY REPORT
COPY FOR: A.J. Brooks, MD

46

KERSHAW COUNTY MEDICAL CENTER
CAMDEN, S.C. 29020

PATIENT: RAMEY, GAYLA
DOCTOR: A.J. Brooks, MD
ADM DATE: 09/21/2007

RM#: -
MR#: 0000209492
PT#: 010000396163

W. Lawrence Schoolmeester, MD,MMM
RADIOLOGIST

WLS/tkm
D: 09/24/2007 4:07 P
T: 09/24/2007 9:54 P

cc: A.J. Brooks, MD
W. Lawrence Schoolmeester, MD,MMM

CARDIOLOGY REPORT
COPY FOR: A.J. Brooks, MD

47

Recd. 4/26/07
Scan

KERSHAW COUNTY MEDICAL CENTER
CAMDEN, S.C. 29020

PATIENT:	RAMEY, GAYLA 004646	RM#:	MED1 0312-2
DOCTOR:	Todd Alderson, M.D.	MR#:	0000209492
ADM DAT	09/21/2007	PT#:	010000396163
		DOB:	01/02/1961

REPORT: ECHOCARDIOGRAM

EXAM DATE: 09/22/2007

INDICATION:
Chest pain.

DESCRIPTION:
The left ventricle is normal in size. There is normal left ventricular systolic function with estimated ejection fraction of 65%. The left atrium, right atrium, and right ventricle appear to be normal in size. The are no obvious valvular abnormalities. There is minimal pericardial effusion, and no intracardiac mass is identified. Imaging is somewhat diminished due to poor penetration possibly related to lung disease.

SPECTRAL AND COLOR FLOW DOPPLER:
Spectral and color flow Doppler study reveals the presence of trivial mitral and tricuspid regurgitation. Tricuspid regurgitant envelop is insufficient for estimation of right ventricular pressure.

IMPRESSION:
Normal left ventricular systolic function.

Todd Alderson, M.D.

TA/jc
D: 09/22/2007 2:52 P
T: 09/24/2007 8:25 A

cc: Todd Alderson, M.D.
Olajide A Balogun, MD
A.J. Brooks, MD

CARDIOLOGY REPORT
COPY FOR: A.J. Brooks, MD

48

Rec'd: 9/26/07
Scan

KERSHAW COUNTY MEDICAL CENTER
CAMDEN, S.C. 29020

PATIENT:	RAMEY, GAYLA 0046046	RM#:	MED1 0312-2
ADM DOCTOR:	Olajide A Balogun, MD	MR#:	0000209492
ADM DATE:	09/21/2007	PT#:	010000396163
		DOB:	01/02/1961

CONSULTING PHYSICIAN: Todd Alderson, M.D.
DATE OF SERVICE: 09/22/2007

REASON FOR CONSULTATION:
Chest pain.

HISTORY OF PRESENT ILLNESS:
Galya Ramey is a 46-year-old female who has a history of chronic tobacco uses as well as hyperlipidemia and depression, who presented to the Emergency room yesterday with complaint of chest pain. Her symptoms began approximately 6:00 P.M. while she was lying in bed. She stated that it was intense discomfort in her chest that radiated through her back.

She was unable to give any other qualifying descriptions to the discomfort. She did have some shortness of breath and a little nausea. She's had no palpitations, presyncope or syncope. She's had no orthopnea, PND, or persistent edema. She has had occasional dependent edema at the end of her work shift that resolved after rest.

She has had no dyspnea on exertion, but she stated she felt as though she couldn't quite get a deep breath over the last three days. She has been under a fair amount of stress since the last part of August, when she started four classes in addition to working as a nurse at a nursing home in Ridgway.

Her first two sets of cardiac enzymes are negative. She received Nitroglycerin sublingual three times in the Emergency room without significant improvement. She also received Phenergan and Morphine, which eventually resolved her discomfort. She has had no further discomfort, though she states that she still feels fatigued.

ALLERGIES:
None.

MEDICATIONS:
1. Zoloft 50 mg q.h.s.
2. Lovastatin 40 mg daily.

PATIENT: RAMEY, GAYLA
ADM DOCTOR: Olajide A Balogun, MD
ADM DATE: 09/21/2007

RM#: MED1 0312-2
MR#: 0000209492
PT#: 010000396163
DOB: 01/02/1961

SOCIAL HISTORY:
She smokes a pack and a half a day. She works as above, as a nurse. She is married. Her husband is at the bedside. They live in Lugoff. She denies alcohol use.

SURGICAL HISTORY:
Previous removal of uterine polyp in 1995. The patient otherwise states no other surgeries "to speak of".

FAMILY HISTORY:
Negative for premature coronary disease. Her mother had a history of CHF, but supposedly died of an MI, however this is in the setting of toxemia from C. Difficile colitis.

REVIEW OF SYSTEMS:
Full review of systems is as above, and otherwise noncontributory as listed below.

PHYSICAL EXAM:
Vital signs: Blood pressure 92/62 mm/Hg. Pulse is 70 beats per minute. SATs are 97% on room air. She is 5'8" tall, 152 pounds. She is afebrile. In general, she is in no acute distress. Her affect is somewhat flat. She is alert and oriented. The skin is warm and dry. No rash. HEENT: Normocephalic, atraumatic. There is no scleral icterus or xanthelasma. Neck is supple. Normal venous pressure. Normal carotid upstroke. No carotid bruits. Chest is clear to auscultation bilaterally with good inspiratory effort. Cardiac exam reveals a regular rate. There is a 1/6 systolic murmur heard best at the right upper sternal borders. No S3, S4. Abdomen is soft, nontender, nondistended. No mass or bruits appreciated. Extremities are free of clubbing, cyanosis, or edema. Dorsalis pedis pulses are 2+. Posterior tibialis is 1+ on the right and trace on the left.

DATABASE:
EKG shows normal sinus rhythm. One tracing is consistent with cannot rule out septal infarct age undetermined, however this appears to be lead placement when compared to the subsequent tracing. Chest x-ray shows no acute disease.

LABORATORY DATA:

KERSHAW COUNTY MEDICAL CENTER
CAMDEN, S.C. 29020

PATIENT: RAMEY, GAYLA
ADM DOCTOR: Olajide A Balogun, MD
ADM DATE: 09/21/2007

RM#: MED1 0312-2
MR#: 0000209492
PT#: 010000396163
DOB: 01/02/1961

CK 61. MB 3.4, troponin-T less than 0.010. White count 13.3, hemoglobin 14.1, platelets 274, BUN and creatinine 10 and 0.9, potassium 3.4, glucose 94. Pro-BNP is 48. Initial CK 101 with MB of 4, troponin-T of less than 0.010. INR 0.94. UA is negative.

IMPRESSION:
1. Chest pain.
2. Chronic tobacco use.
3. Hyperlipidemia treated with Lovastatin.
4. Depression.

RECOMMENDATION:
At this time will complete her rule out with third set of cardiac enzymes. An echocardiogram has been performed, and we will check on the results of this study. Also add an assessment profile to this morning's blood.

I discussed smoking cessation with her and she stated that her husband told her she stopped smoking when she was admitted. We will plan for a stress Cardiolite study on Monday.

Todd Alderson, M.D.

TA/at2
D: 09/22/2007 2:41 P
T: 09/22/2007 3:08 P

cc: Todd Alderson, M.D.
Olajide A Balogun, MD
A.J. Brooks, MD

KERSHAW COUNTY MEDICAL CENTER
1315 Roberts Street
Post Office Box 7003
Camden, SC 29021-7003 Tel. (803) 432-4311

K10000396163 IN ADM 09/21/07 SEC P
RAMEY, GAYLA
HALOGEN, OLAJIDE A MD
MRN M0000309493 AGE 46
DOB 01/02/1961 RACE CA

Discharge Instructions

Please bear down as you are making multiple copies

Diagnosis: Chest Pain - Multiple Risk Factors
Hypertension
COPD
Tobacco Dependence
Hyperchol/Obesity
DM, FHx Surgery
Old Tobacco

Discharge Date: _____ Time: _____ Weight at Discharge: _____ pounds
Condition on D/C: _____
Diet: ☐ Regular ☐ Low Salt ☐ Low Fat ☐ Cal ADA _____ ☐ Other _____
Activity: ☐ No Restriction ☐ Rest at Home ☐ Return to Work/School on _____
Mode of Discharge: ☐ Wheelchair ☐ Arms ☐ Stretcher ☐ EMS ☐ Other _____
Dicharge to: ☐ Home ☐ Nursing Home _____ ☐ Other _____

☐ Home Health ☐ Hospice
Phone # _____
Call to agency made by: _____

DME:
Company: _____
Phone # _____
Call to agency made by: _____

Disease Management:
☐ Weight Monitoring
☐ Contact doctor if symptoms worsen

Special Instructions: Schedule Dept US of Gall Bladder

Follow-Up doctor appointments:
Follow-up appointment with Dr. Rebecca Burton in 10 Days Call # 438-6123 for appointment. Dr Brock's pt
Follow-up appointment with Dr. _____ In _____ Call # _____ for appointment.
Follow-up appointment with Dr. _____ In _____ Call # _____ for appointment.

I understand the discharge instructions as they have been explained to me and I have received a copy.
I understand that smoking and second-hand smoke are harmful to my health and the health of those around me, and that quitting smoking greatly reduces the risk of adverse health effects. Quitline Support 1-800-QUIT-NOW.

Patient/Significant Other: _____ Date: _____ Time: _____
Nurse: _____ Date: _____ Time: _____
Physician _____ Date: _____ Time: _____
MD Signature will initiate orders for Hospital/Home Health/Hospice/SNF

PRESCRIPTIONS
Name Gayla Ramey
Address 9/02/1961

Date 9/24/07
ALLERGIES

RX	MG.	NO.	DIRECTIONS	REFILLS
Chantix Start			Month pack	0
Chantix			Continuing month pack	1

DO NOT COPY

White – Chart Yellow – MD Pink – Patient / HH / NSG Home

52

Rec'd: 10/9/07
Scan

KERSHAW COUNTY MEDICAL CENTER
CAMDEN, S.C. 29020

PATIENT:	RAMEY, GAYLA 0040446 0004	RM#:	MED1 0312-2
DOCTOR:	A.J. Brooks, MD	MR#:	0000209492
ADM DAT	09/21/2007	PT#:	010000396163
		DOB:	01/02/1961

REPORT: NUCLEAR STRESS TEST EXAM DATE: 09/24/2007

46 year-old patient with recurring chest discomfort.

RESTING ELECTROCARDIOGRAM:
Resting electrocardiogram shows sinus rhythm and is normal.

EXERCISE:
The patient exercised a total of 8 minutes and 15 seconds, achieving a maximum recorded heart rate of 150, which is 86% of her maximum predicted heart rate. Peak systolic blood pressure recorded was 160. Exercise terminated secondary to an adequate heart rate being achieved.

ELECTROCARDIOGRAPHIC INTERPRETATION:
At peak exercise 1 mm of ST segment depression is seen in the inferior leads. No arrhythmias occurred.

NUCLEAR SCANNING:
Radioisotope uptake demonstrates a mild anterior wall defect which is actually worse on the rest scan. The gated SPECT shows normal thickening and contractility throughout with a well preserved ejection fraction of 65%.

IMPRESSION:
1. Normal SPECT Cardiolite scanning without any definite ischemia or scarring. Attenuation artifact is suspected.
2. Normal wall motion analysis.

CARDIOLOGY REPORT
CHART COPY

53

KERSHAW COUNTY MEDICAL CENTER
CAMDEN, S.C. 29020

PATIENT: RAMEY, GAYLA
DOCTOR: A.J. Brooks, MD
ADM DATE: 09/21/2007

RM#: -
MR#: 0000209492
PT#: 010000396163

W. Lawrence Schoolmeester, MD,MMM
RADIOLOGIST

WLS/tkm
D: 09/24/2007 4:07 P
T: 09/24/2007 9:54 P

cc: A.J. Brooks, MD
W. Lawrence Schoolmeester, MD,MMM

CARDIOLOGY REPORT
CHART COPY

54

KERSHAW COUNTY MEDICAL CENTER
CAMDEN, S.C. 29020

PATIENT:	RAMEY, GAYLA	RM#:	MED1 0312-2
DOCTOR:	A.J. Brooks, MD	MR#:	0000209492
ADM DATE:	09/21/2007	PT#:	010000396163
DSC DATE:	09/24/2007	DOB:	01/02/1961

DISCHARGE DIAGNOSES:

1. Chest pain noncardiac.
2. Multiple risk factors for heart disease.
3. COPD.
4. Tobacco dependence.
5. Hyperlipidemia.
6. Abnormal EKG suggesting old infarct.

DISCHARGE MEDICATIONS:

1. Zoloft 50 mg daily.
2. Lovastatin 40 mg daily.

LABORATORY DATA:
Two initial sets of cardiac enzymes were within normal limits. Pro-BNP is 48. One EKG cannot rule out old septal infarct. Normal sinus rhythm. Glucose 94, BUN 10, creatinine 0.9.

HOSPITAL COURSE:
The patient came to the hospital through the Emergency room because of chest pain that she felt at rest. Cardiology was consulted and an echocardiogram was ordered, which was within normal limits, and a nuclear stress test, which was within normal limits. The patient was strongly advised to stop smoking. She will be worked up on an outpatient basis for gastrointestinal problems causing her recurrent noncardiac chest pain. The first test that will done will be an ultrasound of the gallbladder. She will return to Dr. Brooks office in ten days. A prescription has been written for Chantix.

DISCHARGE SUMMARY
COPY FOR: A.J. Brooks, MD

55.

KERSHAW COUNTY MEDICAL CENTER
CAMDEN, S.C. 29020

PATIENT: RAMEY, GAYLA
DOCTOR: A.J. Brooks, MD
ADM DATE: 09/21/2007
DSC DATE: 09/24/2007

RM#: -
MR#: 0000209492
PT#: 010000396163

A.J. Brooks, MD

Dictated by: Patricia Davis Burton, NP
PDB/at2
D: 09/24/2007 5:29 P
T: 10/24/2007 8:49 P

cc: A.J. Brooks, MD
Patricia Davis Burton, NP

DISCHARGE SUMMARY
COPY FOR: A.J. Brooks, MD

0/25/07 10:32 Privileged Information. Any unauthorized review, use, disclosure or distribution is prohibited. (803) 713-6818 HIM Dept. Page

KERSHAW COUNTY MEDICAL CENTER
CAMDEN, S.C. 29020

PATIENT:	RAMEY, GAYLA	RM#:	MED1 0312-2
DOCTOR:	A.J. Brooks, MD	MR#:	0000209492
ADM DATE:	09/21/2007	PT#:	010000396163
DSC DATE:	09/24/2007	DOB:	01/02/1961

DISCHARGE DIAGNOSES:

1. Chest pain noncardiac.
2. Multiple risk factors for heart disease.
3. COPD.
4. Tobacco dependence.
5. Hyperlipidemia.
6. Abnormal EKG suggesting old infarct.

PB.
OCT 25 2007
10-31-07

DISCHARGE MEDICATIONS:

1. Zoloft 50 mg daily.
2. Lovastatin 40 mg daily.

LABORATORY DATA:
Two initial sets of cardiac enzymes were within normal limits. Pro-BNP is 48. One EKG cannot rule out old septal infarct. Normal sinus rhythm. Glucose 94, BUN 10, creatinine 0.9.

HOSPITAL COURSE:
The patient came to the hospital through the Emergency room because of chest pain that she felt at rest. Cardiology was consulted and an echocardiogram was ordered, which was within normal limits, and a nuclear stress test, which was within normal limits. The patient was strongly advised to stop smoking. She will be worked up on an outpatient basis for gastrointestinal problems causing her recurrent noncardiac chest pain. The first test that will done will be an ultrasound of the gallbladder. She will return to Dr. Brooks office in ten days. A prescription has been written for Chantix.

10/25/07
D

DISCHARGE SUMMARY
COPY FOR:

57

KERSHAW COUNTY MEDICAL CENTER
CAMDEN, S.C. 29020

PATIENT: RAMEY, GAYLA
DOCTOR: A.J. Brooks, MD
ADM DATE: 09/21/2007
DSC DATE: 09/24/2007

RM#: -
MR#: 0000209492
PT#: 010000396163

A.J. Brooks, MD

Dictated by: Patricia Davis Burton, NP
PDB/at2
D: 09/24/2007 5:29 P
T: 10/24/2007 8:49 P

cc: A.J. Brooks, MD
Patricia Davis Burton, NP

DISCHARGE SUMMARY
COPY FOR:

58

Quest Diagnostics

Quest on Demand™

REPORT STATUS Final

PATIENT INFORMATION
RAMEY, GAYLA R

ORDERING PHYSICIAN
BROOKS, ALICE J

CLIENT INFORMATION
7189992
ALICE J BROOKS, MD
116 STANDARD WAREHOUSE RD
LUGOFF, SC 29078-9670

QUEST DIAGNOSTICS INCORPORATED
CLIENT SERVICE 770.934.9205

EOV10-31-07
AB 10-15-07

DOB: 01/02/1961 Age: 46
GENDER: F
ID: 0488701
PHONE: [redacted]

SPECIMEN INFORMATION
SPECIMEN: AL7999
REQUISITION: 72195
LAB REF NO:

Room/Loc: LAB

COLLECTED: 10/10/2007 08:30
RECEIVED: 10/10/2007 19:28
REPORTED: 10/11/2007 03:46

COMMENTS: FASTING

Test Name	In Range	Out of Range	Reference Range	Lab
LIPID PANEL WITH REFLEX TO DIRECT LDL				
TRIGLYCERIDES	67		<150 mg/dL	AT
CHOLESTEROL, TOTAL	153		125-200 mg/dL	AT
HDL CHOLESTEROL	45		> OR = 40 mg/dL	AT
LDL-CHOLESTEROL	95		<130 mg/dL (calc)	AT
	DESIRABLE RANGE <100 MG/DL FOR PATIENTS WITH CHD OR DIABETES AND <70 MG/DL FOR DIABETIC PATIENTS WITH KNOWN HEART DISEASE.			
CHOL/HDLC RATIO	3.4		< OR = 5.0 (calc)	AT
COMPREHENSIVE METABOLIC PANEL W/EGFR				AT
GLUCOSE	98		65-99 mg/dL FASTING REFERENCE INTERVAL	
UREA NITROGEN (BUN)	10		7-25 mg/dL	
CREATININE	0.9		0.5-1.2 mg/dL	
GFR ESTIMATED	>60		> OR = 60 mL/min/1.73m2 IF THE PATIENT IS AFRICAN-AMERICAN, PLEASE MULTIPLY THIS RESULT BY 1.21. THIS RESULT HAS BEEN CALCULATED ASSUMING THE PATIENT IS NON-AFRICAN AMERICAN.	
BUN/CREATININE RATIO	11		6-22 (calc)	
SODIUM	140		135-146 mmol/L	
POTASSIUM	4.9		3.5-5.3 mmol/L	
CHLORIDE	107		98-110 mmol/L	
CARBON DIOXIDE	25		21-33 mmol/L	
CALCIUM	9.2		8.6-10.2 mg/dL	
PROTEIN, TOTAL	7.0		6.2-8.3 g/dL	
ALBUMIN	4.4		3.6-5.1 g/dL	
GLOBULIN	2.6		2.2-3.9 g/dL (calc)	
ALBUMIN/GLOBULIN RATIO	1.7		1.0-2.1 (calc)	
BILIRUBIN, TOTAL	0.4		0.2-1.2 mg/dL	
ALKALINE PHOSPHATASE	56		33-115 U/L	
AST	15		10-35 U/L	
ALT	10		6-40 U/L	

Performing Laboratory Information:

AT Quest Diagnostics-Atlanta 1777 Montreal Cir Tucker GA 30084 Laboratory Director: William Miller

Page 1 - End of Report

RAMEY, GAYLA R - AL799933D

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KERSHAW COUNTY MEDICAL CENTER
CAMDEN, S.C. 29020

PATIENT: RAMEY, GAYLA
DOCTOR: D. Paul Christenberry, MD
ADM DATE: 10/18/2007

RM#: -
MR#: 0000209492
PT#: 010000401549
DOB: 01/02/1961

SURGEON: D. Paul Christenberry, MD DATE OF SURGERY: 10/18/2007

PREOPERATIVE DIAGNOSIS:
Symptomatic gallstones.

POSTOPERATIVE DIAGNOSIS:
Same.

OPERATION:
Laparoscopic cholecystectomy with intraoperative cholangiography.

ANESTHESIA:
General.

FINDINGS:
Minimal gallbladder inflammation. Intraoperative cholangiogram was noted to be normal with the exception of what were felt to be two bubbles in the common bile duct (moved easily with change of position and were perfectly round).

PROCEDURE:
The patient was brought to the operating room where general endotracheal anesthesia was introduced without complication. The abdomen was prepped and draped in the usual sterile manner. An incision was made just below the umbilicus using a 15 bladed knife. The subcutaneous tissue was spread down to the fascia which was elevated using 0 Vicryl stay sutures and then transected using electrocautery. The peritoneal cavity was entered bluntly using a Kelly clamp. Hasson cannula was introduced. The abdomen was insufflated to 15 mmHg using carbon dioxide. Three 5 mm trocars were then placed, two in the right upper quadrant and one in the epigastric area, all under direct visualization without difficulty. The gallbladder was retracted anteriorly and cephalad by its body and laterally by its neck. The cystic duct was dissected circumferentially at its juncture with the gallbladder. A clip was placed in this position. The cystic artery was doubly clipped on the patient's side and singly clipped on the specimen side. The cystic duct was partially transected using Endoshears. A Reddick cholangiocatheter was used to obtain a cholangiogram which revealed free spill in the duodenum, the two aforementioned filling defects which were felt to represent air bubbles, and normal anatomy. The cholangiocatheter was then removed.

KERSHAW COUNTY MEDICAL CENTER
CAMDEN, S.C. 29020

PATIENT: RAMEY, GAYLA
DOCTOR: D. Paul Christenberry, MD
ADM DATE: 10/18/2007
RM#:
MR#: 0000209492
PT#: 010000401549

The cystic duct remnant was doubly clipped on the patient's side. The cystic duct and cystic artery were transected using Endoshears. The gallbladder was taken off of the liver bed using a combination of blunt, sharp, and electrocautery dissection and was removed through the supraumbilical port. The area of dissection was irrigated and noted to be hemostatic. Clips were noted to be in good position with no bleeding or bile leak. The trocars were removed under direct visualization with no bleeding from any trocar site appreciated as the intraabdominal pressure was allowed to fall. The Hasson cannula was removed. All excess CO2 was expressed. The fascia in the subumbilical incision was reapproximated using running 0 Vicryl suture. All skin incisions were closed using subcuticular 4-0 Monocryl sutures. Steri-Strips and sterile dressings were applied. Anesthesia was reversed. The patient was taken to the recovery area in stable condition, having tolerated the procedure well.

D. Paul Christenberry, MD

DPC/rcl
D: 10/18/2007 11:21 A
T: 10/24/2007 8:20 A

cc: A.J. Brooks, MD
D. Paul Christenberry, MD

OPERATIVE REPORT
COPY FOR: A.J. Brooks, MD

61

KERSHAW COUNTY MEDICAL CENTER
1315 Roberts Street
Camden, South Carolina 29020

SURGICAL PATHOLOGY REPORT

Name: RAMEY,GAYLA
Date: 10/18/07 Sex: F
Pathology #: S07-3102
Room: OPSURG

Age: 46
MR#: M000209492
Submitting Dr: CHRISTENBERRY,DAVID MD

DOB: 01/02/1961
Acct #: K10000401549

NATURE OF SPECIMEN
Gallbladder

CLINICAL HISTORY
Gallbladder dysfunction

GROSS DESCRIPTION
"Gallbladder" Received is a pink-blue gallbladder which is 10.2 x 3.0 x 1.8 cm. There is no gross evidence of a perforation along the serosal surface. Nodularity cannot be palpated within the serosal surface surrounding the gallbladder neck. Upon cut section, two multifaceted yellow green stones which measure in greatest dimension up to 1.0 cm are noted within the gallbladder sac. These stones will be washed and returned to the patient at the request of the surgeon. The mucosal surface is brown, and ulcerations are not seen. The wall thickness is approximately 0.2 cm. Representative sections of gallbladder are submitted in one cassette.

MICROSCOPIC DESCRIPTION
Sections of gallbladder show a focally denuded epithelial lining. A slight increase in the number of chronic inflammatory cells can be appreciated within the lamina propria. Occasional Rokitansky-Aschoff sinuses are seen. Vascular congestion is noted within the serosa. There is no evidence of malignancy within any of these sections.

FINAL DIAGNOSIS
Gallbladder, Cholecystectomy:
Mild Chronic Cholecystitis.

RBT:ag
10/19/07

Department of Pathology
Electronically Signed By:
Renee B. Thomas, M.D., Pathologist
<signature on file>
10/19/07

62

KERSHAW COUNTY MEDICAL CENTER
1315 Roberts Street
Camden, South Carolina 29020

SURGICAL PATHOLOGY REPORT

Name: RAMEY,GAYLA Sex: F Age: 46 DOB: 01/02/1961
Date: 10/18/07 MR#: M000209492 Acct #: K10000401549
Pathology #: S07-3102 Submitting Dr: CHRISTENBERRY,DAVID MD
Room: OPSURG

NATURE OF SPECIMEN
Gallbladder

CLINICAL HISTORY
Gallbladder dysfunction

GROSS DESCRIPTION
"Gallbladder" Received is a pink-blue gallbladder which is 10.2 x 3.0 x 1.8 cm. There is no gross evidence of a perforation along the serosal surface. Nodularity cannot be palpated within the serosal surface surrounding the gallbladder neck. Upon cut section, two multifaceted yellow green stones which measure in greatest dimension up to 1.0 cm are noted within the gallbladder sac. These stones will be washed and returned to the patient at the request of the surgeon. The mucosal surface is brown, and ulcerations are not seen. The wall thickness is approximately 0.2 cm. Representative sections of gallbladder are submitted in one cassette.

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Gallbladder, Cholecystectomy:
Mild Chronic Cholecystitis.

RBT:ag
10/19/07

Department of Pathology
Electronically Signed By:
Renee B. Thomas, M.D., Pathologist
<signature on file>
10/19/07

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CAMDEN GENERAL AND VASCULAR SURGERY
PAUL CHRISTENBERRY, M.D., F.A.C.S.
1001 FAIRLAWN DRIVE • CAMDEN, SC 29020-4525
PHONE: 803-432-8989 • FAX: 803-432-6382

October 24, 2007

Alice J. Brooks, M.D.
116 Standard Warehouse Rd.
Lugoff, SC 29078

RE: Gayla Ramey

Dear Alice,

Gayla returned today after her laparoscopic cholecystectomy. Her wounds are healing satisfactorily.

I will plan on seeing her back in the office in one week's time to make sure she heals without further difficulty.

Enclosed you will find the copy of her path report for inclusion in her records there at your office.

Thank you again.

Sincerely,

D. Paul Christenberry, M.D., F.A.C.S.
/at

(Dictated but not read)

Enclosure

64

Recd: 11/7/07
PB

CAMDEN GENERAL AND VASCULAR SURGERY
PAUL CHRISTENBERRY, M.D., F.A.C.S.
1001 FAIRLAWN DRIVE • CAMDEN, SC 29020-4525
PHONE: 803-432-8989 • FAX: 803-432-6382

October 31, 2007

Alice J. Brooks, M.D.
116 Standard Warehouse Rd.
Lugoff, SC 29078

RE: Gayla Ramey

Dear Alice,

I had the pleasure of seeing Gayla Ramey back in the office today after her recent laparoscopic cholecystectomy.

On follow up today, her wounds are healing satisfactorily. I have asked her to return to see me should she have any difficulties.

Enclosed you will find a copy of her path note for inclusion in her records there at your office.

Thank you again for allowing me to see her.

Sincerely,

D. Paul Christenberry, M.D., F.A.C.S.
/at

(Dictated but not read)

Enclosure

11/12/07

EDV
11/14/07
PB

65

ALICE J BROOKS MD PA
PO BOX 39
LUGOFF SC 29078
803 438 6023

MEDICAL RECORDS REPORT

PATIENT NO: 004646

ATIENT : **RAMEY, GAYLA R**
DDRESS: [redacted]
M TEL: [redacted] WK TEL:
CCUPAT
UARAN , GAYLA R

DOB: 01/02/1961 (50)

PT CHART #: **0488701**

D : 11/14/2007 ORDERED BY: AMY
D : 11/14/2007 ENTERED BY: BRENDA
: 002 BURTON, PATRICIA D
PANEL NAME: **NONE**

TEST TITLE	RESULTS
HEMOCC	lot 14055 exp 9/09 RESULT NEG..PB/BB

ldo

Report Electronically Generated by AMERICAN MEDICAL SOFTWARE (R)

ALICE J BROOKS MD PA
PO BOX 39
LUGOFF SC 29078
803 438 6023

MEDICAL RECORDS REPORT

PATIENT NO: 004646

ATIENT NAME: **RAMEY, GAYLA R**
DDRESS: [redacted]
M TEL: [redacted] WK TEL:
CCUPATION:
UARANTOR: RAMEY, GAYLA R

DOB: 01/02/1961 (50)

PT CHART #: **0488701**

DATE ORDERED: 11/14/2007 ORDERED BY: AMY
DATE ENTERED: 11/14/2007 ENTERED BY: KELLIE
PROVIDER: 001 BROOKS, ALICE J
PANEL NAME: **NONE**

'EST TITLE	RESULTS	
JRINALYSIS	GLU	NEGATIVE
	BIL	NEGATIVE
	KET	NEGATIVE
	SG	1.010
	BLO	NEGATIVE
	pH	6.5
	PRO	NEGATIVE
	URO	1.0 E.U./dL
	NIT	NEGATIVE
	LEU	NEGATIVE
	3 EPI	
	PDB	

67

Report Electronically Generated by AMERICAN MEDICAL SOFTWARE (R)

Quest Diagnostics

Quest on Demand™

QUEST DIAGNOSTICS INCORPORATED
CLIENT SERVICE 770.934.9205

SPECIMEN INFORMATION
SPECIMEN: AL606885E
REQUISITION: 7190800
LAB REF NO: AL606885E

COLLECTED: 11/14/2007 00:00
RECEIVED: 11/15/2007 03:05
REPORTED: 11/27/2007 13:24

PATIENT INFORMATION
RAMEY, GAYLA R

DOB: 01/02/1961 Age: 46
GENDER: F

ID: 0488701
PHONE: [redacted]

REPORT STATUS **Final**

ORDERING PHYSICIAN
BURTON, PATRICIA D
CLIENT INFORMATION
7189992
ALICE J BROOKS, MD
116 STANDARD WAREHOUSE RD
LUGOFF, SC 29078-9670

12/3/2007 pdb

Test Name		Lab
	PATHOLOGY REPORT	AT
SUREPATH-FP W/REFL HPV		
REPORT STATUS:	FINAL	
CLINICAL INFORMATION:	Normal exam	
LMP:	10/25/07	
PREV. PAP:	9-11-06	
PREV. BX:	????????????????????	
SOURCE:	Cervix	
STATEMENT OF ADEQUACY:	Satisfactory for evaluation. Endocervical/transformation zone component present.	
INTERPRETATION/RESULT:	Negative for intraepithelial lesion or malignancy.	
COMMENT:	This case was successfully processed by the Tripath FocalPoint (TM) slide profiler. Based on the cytology result, reflex High/Int Risk HPV DNA Probe testing is not performed.	
CYTOTECHNOLOGIST:	MMC CT(ASCP)	

Performing Laboratory Information:

AT Quest Diagnostics-Atlanta 1777 Montreal Cir Tucker GA 30084 Laboratory Director: William Miller

12/04/07 LAB RET..BB

RAMEY, GAYLA R - AL606885E

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CENTRAL CAROLINA TECHNICAL COLLEGE
506 North Guignard Dr.
Sumter, SC 29150

PHYSICAL EXAMINATION AND IMMUNIZATION FORM

TO BE COMPLETED BY STUDENT

Name Gayla Ramey Phone [redacted] DOB 01-02-61 CID _____

Address [redacted] City [redacted] State [redacted] Zip [redacted]

In case of emergency notify:

Name James Ramey Phone _____ Relationship _____

Address Same City _____ State _____ Zip _____

List any current health problems that may affect my ability to participate in patient care:

I hereby certify that all information on this form is correct. I understand that false information will be sufficient cause for the college to cancel my enrollment and require withdrawal. I will report any changes in my health status to my Department Chair/Program Manager. This form must be renewed with each admission to the Health Sciences Division. I authorize CCTC to release this information to the agencies where I have clinical assignments.

Student Signature Gayla Ramey Date 9/19/08

TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT

I have completed a physical exam on this student and:

I consider the applicant physically qualified for college classes and patient care? Yes X No ___

I consider the applicant emotionally qualified for college classes and patient care? Yes X No ___

Please furnish any information that may affect this student's ability to participate fully in patient care in a clinical setting, including chronic illnesses, infectious disease or pregnancy:

Print Provider's Name: Alice J. Brooks Title: MD

Provider Signature _____ Date: 9-19-08

Address 1116 Standard Warehouse Rd Lugoff, SC 29078 Phone: 803-438-6023

10/05

69

IMMUNIZATION RECORD

Name Gayla Ramey CID _____

Complete documentation of immunization status is required **by the first class day in a Health Sciences clinical course.** Each immunization or titer must have a specific date and be verified with the signature of a physician, nursing or health care professional administering immunization.

Please do not attach immunization records or test results; they must be transcribed to this form.

VACCINE	IMMUNIZATION HISTORY	HEALTH CARE PROFESSIONAL VERIFICATION SIGNATURE
TETANUS TOXOID *(Booster required every 10 years)*	Date of vaccine: 9-11-2006	HCP Signature [redacted]
RED MEASLES (RUBEOLA) 2 vaccines **Read information below*	Date of Titer: 7-14-00 Results: [X] immune or, Date of vaccines: #1 _____ #2 _____	HCP Signature _____
GERMAN MEASLES (RUBELLA) **Read information below*	Date of Titer: 7-14-00 Results: [X] immune or, Date of vaccine: #1 _____	HCP Signature _____
2STEP TB SKIN TEST: Plant PPD #1: read in 48 hrs -72 hrs	CXR ordered NO further PPD'd. Step I: Date Given: _____ Date Read: _____ [ ] negative [ ] positive	HCP Signature _____
Plant PPD #2: in 1-3 weeks from date PPD #1 planted, read in 48 hrs to 72 hrs	Step II: Date Given _____ Date Read _____ [ ] negative [ ] positive	HCP Signature _____

The Two Step TB skin test (Mantoux) is required upon admission followed by a repeat PPD every 12 months. Some clinical sites require PPD not be older than 3-6 months. The tine test or the monovec test is not acceptable. Students with a history of a 2 step PPD and recurrent annual PPD are not required to have a repeated 2 step PPD, but must submit proof from provider.

Students with a documented history of a positive PPD must attach one of the following upon admission and annually:

a. *Physician's statement stating chest x-ray is negative for TB or,*
b. *Physician's statement stating chest x-ray not needed or,*
c. *Physician's statement stating currently under treatment with Isoniazid (INH).*

HEPATITIS B: Hepatitis B vaccine is optional. *Student who cannot or will not take the vaccine will be required to sign a waiver.*	Titer (anti HBs) Date 6-24-? Results: [X] immune or. Date of Disease: _____ or. Dates of injections: #1 _____ #2 _____ #3 _____	HCP Signature _____ HCP Signature _____ HCP Signature _____
VARICELLA (CHICKEN POX)	Year of illness 1967 or, (If year of illness by history no signature required.) Titer Date: _____ Results: [ ] immune or, Date of vaccine: _____ (If titer is negative vaccine required.)	HCP Signature _____

*Rubeola (Measles) and Rubella (German Measles): The student should receive an additional MMR vaccine prior to admission unless there is a physician's statement that states the student:

a. has laboratory evidence of Rubeola and Rubella immunity or,
b. is pregnant or trying to conceive or,
c. has had an anaphylactic reaction to gelatin or,
d. can document 2 MMR vaccines after the first birthday.

Research does not support that an allergy to eggs is a contraindication.

10/05

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AB
SEP 23 2008

KERSHAW COUNTY MEDICAL CENTER
Radiology Department
Haile and Roberts Streets
Camden, South Carolina 29020
(803)713-6531

Patient: RAMEY,GAYLA
[redacted]

Age: 47 Sex: F

DOB: 01/02/1961

Ord Dr: BROOKS, ALICE MD

MRN: M000209492
Acct #: K1000049822
Req #: 08-0032172

Serv Dt/Tm: 09/22/08 /
Loc: WWRAD Rm/Bed:
Status: REG CLI

BROOKS,ALICE MD
116 STANDARD WAREHOUSE RD
LUGOFF, SC 29078

REASON FOR EXAM: COUGH, POSITIVE PPD REACTION

CHEST 9-22-08

Two views are compared to 7-27-06. A small noncalcified nodule is again noted in the left lung base unchanged. No acute infiltrate, pleural effusion or cardiomegaly is seen.

IMPRESSION: NO ACTIVE DISEASE.

Electronically signed by:YASSEEN KUZBARY MD <<Signature on File>>

Trans by: JAS
Trans date/time: 09/22/08 2001

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Ordering Physician's copy

1 of 1

Signed
cc:BROOKS,ALICE MD
Report #0922-0130

LabCorp
LabCorp Burlington
1447 York Court, Burlington, NC 27215-3361
Phone: 800-762-4344

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	Page #:
339-078-3163-0	S	BN	COMPLETE	1

ADDITIONAL INFORMATION SS#: ***-**-7482

0488701 FASTING: Y
PHONE: [redacted] DOB: 1/02/1961

PATIENT NAME	SEX	AGE(YR/MOS.)
RAMEY,GAYLA R	F	47 / 11

PT. ADD.: [redacted] SC 29078-0000

DATE OF COLLECTION	TIME	DATE RECEIVED	DATE REPORTED	TIME	
12/04/2008	8:30	12/04/2008	12/05/2008	5:37	2121

CLINICAL INFORMATION
CD- 20138003181

PHYSICIAN ID.	NPI	PATIENT ID.
BROOKS A	1275573420	004646

ACCOUNT: Alice J Brooks MD Clinical Act [redacted]
116 Standard Warehouse Road
Lugoff SC 29078-0090
ACCOUNT NUMBER: 39432640

TEST	RESULT		LIMITS	LAB
CBC With Differential/Platelet				
WBC	9.8	x10E3/uL	4.0 - 10.5	01
Effective December 08, 2008, the pediatric reference intervals will be changing on all result codes that are included in CBC With Differential/Platelet(005009).				
RBC	4.20	x10E6/uL	3.80 - 5.10	01
Hemoglobin	12.9	g/dL	11.5 - 15.0	01
Hematocrit	37.4	%	34.0 - 44.0	01
MCV	89	fL	80 - 98	01
MCH	30.7	pg	27.0 - 34.0	01
MCHC	34.5	g/dL	32.0 - 36.0	01
RDW	13.6	%	11.7 - 15.0	01
Platelets	263	x10E3/uL	140 - 415	01
Neutrophils	62	%	40 - 74	01
Lymphs	30	%	14 - 46	01
Monocytes	6	%	4 - 13	01
Eos	2	%	0 - 7	01
Basos	0	%	0 - 3	01
Neutrophils (Absolute)	6.1	x10E3/uL	1.8 - 7.8	01
Lymphs (Absolute)	2.9	x10E3/uL	0.7 - 4.5	01
Monocytes(Absolute)	0.6	x10E3/uL	0.1 - 1.0	01
Eos (Absolute)	0.2	x10E3/uL	0.0 - 0.4	01
Baso (Absolute)	0.0	x10E3/uL	0.0 - 0.2	01
Comp. Metabolic Panel (14)				
Glucose, Serum	90	mg/dL	65 - 99	01
BUN	11	mg/dL	5 - 26	01
Creatinine, Serum	0.90	mg/dL	0.57 - 1.00	01
Glom Filt Rate, Est If African-American	>59	mL/min/1.73	>59	
	>59	mL/min/1.73	>59	
Note: Persistent reduction for 3 months or more in an eGFR <60 mL/min/1.73 m2 defines CKD. Patients with eGFR values >/=60 mL/min/1.73 m2 may also have CKD if evidence of persistent proteinuria is present. Additional information may be found at www.kdoqi.org.				
BUN/Creatinine Ratio	12		8 - 27	
Sodium, Serum	142	mmol/L	135 - 145	01
Potassium, Serum	4.1	mmol/L	3.5 - 5.2	01
Chloride, Serum	104	mmol/L	97 - 108	01
Carbon Dioxide, Total	27	mmol/L	20 - 32	01
Calcium, Serum	9.3	mg/dL	8.5 - 10.6	01

Continued on Next Page

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LabCorp Burlington
1447 York Court, Burlington, NC 27215-3361

Phone: 800-762-4344

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	Page #: 2
339-078-3163-0	S	BN	COMPLETE	

ADDITIONAL INFORMATION SS#: ***-**-7482

0488701 FASTING: Y
PHONE: 803-438-5047 DOB: 1/02/1961

PATIENT NAME	SEX	AGE(YR/MOS.)
RAMEY,GAYLA R	F	47 / 11

PT. ADD.: [redacted]

DATE OF COLLECTION	TIME	DATE RECEIVED	DATE REPORTED	TIME	
12/04/2008	8:30	12/04/2008	12/05/2008	5:37	2121

CLINICAL INFORMATION
CD-20138003181

PHYSICIAN ID.	NPI	PATIENT ID.
BROOKS A	1275573420	004646

ACC[redacted] Alice Brooks MD Clincial Act
116 Standard Warehouse Road
Lugoff SC 29078-0000
ACCOUNT NUMBER: 39432640

TEST	RESULT		LIMITS	LAB
Protein, Total, Serum	6.5	g/dL	6.0 - 8.5	01
Albumin, Serum	3.8	g/dL	3.5 - 5.5	01
Globulin, Total	2.7	g/dL	1.5 - 4.5	
A/G Ratio	1.4		1.1 - 2.5	
Bilirubin, Total	0.4	mg/dL	0.1 - 1.2	01
Alkaline Phosphatase, S	68	IU/L	25 - 150	01
AST (SGOT)	19	IU/L	0 - 40	01
ALT (SGPT)	20	IU/L	0 - 40	01
Lipid Panel With LDL/HDL Ratio				
Cholesterol, Total	206 H	mg/dL	100 - 199	01
> Triglycerides	123	mg/dL	0 - 149	01
HDL Cholesterol	42	mg/dL	>39	01
Comment				
According to ATP-III Guidelines, HDL-C >59 mg/dL is considered a negative risk factor for CHD.				
VLDL Cholesterol Cal	25	mg/dL	5 - 40	
> LDL Cholesterol Calc	139 H	mg/dL	0 - 99	01
Comment				
If initial LDL-cholesterol result is >100 mg/dL, assess for risk factors.				
> LDL/HDL Ratio	3.3H	ratio units	0.0 - 3.2	

LAB: 01 BN LabCorp Burlington
1447 York Court, Burlington, NC 27215-3361
DIRECTOR: William F Hancock MD

Pat Name: RAMEY,GAYLA R	Pat ID: 004646	Spec #: 339-078-3163-0	Seq #: 2121

Results are Flagged in Accordance with Age Dependent Reference Ranges
LCM Version: 03.23.00

Last Page of Report

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ALICE J BROOKS MD PA
PO BOX 39
LUGOFF SC 29078
803 438 6023

MEDICAL RECORDS REPORT

PATIENT NO: 004646

ATIENT NAME: **RAMEY, GAYLA R**
DDRESS: [redacted]
M TEL: [redacted] WK TEL:
CCUPATION:
UARANTOR: RAMEY, GAYLA R

DOB: 01/02/1961 (50) [redacted] PT CHART [redacted]0488701

DATE ORDERED: 12/12/2008 ORDERED BY: AMY
DATE ENTERED: 12/12/2008 ENTERED BY: KELLIE
PROVIDER: 001 BROOKS, ALICE J
PANEL NAME: **NONE**

TEST TITLE	RESULTS	
URINALYSIS	GLU	NEGATIVE
	BIL	NEGATIVE
	KET	NEGATIVE
	SG	1.010
	BLO	NEGATIVE
	pH	6.0
	PRO	NEGATIVE
	URO	0.2 E.U./dL
	NIT	NEGATIVE
	LEU	TRACE
	NEG	
	AB	

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LabCorp
LabCorp Burlington
1447 York Court, Burlington, NC 27215-3361
Phone: 800-762-4344

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	Page #:
109-078-3340-0	S	BN	COMPLETE	1

ADDITIONAL INFORMATION SS#: ***-**-7482

0488701 FASTING: Y
PHONE: 803-438-5047 DOB: 1/02/1961

PATIENT NAME	SEX	AGE(YR/MOS)
RAMEY,GAYLA R	F	49 / 3

PT. ADD.: [redacted]

DATE OF COLLECTION	TIME	DATE RECEIVED	DATE REPORTED	TIME	
4/19/2010	9:49	4/19/2010	4/20/2010	5:37	6897

CLINICAL INFORMATION
CD- 20138007951

PHYSICIAN ID.	NPI	PATIENT ID.
BROOKS A	1275573420	004646

ACCOUNT: Alice J Brooks MD Clincial Act
116 Standard Warehouse Road
LugoIT SC 29078-0000
ACCOUNT NUMBER: 39432640

	TEST	RESULT		LIMITS	LAB
	CBC With Differential/Platelet				
>	WBC	10.8H	x10E3/uL	4.0 - 10.5	01
	RBC	4.99	x10E6/uL	3.80 - 5.10	01
>	Hemoglobin	15.5H	g/dL	11.5 - 15.0	01
>	Hematocrit	44.7H	%	34.0 - 44.0	01
	MCV	90	fL	80 - 98	01
	MCH	31.1	pg	27.0 - 34.0	01
	MCHC	34.7	g/dL	32.0 - 36.0	01
	RDW	12.9	%	11.7 - 15.0	01
	Platelets	270	x10E3/uL	140 - 415	01
	Neutrophils	67	%	40 - 74	01
	Lymphs	23	%	14 - 46	01
	Monocytes	8	%	4 - 13	01
	Eos	1	%	0 - 7	01
	Basos	1	%	0 - 3	01
	Neutrophils (Absolute)	7.3	x10E3/uL	1.8 - 7.8	01
	Lymphs (Absolute)	2.5	x10E3/uL	0.7 - 4.5	01
	Monocytes(Absolute)	0.9	x10E3/uL	0.1 - 1.0	01
	Eos (Absolute)	0.1	x10E3/uL	0.0 - 0.4	01
	Baso (Absolute)	0.1	x10E3/uL	0.0 - 0.2	01
	Immature Granulocytes	0	%	0 - 1	01
	Immature Grans (Abs)	0.0	x10E3/uL	0.0 - 0.1	01
	Comp. Metabolic Panel (14)				
	Glucose, Serum	95	mg/dL	65 - 99	01
	BUN	9	mg/dL	5 - 26	01
	Creatinine, Serum	0.89	mg/dL	0.57 - 1.00	01
	eGFR	>59	mL/min/1.73	>59	
	eGFR AfricanAmerican	>59	mL/min/1.73	>59	
	Note: Persistent reduction for 3 months or more in an eGFR <60 mL/min/1.73 m2 defines CKD. Patients with eGFR values >/=60 mL/min/1.73 m2 may also have CKD if evidence of persistent proteinuria is present. Additional information may be found at www.kdoqi.org.				
	BUN/Creatinine Ratio	10		8 - 27	
	Sodium, Serum	140	mmol/L	135 - 145	01
	Potassium, Serum	3.8	mmol/L	3.5 - 5.2	01
	Chloride, Serum	103	mmol/L	97 - 108	01
	Carbon Dioxide, Total	24	mmol/L	20 - 32	01
	Calcium, Serum	9.5	mg/dL	8.7 - 10.2	01
	Protein, Total, Serum	6.8	g/dL	6.0 - 8.5	01

Pat Name: RAMEY,GAYLA R | Pat ID: 004646 | Spec #: 109-078-3340-0 | Seq #: 6897

Results are Flagged in Accordance with Age Dependent Reference Ranges
LCM Version: 03.23.00

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LabCorp Burlington
1447 York Court, Burlington, NC 27215-3361

Phone: 800-762-4344

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	Page #: 2
109-078-3340-0	S	BN	COMPLETE	

ADDITIONAL INFORMATION SS#: ***-**-7482

0488701 FASTING: Y
PHONE: 803-438-5047 DOB: 1/02/1961

PATIENT NAME	SEX	AGE(YR/MOS)
RAMEY,GAYLA R	F	49 / 3

PT. ADD.: [redacted]
[redacted] SC 29078-0000

DATE OF COLLECTION	TIME	DATE RECEIVED	DATE REPORTED	TIME	
4/19/2010	9:49	4/19/2010	4/20/2010	5:37	6897

CLINICAL INFORMATION
CD- 20138007951

PHYSICIAN ID.	NPI	PATIENT ID.
BROOKS A	1275573420	004646

ACCOUNT: Alice J Brooks MD Clincial Act
116 Standard Warehouse Road
Lugoff SC 29078-0000
ACCOUNT NUMBER: [redacted]9432640

TEST	RESULT		LIMITS	LAB
Albumin, Serum	4.3	g/dL	3.5 - 5.5	01
Globulin, Total	2.5	g/dL	1.5 - 4.5	
A/G Ratio	1.7		1.1 - 2.5	
Bilirubin, Total	0.4	mg/dL	0.1 - 1.2	01
Effective April 26, 2010, Bilirubin, Total, reference interval will be changing to:			mg/dL	
Newborns, term and near term:				
24 hours old:			0.0 - 8.0	
48 hours old:			0.0 - 13.2	
72 hours old:			0.0 - 15.6	
96 hours to 1 month old:			0.0 - 16.6	
Children 1 month and older and Adults:			0.0 - 1.2	
Panic value will be changed such that results >17.0 mg/dL will be called as panics.				
Alkaline Phosphatase, S	65	IU/L	25 - 150	01
AST (SGOT)	17	IU/L	0 - 40	01
ALT (SGPT)	23	IU/L	0 - 40	01
Lipid Panel With LDL/HDL Ratio				
Cholesterol, Total	134	mg/dL	100 - 199	01
Triglycerides	113	mg/dL	0 - 149	01
HDL Cholesterol	43	mg/dL	>39	01
Comment				
According to ATP-III Guidelines, HDL-C >59 mg/dL is considered a negative risk factor for CHD.				
VLDL Cholesterol Cal	23	mg/dL	5 - 40	
LDL Cholesterol Calc	68	mg/dL	0 - 99	
LDL/HDL Ratio	1.6	ratio units	0.0 - 3.2	

LAB: 01 BN LabCorp Burlington DIRECTOR: William F Hancock MD
1447 York Court, Burlington, NC 27215-3361

Pat Name: RAMEY,GAYLA R	Pat ID: 004646	Spec #: 109-078-3340-0	Seq #: 6897

Results are Flagged in Accordance with Age Dependent Reference Ranges
Last Page of Report

LCM Version: 03.23.00

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5/10/10 LAB RETRIEVE...AD

LabCorp

LabCorp Burlington CYTO
1447 York Court
Burlington NC 27215-3361
Phone: 800-222-7566

Specimen Number	Patient ID	Control Number	Account Number	Account Phone	Route
118-Y17-2055-0	004646	20138008045	39432640	803-438-6023	99

Patient Last Name: RAMEY
Patient First Name: GAYLA
Patient Middle Name: R
Patient SS#: ***-**-7482
Patient Phone: [redacted]
Total Volume:
Age (Y/M/D): 049/03/26
Date of Birth: 01/02/61
Sex: F
Fasting: No
Patient Address: [redacted]

Account Address
Alice J Brooks MD Clincial Act
116 Standard Warehouse Road
Lugoff SC 29078

Additional Information
CO-CSF2010-11820550
UPIN: E56897

Date/Time Collected	Date Entered	Date/Time Reported	Physician Name	NPI#	Physician ID
04/28/10 16:09 ET	04/28/10	05/03/10 05:35 ET	BROOKS, A	1275573420	

Tests Ordered:
Pap IG, HPV-hr

Clinician Provided ICD-9 & Clinical History: (01)
V76.2 ; Screening for malignant neoplasm of the cervix

Clinician Provided Cytology Information:
GYN Source:
Dates / Results LMP-01-10 LAST PAP-11-14-07
Number of Containers:01 TriPath Collection Vial

(01)
Diagnosis:
NEGATIVE FOR INTRAEPITHELIAL LESION AND MALIGNANCY.

Specimen Adequacy: (01)
Satisfactory for evaluation. Endocervical and/or squamous metaplastic cells (endocervical component) are present.

LabCorp Cytology History: (01)

	03/25/2004		
MALIGNANT			
HGSIL			
LGSIL			
AGUS			
ASCUS			
NEGATIVE	085-C99-0040-0		
OTHER			
UNSATISFACTORY			

(03)
HPV Results:
HPV, high-risk: NEGATIVE
This high-risk HPV test detects thirteen high-risk types (16/18/31/33/35/39/45/51/52/56/58/59/68) without differentiation.

(01)
Comments:
The Pap smear is a screening test designed to aid in the detection of premalignant and malignant conditions of the uterine cervix. It is not a diagnostic procedure and should not be used as the sole means of detecting cervical cancer. Both false-positive and false-negative reports do occur.

Test Methodology:
This liquid based SurePath(R) pap test was screened with the assistance of an image guided system.

PAP Performed by (02)
Shirley J McKellar, Supervisory Cytotechnologist (ASCP)

(01) S1	LabCorp Burlington CYTO	1447 York Court	Burlington NC 27215-3361	Lab: 800-222-7566	Dir: William F Hancock, MD
(02) GF	LabCorp Burlington Cytology	2039 Willow Springs Lane	Burlington NC 27215	Lab: 800-222-7566	Dir: Sandra Bigner, MD
(03) BN	LabCorp Burlington	1447 York Court	Burlington NC 27215-3361	Lab: 800-762-4344	Dir: William F Hancock, MD

For inquiries, the physician may contact the lab using the numbers indicated above:

RAMEY, GAYLA R	004646	118-Y17-2055-0	Seq #7023

FINAL REPORT

Page 1 of 1

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LabCorp Laboratory Corporation of America

LabCorp Burlington
1447 York Court, Burlington, NC 27215-3361
Phone: 800-762-4344

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	Page #: 1
295-078-3213-0	S	BN	COMPLETE	

ADDITIONAL INFORMATION SS#: ***-**-7482

CHT 0488701 FASTING: Y
PHONE: 803-295-0607 DOB: 1/02/1961

PATIENT NAME	SEX	AGE(YR/MOS)
RAMEY,GAYLA R	F	49 / 9

PT. ADD.: [redacted]

DATE OF COLLECTION TIME	DATE RECEIVED	DATE REPORTED	TIME	
10/22/2010 9:29	10/22/2010	10/23/2010	5:37	8720

CLINICAL INFORMATION
CD-20138009691

PHYSICIAN ID.	NPI	PATIENT ID.
BROOKS A	1275573420	004646

ACCOUNT: Alice J Brooks MD Clincial Act [redacted]
116 Standard Warehouse Road
Lugoff SC 29078-0000
ACCOUNT NUMBER: 39432640

	TEST	RESULT		LIMITS	LAB
	CBC With Differential/Platelet				
	WBC	8.6	x10E3/uL	4.0 - 10.5	01
	RBC	5.05	x10E6/uL	3.80 - 5.10	01
>	Hemoglobin	16.2H	g/dL	11.5 - 15.0	01
>	Hematocrit	47.1H	%	34.0 - 44.0	01
	MCV	93	fL	80 - 98	01
	MCH	32.1	pg	27.0 - 34.0	01
	MCHC	34.4	g/dL	32.0 - 36.0	01
	RDW	13.2	%	11.7 - 15.0	01
	Platelets	263	x10E3/uL	140 - 415	01
	Neutrophils	67	%	40 - 74	01
	Lymphs	24	%	14 - 46	01
	Monocytes	8	%	4 - 13	01
	Eos	1	%	0 - 7	01
	Basos	0	%	0 - 3	01
	Neutrophils (Absolute)	5.7	x10E3/uL	1.8 - 7.8	01
	Lymphs (Absolute)	2.1	x10E3/uL	0.7 - 4.5	01
	Monocytes(Absolute)	0.7	x10E3/uL	0.1 - 1.0	01
	Eos (Absolute)	0.1	x10E3/uL	0.0 - 0.4	01
	Baso (Absolute)	0.0	x10E3/uL	0.0 - 0.2	01
	Immature Granulocytes	0	%	0 - 1	01
	Immature Grans (Abs)	0.0	x10E3/uL	0.0 - 0.1	01
	Comp. Metabolic Panel (14)				
	Glucose, Serum	96	mg/dL	65 - 99	01
	BUN	11	mg/dL	5 - 26	01
	Creatinine, Serum	1.00	mg/dL	0.57 - 1.00	01
>	eGFR	59 L	mL/min/1.73	>59	
	eGFR AfricanAmerican	>59	mL/min/1.73	>59	

Note: Persistent reduction for 3 months or more in an eGFR <60 mL/min/1.73 m2 defines CKD. Patients with eGFR values >/=60 mL/min/1.73 m2 may also have CKD if evidence of persistent proteinuria is present. Additional information may be found at www.kdoqi.org.

	BUN/Creatinine Ratio	11		8 - 27	
	Sodium, Serum	143	mmol/L	135 - 145	01
	Potassium, Serum	3.9	mmol/L	3.5 - 5.2	01
	Chloride, Serum	103	mmol/L	97 - 108	01
	Carbon Dioxide, Total	25	mmol/L	20 - 32	01
	Calcium, Serum	9.3	mg/dL	8.7 - 10.2	01
	Protein, Total, Serum	6.6	g/dL	6.0 - 8.5	01

Pat Name: RAMEY,GAYLA R	Pat ID: 004646	Spec #: 295-078-3213-0	Seq #: 8720

Results are Flagged in Accordance with Age Dependent Reference Ranges
LCM Version: 03.25.00

Continued on Next Page

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LabCorp Burlington
1447 York Court, Burlington, NC 27215-3361

Phone: 800-762-4344

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	Page #: 2
295-078-3213-0	S	BN	COMPLETE	

ADDITIONAL INFORMATION SS#: ***-**-7482

CHT 0488701 FASTING: Y
PHONE: 803-295-0607 DOB: 1/02/1961

PATIENT NAME	SEX	AGE(YR./MOS.)
RAMEY,GAYLA R	F	49 / 9

PT. ADD.: [redacted]

DATE OF COLLECTION TIME	DATE RECEIVED	DATE REPORTED	TIME	
10/22/2010 9:29	10/22/2010	10/23/2010	5:37	8720

CLINICAL INFORMATION
CD- 20138009691

PHYSICIAN ID.	NPI	PATIENT ID.
BROOKS A	1275573420	004646

ACCOUNT: Alice J Brooks MD Clincial Acct
116 Standard Warehouse Road
Lugoff SC 2907[redacted]
ACCOUNT NUMBER: 39432640

TEST	RESULT		LIMITS	LAB
Albumin, Serum	4.4	g/dL	3.5 - 5.5	01
Globulin, Total	2.2	g/dL	1.5 - 4.5	
A/G Ratio	2.0		1.1 - 2.5	
Bilirubin, Total	0.5	mg/dL	0.0 - 1.2	01
Alkaline Phosphatase, S	71	IU/L	25 - 150	01
AST (SGOT)	13	IU/L	0 - 40	01
ALT (SGPT)	9	IU/L	0 - 40	01
Lipid Panel With LDL/HDL Ratio				
Cholesterol, Total	185	mg/dL	100 - 199	01
Triglycerides	69	mg/dL	0 - 149	01
HDL Cholesterol	53	mg/dL	>39	01
Comment				
According to ATP-III Guidelines, HDL-C >59 mg/dL is considered a negative risk factor for CHD.				
VLDL Cholesterol Cal	14	mg/dL	5 - 40	
LDL Cholesterol Calc	118 H	mg/dL	0 - 99	
LDL/HDL Ratio	2.2	ratio units	0.0 - 3.2	

LAB: 01 BN LabCorp Burlington DIRECTOR: William F Hancock MD
1447 York Court, Burlington, NC 27215-3361

Pat Name: RAMEY,GAYLA R	Pat ID: 004646	Spec #: 295-078-3213-0	Seq #: 8720

Results are Flagged in Accordance with Age Dependent Reference Ranges
LCM Version: 03.25.00

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4046
NOV 01 2010
4.27.11

KershawHealth Medical Center
Radiology Department
Haile and Roberts Streets
Camden, South Carolina 29020
(803)713-6531

Patient: RAMEY,GAYLA R
[redacted]8

Age: 49 Sex: F

DOB: 01/02/1961

Serv Dt/Tm: 10/27/10 / 1726
Loc: ELGRAD
Status: REG CLI

Ord Dr: BROOKS, ALICE MD MRN: M000209492
Rm/Bed: Acct #: K10000730899
Req #: 10-0045600

REASON FOR EXAMINATION: NODULE FOLLOW-UP

CHEST PA/LATERAL 10-27-10

Two views are compared with the study of 11-23-09 and reveals a nodule over the left lung base which could be the patient's nipple. Recommend a repeat PA view of the chest with nipple marker in place. Also a minimal oblique view with the nipple marker is recommended. No other acute cardiopulmonary disease is seen.

Repeat PA + oblique with nipple marker
AB

Electronically signed by:DONALD J COPLEY MD <<Signature on File>>

Trans by: APS
Trans date/time: 10/28/10 0823

Signed
cc:BROOKS,ALICE MD
Report #1028-0003

Additional copy
1

Pt aware 11.8.10
Referral Sent RB

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KershawHealth Medical Center
Radiology Department
Haile and Roberts Streets
Camden, South Carolina 29020
(803)713-6531

4646
NOV 1 1 2010
4.27.11

Patient: RAMEY,GAYLA R [redacted]

Age: 49 Sex: F

DOB: 01/02/1961

Serv Dt/Tm: 11/11/10 /
Loc: WWRAD
Status: REG CLI

Ord Dr: BROOKS, ALICE MD MRN: M000209492
Rm/Bed: Acct #: K10000735433
Req #: 10-0047987

REASON FOR EXAM: ABNORMAL PA/LAT CHEST

TWO VIEW CHEST 11-11-10

Comparison is made with 10-27-10 and reveals a nodular density over the left lung base which is not marked by the nipple marker and may be within the lung therefore chest CT is recommended for further evaluation.

IMPRESSION: NODULAR DENSITY OVER LEFT LOWER LUNG DOES NOT APPEAR TO BE NIPPLE THEREFORE CHEST CT IS RECOMMENDED FOR FURTHER EVALUATION. NO OTHER ACUTE CHANGES NOTED.

Electronically signed by:DONALD J COPLEY MD

Trans by: JAS
Trans date/time: 11/11/10 1240

11-12-10
Pt aware (AD)

Draft
cc:
Report #1111-0080

Draft copy

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11/11/2010 14:13 8034388832 W. WATEREE X-RAY PAGE 01/01

Pt 46#
427.11 EOV
NOV 17 2010

Patient: RAMEY,GAYLA R [redacted]8 Age: 49 Sex: F
DOB: 01/02/1961

Serv Dt/Tm: 11/16/10 / 1504 Ord Dr: BROOKS, ALICE MD MRN: M000209492
Loc: ELGRAD Rm/Bed: Acct #: K10000735948
Status: REG CLI Req #: 10-0048891

REASON FOR EXAMINATION: ABNORMAL CHEST RADIOGRAPH, LEFT LUNG NODULE

UNENHANCED CHEST CT 11-16-10

Multiple axial, coronal and sagittal images were made through the patient's chest without IV contrast enhancement. The thyroid gland is unremarkable. No supraclavicular or axillary adenopathy is seen. There are calcified nodes in the right and left hila and mediastinum consistent with old granulomatous disease. There is a calcified nodule in the left lung base felt to account for the nodular density noted on the chest radiograph. This is consistent with a granuloma and part of a Ghon's complex. This measures 14 mm in diameter. There is a small hiatal hernia present. There are some coronary artery calcifications are present.

IMPRESSION: OLD GRANULOMATOUS DISEASE WITH GHON'S COMPLEX ON THE LEFT. OTHER CALCIFIED MEDIASTINAL AND RIGHT HILAR ADENOPATHY IS SEEN. ATHEROSCLEROTIC CHANGES NOTED IN THE CORONARY ARTERIES. THERE IS PROBABLE MINIMAL SCARRING IN THE RIGHT MIDDLE LOBE. STATUS POST CHOLECYSTECTOMY. SMALL HIATAL HERNIA.

Electronically signed by:DONALD J COPLEY MD

Trans by: APS
Trans date/time: 11/16/10 1646

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Patient aware will recall if any symptoms 11.17.10 NB

ALICE J BROOKS MD PA
PO BOX 39
LUGOFF SC 29078
803 438 6023

PRESCRIPTION REPORT

PATIENT NO: 004646

ATIENT NAME: **RAMEY, GAYLA R**
DDRESS: [redacted]
H TEL: 8[redacted] WK TEL:
CCUPATION:
JARANTOR: RAMEY, GAYLA R

DOB: 01/02/1961 (50)

PT CHART #: **0488701**

ATE RX ISP TTD	MEDICINE REFILLS	PRINT	PRESCRIBING PROVIDER	DOSAGE/SIG
2/29/2010 TUBE	METROGEL VAGINAL 0	Y	001 BROOKS, ALICE J	1APPLICATOR QHS
.0/27/2010 :0 1	LOVASTATIN 5	Y	001 BROOKS, ALICE J	40MG TAKE IN PM
.0/27/2010 30 1	HCTZ 5	Y	001 BROOKS, ALICE J	25MG
10/27/2010 30 1	FLEXERIL 5	2	001 BROOKS, ALICE J	10MG TAKE ONE QHS

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803 438 6023

MEDICAL RECORDS INFORMATION

PATIENT NAME: **RAMEY, GAYLA R** PATIENT NO: **004646**

OFFICE VISIT ON 12/29/2010
ENTERED BY: DRBROOKS

PROVIDER: BROOKS, ALICE J

**********CHIEF COMPLAINT**********
REASON FOR TODAY'S VISIT: C/O VAGINAL BLEEDING ON 12/13/10 - 12/19/20. SPOTTING ON 12/20/10. INTERCOURSE ON 12/21/10 AND HAD INCREASED BRIGHT RED BLOOD AFTER THIS AND ON 12/23/10, SHE HAD A BROWNISH COLOR DISCHARGE W/ ODOR. HAS NOT HAD A CYCLE OTHER THAN SPOTTING IN MAY 2010 FOR 4-5 DAYS. SHE HAS DISCOMFORT IN HER PELVIC AREA, HEADACHE, SOME DIZZINESS. THE 1ST DIZZY EPISODE WAS PRIOR TO 12/13/10 AND SHE HAS HAD 3-4 EPISODES SINCE. HOWEVER THE HEADACHES HAVE BEEN EVERYDAY AND THIS IS NOT USUAL FOR HER. SHE WANTS TO MAKE SURE SHE DOES NOT HAVE AN INFECTION.

**********PMHX**********
NO CHANGE IN PMHX, FMHX, SOC.HX, EXCEPT AS NOTED IN CC.
**********ROS**********
NEGATIVE EXCEPT AS DESCRIBED IN CC AND HPI
**********PE**********
HEART: RRR NORMAL S1 AND S2, NO MURMUR, GALLOP, CLICK OR RUB HEARD
LUNGS: CLEAR TO AUSCULTATION
ABD: SOFT NON TENDER, NO HSM, NORMAL BS
PELVIC NORMAL EXTERNAL
NORMAL INTERNAL
NO SIGN OF BLOOD
WET PREP NEGATIVE
DX:BV
TX:METRONIDADOLE VAG

PT INFORMED OF MESSAGE CENTER FOR ANY LAB/X-RAY REPORTS OR SCHEDULED APPOINTMENTS.
AB

SIGNATURE: _____

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VITAL SIGNS ON 12/29/2010
ENTERED BY: AMY

PROVIDER: BROOKS, ALICE J

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803 438 6023

MEDICAL RECORDS INFORMATION

PATIENT NAME: **RAMEY, GAYLA R** PATIENT NO: **004646**

VITAL SIGNS
BLOOD PRESSURE: 102/60-L
WEIGHT:153

SIGNATURE: _____

FLU VACCINE ON 11/16/2010
ENTERED BY: DIANA
PROVIDER: BROOKS, ALICE J

MAN:SANOFI PASTEUR
LOT:U3727AA
EXP:30JUN11
SITE:0.5CC IM LD

INITIALS:DG

SIGNATURE: _____

OUTBOUND REFERRALS ON 11/12/2010
ENTERED BY: AMY
PROVIDER: BROOKS, ALICE J

REFERRAL
FOR:CT CHEST
DX: ABN CHEST XRAY 11/11/10; LEFT LUNG NODULE
COMMENTS: APPOINTMENT 11/16/10 @ 3:00PM

SIGNATURE: _____

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OUTBOUND REFERRALS ON 11/09/2010
ENTERED BY: BECKY
PROVIDER: BROOKS, ALICE J

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803 438 6023

MEDICAL RECORDS INFORMATION

PATIENT NAME: **RAMEY, GAYLA R** PATIENT NO: 004646

REFERRAL
FOR:REPEAT PA + OBLIQUE CHEST X RAY WITH NIPPLE MARKER
DX:ABNORMAL PA/LATERAL
COMMENTS:THE PATIENT IS TO HAVE X RAY DONE EITHER 11.9.10 OR 11.10.10 DUE TO WORK SCHEDULE. PATIENT AWARE. RB

SIGNATURE: _____

OFFICE VISIT ROUTINE ON 10/27/2010
PROVIDER: BROOKS, ALICE J ENTERED BY: DRBROOKS

REASON FOR OV
THE PATIENT PRESENTS TODAY FOR:
FOLLOW UP OF LIPIDS.FOLLOW UP OF LABS.HEALTH MAINTENANCE AND REVIEW OF MEDICAL PROBLEMS.
THE PATIENT COMPLAINS OF: HAS BEEN OFF ALL OF HER MEDICATIONS X 3 MOS. SHE IS REQUESTING REFILLS TODAY PARTICULARLY ON HCTZ DUE TO SHE HAS BEEN RETAINING FLUID.

REVIEW OF SYSTEMS

THE REMAINDER OF THE ROS IS BENIGN.

REVIEW OF PAST HISTORY
THE PATIENTS PAST MEDICAL HISTORY WAS REVIEWED AND FOUND TO BE UNCHANGED.
THE SOCIAL HISTORY WAS FOUND TO BE UNCHANGED.
THE FAMILY HISTORY WAS UNCHANGED.

OBJECTIVE

HEART:
NORMAL S1 AND S2 WERE HEARD. NO MURMUR OR GALLOP NOTED.
LUNGS:
THE LUNGS ARE CLEAR TO AUSCULTATION. NO WHEEZES RALES OR RHONCHI NOTED.
dx: NICOTINE ADDICTION; LUNG NODULE; POLYCYTHEMIA
TX: LAB/EOV
PT TO RESTART MEDS
AB

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MEDICAL RECORDS INFORMATION

PATIENT NAME: **RAMEY, GAYLA R** PATIENT NO: 004646

SIGNATURE: _____

VITAL SIGNS ON 10/27/2010
ENTERED BY: AMY

PROVIDER: BROOKS, ALICE J

VITAL SIGNS
BLOOD PRESSURE: 108/70-L
WEIGHT:150

SIGNATURE: _____

EOV ON 04/28/2010
ENTERED BY: DRBROOKS

PROVIDER: BROOKS, ALICE J

Date Created: 4/28/10

Chart Number: 0488701
Patient Name: Ramey, Gayla R
DOB: 01/02/1961 Sex: Female
Ethnic Origin: WHITE, NON-HISPANIC
Doctor: ALICE J. BROOKS M.D.

**********CHIEF COMPLAINT**********
EXTENDED OV, PAP SMEAR AND CLINICAL BREAST EXAM

LABS -- DISCUSSED
**********REVIEW OF SYSTEMS**********
THIS PATIENT DENIES FEVER, HA, PND, ALLERGIES, ST, COUGH, FATIGUE, SOB, CHEST PAIN, N/V/C/D, URINARY SYMPTOMS, SWELLING OR NEUROLOGIC CHANGES.

**********PATIENT HISTORY**********
ALLERGIES: NKDA

CHILDHOOD ILLNESSES:ALL ROUTINE

ADULT ILLNESSES: MENORRHAGIA, HYPERLIPIDEMIA, INSOMNIA, DEPRESSION, COPD, HYPOKALEMIA-RESOLVED, TOBACCO DEPENDENCE

INJURIES/FX'S: FX PINKY

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MEDICAL RECORDS INFORMATION

PATIENT NAME: **RAMEY, GAYLA R** PATIENT NO: 004646

SURGERIES: UTERINE POLYP REMOVED 1994, GALLBLADDER REMOVED 10/18/07

HOSPITALIZATIONS: RESPIRATORY INFECTION AND CHILDBIRTH

CURRENT MEDICATIONS: LOVASTATIN 40MGS,HCTZ 25MGS, FLEXERIL 10MGS, ALEVE PRN

LMP: 3-4 MTHS AGO
MENARCHE:11
LAST PAP SMEAR 11/14/07 3-4 NEGATIVE
LAST MAMMOGRAM: 09/01/06 NEGATIVE

HX OF ABNORMAL PAP SMEARS: NO
HX OF ABNORMAL MAMMOGRAMS: NO

G 5 P4 A1 MISCARRIAGE
PREGNANCY HISTORY:
FULL TERM: 4
SVD: 4
COMPLICATIONS WITH PREGNANCY: NO
AGE AT FIRST PREGNANCY: 15
BREAST FEED: TRIED WITH 3RD

BIRTH CONTROL METHOD: VASECTOMY
H/O STD'S: NO

IMMUNIZATIONS:
YEARLY FLU VACCINE: 11/13/2007
PNEUMOVAX: 2004
HEP B SERIES: YES
LAST TETANUS INJ (WITHIN 10 YEARS): 9/11/2006

LAST EYE EXAM: LONG TIME
LAST DENTAL EXAM: UNKNOWN

BONE DENSITY SCAN: NONE

COLONOSCOPY: NONE

PROBLEMS WITH VOIDING: NONE

**********FAMILY HISTORY**********
HX OF FEMALE RELATED CANCER: MOTHER UTERINE OR CERVICAL CANCER
FAMILY HX OF OSTEOPOROSIS: MOTHER AND MATERNAL GRANDMOTHER
MOTHER: DECEASED AGE 65, HTN, COPD, CHF, CARDIAC, UTERINE OR CERVICAL CA AT AGE 29; OSTEOPOROSIS
FATHER: 69 HTN

SIBLINGS: 1 BROTHER-HEALTHY; 2 SISTERS ONE HAD BREAST BIOPSY

MGM: DECEASED OSTEOPOROSIS
MGF: DECEASED 45 SUICIDE UNSURE
PGM: DECEASED DM
PGF: DECEASED STROKE

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MEDICAL RECORDS INFORMATION

PATIENT NAME: **RAMEY, GAYLA R** PATIENT NO: 004646

**********SOCIAL HISTORY**********
TOBACCO USE: YES 1-1.5 PPD 28-30 YRS
ETOH: NO
RECREATIONAL DRUG USE: NO TYPE:
CAFFEINE INTAKE: DRINKING DECAFF FOR FEW MONTHS
EXERCISE: NO
EMPLOYED: RIDGEWAY HEALTH AND REHAB
MARITAL STATUS: MARRIED
LIVING ARRANGEMENTS: LIVES WITH HUSBAND AND YOUNGEST CHILD 4 GRANDCHILDREN AND 2 MIDDLE DAUGHTERS
**********PHYSICAL**********
NEURO: THE PATIENT IS WELL DEVELOPED. A&O X3, PLEASANT AFFECT. CRANIAL NERVE II-XII INTACT TO INCLUDE DTR'S AND SENSATION. SENSE OF TASTE NOT TESTED.

HEAD: HEAD IS ATRAUMATIC AND NORMOCEPHALIC, HELD MIDLINE & ERECT WITH FEATURES SYMMETRIC. SCALP MOVES FREELY UNDER EXAMINING FINGERS. NO TENDERNESS NOTED. TEMPORAL ARTERIES PALPABLE BUT NOT THICKENED. NO DEFECTS OR DEFORMITIES NOTED.

EYES: PATIENT DENIES PAIN, DISCOMFORT, ITCHING, BLURRED VISION, OR DOUBLE VISION. PUPILS ARE EQUAL, ROUND & REACTIVE TO LIGHT AND ACCOMODATION. EXTRA OCULAR MOVEMENTS INTACT. PERIPHERAL VISION INTACT AT 75 DEGREES BILATERALLY. INSPECTION OF LIDS AND CONJUNCTIVAE WITHIN NORMAL LIMITS.

EARS: AURICLE IN ALIGNMENT, NO MASSES, LESIONS, SCARS OR TENDERNESS NOTED. EXTERNAL AUDITORY CANALS UNOBSTRUCTED. TYMPANIC MEMBRANES ARE TRANSLUCENT PEARLY GREY IN COLOR, INTACT, MOBILE, GOOD LIGHT REFLEX AND BONY LANDMARKS PRESENT.
WHISPER TEST, WEBER AND RINNE WITHIN NORMAL LIMITS, MIDLINE, NONLATERALIZING AND AIR > BONE CONDUCTION.

NOSE: NO DISCHARGE OR POLYPS, MUCOSA PINK AND MOIST, SEPTUM MIDLINE AND PATENT BILATERALLY, TURBINATES CLEAR. NO ERYTHEMA OR PURULENCE WAS NOTED. NO FRONTAL OR MAXILLARY TENDERNESS ON PALPATION OR PERCUSSION.

MOUTH: LIPS ARE SYMMETRICAL, COLOR PINK, WITHOUT EDEMA OR SURFACE ABNORMALITIES. BUCCAL MUCOSA PINK AND MOIST WITHOUT LESIONS, GINGIVAE RED AND BOGGY; TONGUE MIDLINE; NO LESIONS OR TREMORS. TEETH IN GOOD REPAIR. HARD AND SOFT PALATE INSPECTED NO OBVIOUS ABNORMALITIES NOTED.

THROAT: UVULA RISES EVENLY, OROPHARYNX PINK AND MOIST WITHOUT EXUDATE OR ERYTHEMA, NO HOARSENESS. ENUCIATES WORDS CLEARLY.

NECK: TRACHEA MIDLINE. THE NECK IS SUPPLE, NON-TENDER, WITHOUT JVD OR BRUITS. FULL RANGE OF MOTION. THERE IS NO ADENOPATHY OR THYROMEGALY PRESENT. THYROID IS SMOOTH, SOFT, NON-TENDER, & MOVES FREELY WHEN PATIENT SWALLOWS.

LUNGS: CLEAR TO AUSCULTATION AND PERCUSSION. NO RALES, RHONCHI, OR WHEEZES WERE HEARD. VESICULAR BREATH SOUNDS OVER PERIPHERAL LUNG TISSUE. NON LABORED AND EVEN EFFORT. NO INCREASED OR DIMINISHED TACTILE FREMITUS

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MEDICAL RECORDS INFORMATION

PATIENT NAME: **RAMEY, GAYLA R** PATIENT NO: 004646

NOTED.

HEART: NORMAL S1,S2 REGULAR RATE AND RHYTHM WITHOUT CLICKS GALLOPS, RUBS, OR MURMURS. PMI IS AT THE LMC LINE.

VASCULAR: PULSES IN ALL FOUR EXTREMITIES +3, NO JUGULAR VEIN DISTENTION NOTED, CAPILLARY REFILL 1-2 SECONDS, NO PITTING EDEMA OR SWELLING OF EXTREMITIES NOTED. NO BRUITS AUDIBLE.

BREASTS: PALPATION WITHOUT MASSES, DIMPLES OR AXILLARY ADENOPATHY. SYMMETRICAL SHAPE AND SIZE. NO DISCHARGE FROM NIPPLES.

ABDOMEN: VISUAL INSPECTION OF ABDOMEN WITHOUT MASSES OR LESIONS NOTED. NORMAL BOWEL SOUNDS, NO HEPATO-SPLEENMEGALY NOTED. NO TENDERNESS TO PALPATION. NO GUARDING OR REBOUND. NORMAL TO PERCUSSION. THE PATIENT WAS EVALUATED AND NO HERNIAS PRESENT.

GENITOURINARY: HAIR DISTRIBUTION IS WITHIN NORMAL LIMITS. BLADDER IS WITHOUT FULLNESS, MASSES OR TENDERNESS. THE ORIFICE OF THE URETHRA IS WITHOUT MASSES, TENDERNESS OR SCARING. THE VAGINA IS NORMAL IN COLOR AND RUGGAE. NO LESIONS OR MASSES ARE SEEN. THE UTERUS IS NORMAL IN SIZE, SHAPE AND CONSISTENCY. THERE IS NO CERVICAL MOTION TENDERNESS. THE CERVICAL OS IS WITHOUT LESIONS OR MASSES. cyst NO ADNEXAL TENDERNESS TO PALPATION. NO RECTOCELE OR CYSTOCELE PRESENT.

RECTUM: MANUALLY EVALUATED AND FOUND TO HAVE NORMAL TONE AND NO MASSES. THE PATIENT'S STOOL WAS IMMUNOASSAY NEGATIVE. NO HEMORRHOID NOTED.

MUSCOLOSKELETAL: NORMAL GAIT NOTED. POSTURE STRAIGHT, WITHOUT SCOLIOSIS. MUSCLES & EXTREMITIES SYMMETRIC. MUSCLE STRENGTH APPROPRIATE AND EQUAL BILATERALLY. ACTIVE RANGE OF MOTION.

JOINTS: NORMAL SIZE AND CONTOUR, FULL RANGE OF MOTION, NO REDNESS OR SWELLING. NO EVIDENCE OF INJURY. NO CLICKS, LOCKING, OR LIMITED EXTENSION NOTED.

SKIN: APPROPRIATE COLOR FOR RACE. WARM & DRY W/O LESIONS OR DEFORMITIES.

MONOFILAMENT EXAM NORMAL

DX: MENORRHAGIA, HYPERLIPIDEMIA, INSOMNIA, DEPRESSION, COPD, HYPOKALEMIA-RESOLVED, TOBACCO DEPENDENCE, EOV WITH PAP, CLINICAL BREAST EXAM

PLAN:LAB/OV 6 MOS
AB

PT AWARE OF MESSAGE CENTER FOR X-RAY/LAB RESULTS OR SCHEDULED APPOINTMENTS

ALICE J BROOKS MD PA
PO BOX 39
LUGOFF SC 29078
803 438 6023

MEDICAL RECORDS INFORMATION

PATIENT NAME: **RAMEY, GAYLA R** PATIENT NO: 004646

SIGNATURE: _____

VITAL SIGNS ON 04/28/2010
ENTERED BY: DIANA

PROVIDER: BROOKS, ALICE J

VITAL SIGNS
BLOOD PRESSURE:120/70
WEIGHT:159
HEIGHT:67.5

SIGNATURE: _____

OUTBOUND REFERRALS ON 04/28/2010
ENTERED BY: DIANA

PROVIDER: BROOKS, ALICE J

REFERRAL
FOR:MAMMOGRAM
DX:SCREENING
COMMENTS: PT CAN WALK IN ON TUES,THURS,FRI BETWEEN 8.00AM AND 4.30PM.NO DEODORANT, BODY LOTION OR TALC TO APPT.

SIGNATURE: _____

OFFICE VISIT ON 04/16/2010
ENTERED BY: AMY

PROVIDER: BROOKS, ALICE J

**********CHIEF COMPLAINT**********
REASON FOR TODAY'S VISIT:C/O PAIN IN RIGHT SHOULDER UP INTO THE BACK OF NECK. PAIN IS CONSTANT. THE BURNING SENSATION BECOMES INTENSE SHE STATES. ABOUT A WEEK AND A HALF AGO IT STARTED. PROGRESSIVELY PAIN HAS GOTTEN WORSE .OTC HEAT PATCHES, IBUPROFEN

ALICE J BROOKS MD PA
PO BOX 39
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803 438 6023

MEDICAL RECORDS INFORMATION

PATIENT NAME: **RAMEY, GAYLA R** PATIENT NO: **004646**

**********PMHX**********
NO CHANGE IN PMHX, FMHX, SOC.HX, EXCEPT AS NOTED IN CC.
**********ROS**********
NEGATIVE EXCEPT AS DESCRIBED IN CC AND HPI
**********PE**********
NECK SUPPLE
RIGHT TRAPEZIUS TENDER WITH PALPABLE MUSCLE SPASM REPRODUCING PAIN
PROCEDURE: PREPPED WITH ALCOHOL, 80MG DEPO-MEDROL, 1CC LIDOCAINE
INJECTED; GOOD RESULT
PT RELATED PAIN IMPROVEMENT

HEART: RRR NORMAL S1 AND S2, NO MURMUR, GALLOP, CLICK OR RUB HEARD
LUNGS: CLEAR TO AUSCULTATION
ABD: SOFT NON TENDER, NO HSM, NORMAL BS

DX:TRAPEZIUS SPASM
TX: TRIGGER POINT INJECTION
FLEXERIL 10MG; HEAT & ICE ALTERNATING; PT DUE FOR LABS/EOV.

PT INFORMED OF MESSAGE CENTER FOR ANY LAB/X-RAY REPORTS OR SCHEDULED APPOINTMENTS.

SIGNATURE: _____

VITAL SIGNS ON 04/16/2010 ENTERED BY: BECKY

PROVIDER: BROOKS, ALICE J

VITAL SIGNS
BLOOD PRESSURE:122/74
WEIGHT:165

SIGNATURE: _____

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MEDICAL RECORDS INFORMATION

PATIENT NAME: **RAMEY, GAYLA R** PATIENT NO: **004646**

OFFICE VISIT ROUTINE ON 12/12/2008 ENTERED BY: DRBROOKS

PROVIDER: BROOKS, ALICE J

REASON FOR OV

THE PATIENT PRESENTS TODAY FOR:
FOLLOW UP OF HYPERTENSION.FOLLOW UP OF LIPIDS.FOLLOW UP OF LABS.HEALTH MAINTENANCE AND REVIEW OF MEDICAL PROBLEMS.
THE PATIENT COMPLAINS OF: HAVING MENSTRUAL CYCLE THAT STARTED ON 11/18/08 THAT WAS SPOTTING FOR FIRST 4 DAYS. THEN BLEEDING HEAVILY FOR TWO WEEKS. TWO DAYS AGO WAS DOWN TO SPOTTING AND NOW TODAY NOTHING. STATES SHE DID HAVE SOME LOWER BACK PAIN WITH THE HEAVIER BLEEDING. SOME PRESSURE WITH URINATING. STATES SHE JUST FEELS DRAINED.

REVIEW OF SYSTEMS

THE REMAINDER OF THE ROS IS BENIGN.

REVIEW OF PAST HISTORY

THE PATIENTS PAST MEDICAL HISTORY WAS REVIEWED AND FOUND TO BE UNCHANGED.
THE SOCIAL HISTORY WAS FOUND TO BE UNCHANGED.
THE FAMILY HISTORY WAS UNCHANGED.

OBJECTIVE

HEART:
NORMAL S1 AND S2 WERE HEARD. NO MURMUR OR GALLOP NOTED.
LUNGS:
THE LUNGS ARE CLEAR TO AUSCULTATION. NO WHEEZES RALES OR RHONCHI NOTED.
ABD:NORMAL BOWEL SOUNDS
SEVERAL SCALING LESIONS ON BUTTOCK ELBOW AND LEGS LOOK C/W PSORIASIS
+1 PITTING EDEMA
DX: MENOPAUSAL SXMS, MENORRHAGIA, HYPERLIPIDEMIA

TX:REFER TO GYN KRAEMER FOR POSSIBLE ENDOMETRIAL ABLATION
RESTART LOVASTSTIN
INCREASE HCTZ
AB

ELECTRONICALLY SIGNED BY Alice J. Brooks MD

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MEDICAL RECORDS INFORMATION

PATIENT NAME: **RAMEY, GAYLA R** PATIENT NO: 004646

VITAL SIGNS ON 12/12/2008
ENTERED BY: AMY

PROVIDER: BROOKS, ALICE J

VITAL SIGNS
BLOOD PRESSURE:128/88-L
WEIGHT:182

ELECTRONICALLY SIGNED BY Alice J. Brooks MD

OUTBOUND REFERRALS ON 12/12/2008
ENTERED BY: KELLIE

PROVIDER: BROOKS, ALICE J

REFERRAL
FOR:EVALUATION FOR MENORRHAGIA/POSSIBLE ENDOMETRIAL ABLATION
DX:MENORRHAGIA
COMMENTS:YOUR APPOINTMENT IS ON 12/23/08 @ 2:00PM. IF YOU HAVE ANY QUESTIONS REGARDING THIS APPOINTMENT PLEASE CALL 438-3800. CALL PT WITH APT.LMTRC

12/18/08 PATIENT AWARE OF APPT DATE & TIME. . .KM

ELECTRONICALLY SIGNED BY Alice J. Brooks MD

FLU VACCINE ON 11/28/2008
ENTERED BY: BECKY

PROVIDER: BROOKS, ALICE J

MAN:SANOFI PASTEUR
LOT:U2747AA
EXP:30JUN09
SITE:0.5CC IM LD

9B

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MEDICAL RECORDS INFORMATION

PATIENT NAME: **RAMEY, GAYLA R** PATIENT NO: **004646**

INITIALS:RB

ELECTRONICALLY SIGNED BY Alice J. Brooks MD

OFFICE VISIT ON 11/04/2008 ENTERED BY: DRBROOKS

PROVIDER: BROOKS, ALICE J

**********CHIEF COMPLAINT**********
REASON FOR TODAY'S VISIT: MENSTRUAL CYCLES HAVE GOTTEN IRREGULAR. HAS BEEN 2 MOS SINCE LAST CYCLE. PREVIOUSLY HAD HOT/COLD FLASHES, BUT THAT HAS SUBSIDED.
NONE FOR 2 MOS.
ALSO WANTS TO STOP SMOKING
ALSO NOTED EDEMA
**********PMHX**********
NO CHANGE IN PMHX, FMHX, SOC.HX, EXCEPT AS NOTED IN CC.
**********ROS**********
NEGATIVE EXCEPT AS DESCRIBED IN CC AND HPI
**********PE**********
HEART: RRR NORMAL S1 AND S2, NO MURMUR, GALLOP, CLICK OR RUB HEARD
LUNGS: CLEAR TO AUSCULTATION
+ 1 PITTING EDEMA
DX:MENOPAUSAL, NICOTINE ADDICTION, HTN
TX:CHANTIX, HCTZ
DISCUSSED MENOPAUSE AND RISK OF BLEEDING
AB

PT INFORMED OF MESSAGE CENTER FOR ANY LAB/X-RAY REPORTS OR SCHEDULED APPOINTMENTS.

ELECTRONICALLY SIGNED BY Alice J. Brooks MD

VITAL SIGNS ON 11/04/2008 ENTERED BY: AMY

PROVIDER: BROOKS, ALICE J

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MEDICAL RECORDS INFORMATION

PATIENT NAME: **RAMEY, GAYLA R** PATIENT NO: 004646

VITAL SIGNS
BLOOD PRESSURE:142/84-L
WEIGHT:183

ELECTRONICALLY SIGNED BY Alice J. Brooks MD

OFFICE VISIT ON 09/19/2008
PROVIDER: BROOKS, ALICE J ENTERED BY: AMY

**********CHIEF COMPLAINT**********
REASON FOR TODAY'S VISIT: FORMS FOR NURSING SCHOOL
GOING FOR RN
ALSO NOTES INTERMITTENT COUGH
PT HAS KNOWN POSITIVE PPD
SHE HAD TREATMENT YEARS AGO
HAD A POSITIVE PPD 1 MONTH AGO
WILL NEED CXR FOR COUGH AND POSITIVE PPD
**********PMHX**********
NO CHANGE IN PMHX, FMHX, SOC.HX, EXCEPT AS NOTED IN CC.
**********ROS**********
NEGATIVE EXCEPT AS DESCRIBED IN CC AND HPI
**********PE**********
EARS: TM'S CLEAR, GOOD LIGHT REFLEX.
THROAT: PINK AND MOIST
ADENOPATHY: NONE
HEART: RRR NORMAL S1 AND S2, NO MURMUR, GALLOP, CLICK OR RUB HEARD
LUNGS: CLEAR TO AUSCULTATION

DX:OK FOR NURSING; INTERMITTENT COUGH
TX: GET CXR PA AND LAT

PT INFORMED OF MESSAGE CENTER FOR ANY LAB/X-RAY REPORTS OR SCHEDULED APPOINTMENTS.
AB

100

ELECTRONICALLY SIGNED BY Alice J. Brooks MD

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MEDICAL RECORDS INFORMATION

PATIENT NAME: **RAMEY, GAYLA R** PATIENT NO: 004646

VITAL SIGNS ON 09/19/2008 ENTERED BY: AMY

PROVIDER: BROOKS, ALICE J

VITAL SIGNS
BLOOD PRESSURE:146/84
WEIGHT:174

ELECTRONICALLY SIGNED BY Alice J. Brooks MD

WORK AND SCHOOL EXCUSE ON 04/07/2008 ENTERED BY: BRENDA

PROVIDER: BROOKS, ALICE J

EXCUSE
THIS PATIENT WAS OUT OF SCHOOL/WORK ON THE FOLLOWING DAYS:04/07/08

THEY MAY RETURN TO SCHOOL/WORK ON:04/08/08

THIS EXCUSE MAY NOT BE EXTENDED WITHOUT FIRST CONTACTING OUR OFFICE.

ALICE J. BROOKS, MD

PATRICIA BURTON, FNP

ELECTRONICALLY SIGNED BY Alice J. Brooks MD

VITAL SIGNS ON 04/07/2008 ENTERED BY: BRENDA

PROVIDER: BROOKS, ALICE J

VITAL SIGNS
BLOOD PRESSURE:112/80
WEIGHT:184

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ALICE J BROOKS MD PA
PO BOX 39
LUGOFF SC 29078
803 438 6023

MEDICAL RECORDS INFORMATION

PATIENT NAME: **RAMEY, GAYLA R** PATIENT NO: 004646

ELECTRONICALLY SIGNED BY Alice J. Brooks MD

OFFICE VISIT ON 04/07/2008

PROVIDER: BROOKS, ALICE J ENTERED BY: DRBROOKS

**********CHIEF COMPLAINT**********
REASON FOR TODAY'S VISIT:NECK AND BACK PAIN. THE PAIN RADIATES INTO RIGHT SHOULDER. BURNING PAIN. WORSE WITH FORWARD FLEXION. ALSO WORSE IN AM. OCCAISIONAL FLEXION CAUSES BILAT HEAT SENSATION. 2 WEEKS DURATION. GETTING WORSE.
TRIED NAPROXEN....SLIGHT HELP.
STRETCHING EXERCISES
**********PMHX**********
NO CHANGE IN PMHX, FMHX, SOC.HX, EXCEPT AS NOTED IN CC.
**********ROS**********
NEGATIVE EXCEPT AS DESCRIBED IN CC AND HPI
**********PE**********
FORWARD FLEXION NOT ABLE TO TOUCH CHIN TO CHEST
RETROFLEXION INCREASES PAIN RIGHT TRAPEZIUS AREA
LATERAL FLEXION NOT AS BAD
SOME CREPITUS WITH ROTATION AND RIGHT SIDE PULLS INTO SHOULDER
SPASM IN RIGHT TRAPEZIUS PALPABLE TRIGGER POINT
80MG DEPO MEDROL WITH LIDOCAINE INJECTED INTO TRIGGER POINT
SOME IMPROVEMENT S/P INJ
DX: TRAPEZIUS SPASM/TRIGGER POINT INJECTION
TX: PT INFORMED OF MESSAGE CENTER FOR ANY LAB/X-RAY REPORTS OR SCHEDULED APPOINTMENTS.
FLEXERIL AND NAPROXEN
AB

ELECTRONICALLY SIGNED BY Alice J. Brooks MD

OUTBOUND REFERRALS ON 11/14/2007

PROVIDER: BURTON, PATRICIA D ENTERED BY: BRENDA

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ALICE J BROOKS MD PA
PO BOX 39
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803 438 6023

MEDICAL RECORDS INFORMATION

PATIENT NAME: **RAMEY, GAYLA R** PATIENT NO: 004646

REFERRAL
FOR:MAMMOGRAM
DX:SCREENING MAMMOGRAM
COMMENTS:YOU MAY CALL OR WALK IN FOR AN APPT MON-FRI 9-5PM THEIR TELEPHONE NUMBER IS 436-3680.BB

ELECTRONICALLY SIGNED BY Alice J. Brooks MD

VITAL SIGNS ON 11/14/2007 ENTERED BY: BRENDA
PROVIDER: BURTON, PATRICIA D

VITAL SIGNS
BLOOD PRESSURE:126/76
WEIGHT:180 1/2
HEIGHT: 67 1/2IN
VISION: LT 20/20
RT 20/20
WITHOUT CORRECTION

ELECTRONICALLY SIGNED BY Alice J. Brooks MD

EOV ON 11/14/2007 ENTERED BY: DIANA
PROVIDER: BURTON, PATRICIA D

Date Created: 11/14/07

Chart Number: 0488701
Patient Name: Ramey, Gayla R
DOB: 01/02/1961 Sex: Female
Ethnic Origin: WHITE, NON-HISPANIC
Doctor: ALICE J. BROOKS M.D.

**********CHIEF COMPLAINT**********
EXTENDED OV, PAP SMEAR AND CLINICAL BREAST EXAM

LABS -- DISCUSSED
**********REVIEW OF SYSTEMS**********
THIS PATIENT DENIES FEVER, HA, PND, ALLERGIES, ST, COUGH, FATIGUE, SOB,

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ALICE J BROOKS MD PA
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MEDICAL RECORDS INFORMATION

PATIENT NAME: **RAMEY, GAYLA R** PATIENT NO: 004646

CHEST PAIN, N/V/C/D, URINARY SYMPTOMS, SWELLING OR NEUROLOGIC CHANGES. ALL OTHER SYSTEMS NEGATIVE.
MENSTRUAL CYCLES ARE CHANGING LAST TIME SPOTTED, HAS SOME HOT FLASHES, SLEEPING WELL, DID NOT START CHANTIX

**********PATIENT HISTORY**********

ALLERGIES: NKDA

CHILDHOOD ILLNESSES: ALL ROUTINE

ADULT ILLNESSES: MENORRHAGIA, HYPERLIPIDEMIA, INSOMNIA, DEPRESSION, COPD, HYPOKALEMIA-RESOLVED, TOBACCO DEPENDENCE

INJURIES/FX'S: FX PINKY

SURGERIES: UTERINE POLYP REMOVED 1994, GALLBLADDER REMOVED 10/18/07

HOSPITALIZATIONS: RESPIRATORY INFECTION AND CHILDBIRTH

CURRENT MEDICATIONS: ZOLOFT, LOVASTATIN

LMP: 10/25/07
MENARCHE: 11
LAST PAP SMEAR 9/11/2006 NEGATIVE
LAST MAMMOGRAM: 09/01/06 NEGATIVE

HX OF ABNORMAL PAP SMEARS: NO
HX OF ABNORMAL MAMMOGRAMS: NO
G 5 P4 A1 MISCARRIAGE
PREGNANCY HISTORY:
FULL TERM: 4
SVD: 4
COMPLICATIONS WITH PREGNANCY: NO
AGE AT FIRST PREGNANCY: 15
BREAST FEED: TRIED WITH 3RD

BIRTH CONTROL METHOD: VASECTOMY
H/O STD'S: NO

IMMUNIZATIONS:
YEARLY FLU VACCINE: 11/13/2007
PNEUMOVAX: 3 YRS AGO
HEP B SERIES: YES
LAST TETANUS INJ (WITHIN 10 YEARS): 9/11/2006

LAST EYE EXAM: LONG TIME
LAST DENTAL EXAM: UNKNOWN

BONE DENSITY SCAN: NONE

COLONOSCOPY: NONE

PROBLEMS WITH VOIDING: NONE

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**********FAMILY HISTORY**********

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MEDICAL RECORDS INFORMATION

PATIENT NAME: **RAMEY, GAYLA R** PATIENT NO: 004646

HX OF FEMALE RELATED CANCER: MOTHER UTERINE OR CERVICAL CANCER
FAMILY HX OF OSTEOPOROSIS: MOTHER AND MATERNAL GRANDMOTHER
MOTHER: DECEASED AGE 65, HTN, COPD, CHF, CARDIAC, UTERINE OR CERVICAL CA AT AGE 29; OSTEOPOROSIS
FATHER: 69 HTN

SIBLINGS: 1 BROTHER-HEALTHY; 2 SISTERS ONE HAD BREAST BIOPSY

MGM: DECEASED OSTEOPOROSIS
MGF: DECEASED 45 SUICIDEUNSURE
PGM: DECEASED DM
PGF: DECEASED STROKE

**********SOCIAL HISTORY**********
TOBACCO USE: YES 1-1.5 PPD 28-30 YRS
ETOH: NO
RECREATIONAL DRUG USE: NO TYPE:
CAFFEINE INTAKE: DRINKING DECAFF FOR FEW MONTHS
EXERCISE: NO
EMPLOYED: RIDGEWAY HEALTH AND REHAB
MARITAL STATUS: MARRIED
LIVING ARRANGEMENTS: LIVES WITH HUSBAND AND YOUNGEST CHILD 4 GRANDCHILDREN AND 2 MIDDLE DAUGHTERS
**********PHYSICAL**********
NEURO: THE PATIENT IS WELL DEVELOPED. A&O X3, PLEASANT AFFECT. CRANIAL NERVE II-XII INTACT TO INCLUDE DTR'S AND SENSATION. SENSE OF TASTE NOT TESTED.

HEAD: HEAD IS ATRAUMATIC AND NORMOCEPHALIC, HELD MIDLINE & ERECT WITH FEATURES SYMMETRIC. SCALP MOVES FREELY UNDER EXAMINING FINGERS. NO TENDERNESS NOTED. TEMPORAL ARTERIES PALPABLE BUT NOT THICKENED. NO DEFECTS OR DEFORMITIES NOTED.

EYES: PATIENT DENIES PAIN, DISCOMFORT, ITCHING, BLURRED VISION, OR DOUBLE VISION. THE PATIENT'S VISION WAS 20/20 BILATERALLY. PUPILS ARE EQUAL, ROUND & REACTIVE TO LIGHT AND ACCOMODATION. EXTRA OCULAR MOVEMENTS INTACT. PERIPHERAL VISION INTACT AT 75 DEGREES BILATERALLY. INSPECTION OF LIDS AND CONJUNCTIVAE WITHIN NORMAL LIMITS.

EARS: AURICLE IN ALIGNMENT, NO MASSES, LESIONS, SCARS OR TENDERNESS NOTED. EXTERNAL AUDITORY CANALS UNOBSTRUCTED. TYMPANIC MEMBRANES ARE TRANSLUCENT PEARLY GREY IN COLOR, INTACT, MOBILE, GOOD LIGHT REFLEX AND BONY LANDMARKS PRESENT.
WHISPER TEST, WEBER AND RINNE WITHIN NORMAL LIMITS, MIDLINE, NONLATERALIZING AND AIR > BONE CONDUCTION.

NOSE: NO DISCHARGE OR POLYPS, MUCOSA PINK AND MOIST, SEPTUM MIDLINE AND PATENT BILATERALLY, TURBINATES CLEAR. NO ERYTHEMA OR PURULENCE WAS NOTED. NO FRONTAL OR MAXILLARY TENDERNESS ON PALPATION OR PERCUSSION.

MOUTH: LIPS ARE SYMMETRICAL, COLOR PINK, WITHOUT EDEMA OR SURFACE ABNORMALITIES. BUCCAL MUCOSA PINK AND MOIST WITHOUT LESIONS, GINGIVAE RED AND BOGGY; TONGUE MIDLINE; NO LESIONS OR TREMORS. TEETH IN GOOD REPAIR. HARD AND SOFT PALATE INSPECTED NO OBVIOUS ABNORMALITIES NOTED.

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PO BOX 39
LUGOFF SC 29078
803 438 6023

MEDICAL RECORDS INFORMATION

PATIENT NAME: **RAMEY, GAYLA R** PATIENT NO: 004646

THROAT: GAG REFLEX INTACT, UVULA RISES EVENLY, OROPHARYNX PINK AND MOIST WITHOUT EXUDATE OR ERYTHEMA, NO HOARSENESS. ENUCIATES WORDS CLEARLY.

NECK: TRACHEA MIDLINE. THE NECK IS SUPPLE, NON-TENDER, WITHOUT JVD OR BRUITS. FULL RANGE OF MOTION. THERE IS NO ADENOPATHY OR THYROMEGALY PRESENT. THYROID IS SMOOTH, SOFT, NON-TENDER, & MOVES FREELY WHEN PATIENT SWALLOWS.

LUNGS: CLEAR TO AUSCULTATION AND PERCUSSION. NO RALES, RHONCHI, OR WHEEZES WERE HEARD. VESICULAR BREATH SOUNDS OVER PERIPHERAL LUNG TISSUE. NON LABORED AND EVEN EFFORT. NO INCREASED OR DIMINISHED TACTILE FREMITUS NOTED.

HEART: NORMAL S1,S2 REGULAR RATE AND RHYTHM WITHOUT CLICKS GALLOPS, RUBS, OR MURMURS. PMI IS AT THE LMC LINE.

VASCULAR: PULSES IN ALL FOUR EXTREMITIES +3, NO JUGULAR VEIN DISTENTION NOTED, CAPILLARY REFILL 1-2 SECONDS, NO PITTING EDEMA OR SWELLING OF EXTREMITIES NOTED. NO BRUITS AUDIBLE.

BREASTS: PALPATION WITHOUT MASSES, DIMPLES OR AXILLARY ADENOPATHY. SYMMETRICAL SHAPE AND SIZE. NO DISCHARGE FROM NIPPLES.

ABDOMEN: VISUAL INSPECTION OF ABDOMEN WITHOUT MASSES OR LESIONS NOTED. NORMAL BOWEL SOUNDS, NO HEPATO-SPLEENMEGALY NOTED. NO TENDERNESS TO PALPATION. NO GUARDING OR REBOUND. NORMAL TO PERCUSSION. THE PATIENT WAS EVALUATED AND NO HERNIAS PRESENT.

GENITOURINARY: HAIR DISTRIBUTION IS WITHIN NORMAL LIMITS. BLADDER IS WITHOUT FULLNESS, MASSES OR TENDERNESS. THE ORIFICE OF THE URETHRA IS WITHOUT MASSES, TENDERNESS OR SCARING. THE VAGINA IS NORMAL IN COLOR AND RUGGAE. NO LESIONS OR MASSES ARE SEEN. THE UTERUS IS NORMAL IN SIZE, SHAPE AND CONSISTENCY. THERE IS NO CERVICAL MOTION TENDERNESS. THE CERVICAL OS IS WITHOUT LESIONS OR MASSES. cyst NO ADNEXAL TENDERNESS TO PALPATION. NO RECTOCELE OR CYSTOCELE PRESENT.

RECTUM: MANUALLY EVALUATED AND FOUND TO HAVE NORMAL TONE AND NO MASSES. THE PATIENT'S STOOL WAS GAUIAC NEGATIVE. NO HEMORRHOID NOTED.

MUSCULOSKELETAL: NORMAL GAIT NOTED. POSTURE STRAIGHT, WITHOUT SCOLIOSIS. MUSCLES & EXTREMITIES SYMMETRIC. MUSCLE STRENGTH APPROPRIATE AND EQUAL BILATERALLY. ACTIVE RANGE OF MOTION.

JOINTS: NORMAL SIZE AND CONTOUR, FULL RANGE OF MOTION, NO REDNESS OR SWELLING. NO EVIDENCE OF INJURY. NO CLICKS, LOCKING, OR LIMITED EXTENSION NOTED.

SKIN: APPROPRIATE COLOR FOR RACE. WARM & DRY W/O LESIONS OR DEFORMITIES.

MONOFILAMENT EXAM NORMAL

DX: MENORRHAGIA, HYPERLIPIDEMIA, INSOMNIA, DEPRESSION, COPD, HYPOKALEMIA-RESOLVED, TOBACCO DEPENDENCE EOV WITH PAP, CLINICAL BREAST

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ALICE J BROOKS MD PA
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LUGOFF SC 29078
803 438 6023

MEDICAL RECORDS INFORMATION

PATIENT NAME: **RAMEY, GAYLA R** PATIENT NO: 004646

EXAM

PLAN:
1) stop smoking rx for chantix
2) advise taking calcium,vitamin,exercising,getting enough rest
3) cont meds recheck labs 6 mo
PT AWARE OF MESSAGE CENTER FOR X-RAY/LAB RESULTS OR SCHEDULED
APPOINTMENTS
pdb

ELECTRONICALLY SIGNED BY Alice J. Brooks MD

FLU VACCINE ON 11/13/2007
ENTERED BY: DIANA
PROVIDER: BROOKS, ALICE J

MAN:SANOFI PASTEUR
LOT:U2507AA
EXP:30JUN08
SITE:0.5CC IM LD

INITIALS:DG

ELECTRONICALLY SIGNED BY Alice J. Brooks MD

VITAL SIGNS ON 04/10/2007
ENTERED BY: SHEREE
PROVIDER: BROOKS, ALICE J

VITAL SIGNS
BLOOD PRESSURE:140/80
WEIGHT:175.5

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ALICE J BROOKS MD PA
PO BOX 39
LUGOFF SC 29078
803 438 6023

MEDICAL RECORDS INFORMATION

PATIENT NAME: **RAMEY, GAYLA R** PATIENT NO: 004646

OFFICE VISIT ROUTINE ON 04/10/2007

PROVIDER: BROOKS, ALICE J ENTERED BY: DRBROOKS

REASON FOR OV

THE PATIENT PRESENTS TODAY FOR:
FOLLOW UP OF LIPIDS.FOLLOW UP OF LABS.HEALTH MAINTENANCE AND REVIEW OF MEDICAL PROBLEMS.
THE PATIENT COMPLAINS OF: NO PROBLEMS.
ZOLOFT SEEMS TO BE WORKING.
NO PROBLEMS WITH MEDS.
DISCUSSED LABS.

REVIEW OF SYSTEMS

AND THE REMAINDER OF THE ROS IS BENIGN.

REVIEW OF PAST HISTORY

THE PATIENTS PAST MEDICAL HISTORY WAS REVIEWED AND FOUND TO BE UNCHANGED.THE SOCIAL HISTORY WAS FOUND TO BE UNCHANGED.
THE FAMILY HISTORY WAS UNCHANGED.

OBJECTIVE

HEART:
NORMAL S1 AND S2 WERE HEARD. NO MURMUR OR GALLOP NOTED.

LUNGS:
THE LUNGS ARE CLEAR TO AUSCULTATION. NO WHEEZES RALES OR RHONCHI NOTED.

DX: HYPERLIPIDEMIA
TX: EXERCISE ENCOURAGED
CONT LOVASTATIN
6MOS LAB/EOV
AB

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DOCTORS CARE

Doctors Care

EXAM ROOM TIME 2:27 | CHECKOUT TIME | TICKET NO.

ACCOUNT NUMBER	DATE	TIME		
471935	03/11/11 FRIDAY	10:29am	NON PHYSICIAN, RIDGEVIEW	2142387

& ADDRESS
RAMEY, GAYLA
1[redacted]

[redacted]

WRK:
INSURED: RAMEY, GAYLA
INS: WC/ESIS/ACE
REASON: -
NICKNAME:

DOB: 01/02/1961 (50 years)
GENDER: F

IBG:
CELL:

RELATION: SELF

COPAY: WC

INSURANCE BALANCE $0.00
ACCOUNT BALANCE $0.00
CURRENT CHARGES
AMOUNT PAID
NEW BALANCE

CASH	CHECK	M.O.	C.C.

fell at work, Rt Arm/Hand bruised. Swollen

al Hx | Family Hx | Social Hx
DM -F | Alcohol -
HTN -F | Tobacco -

ROS (/ or O): Fatigue, ~~Wt. Loss~~, Fever, Chills, Nasal Congestion, Sinus Pain, Sore Throat, CP, SOB, Cough, Sputum, Wheezing, ABD Pain, N, V, D, Constip., Dysuria, Freq., Urgency, Back Pain, Pelvic Pain, Vag. D/C, Headache, Syncope, Rash
☒ All others negative M.K.

Allergies: NKDA

Medications: HCTZ 25mg Lovastatin 40mg

hart rev., no sig chg ____ Above Hx reviewed M.K.

☒ Med List Reviewed M.K.

	BP	Pulse	Resp	Temp
7	116/78	64	16	98.2

☐ Pulse Ox ____ ☐ LMP ~~____~~
☐ Chaperone ____ ☐ Tetanus UTD

CAL: (see reverse) Omit if N/A
ml., O if abnml. & give details)
ieral
ENT
ck
les
gs

Chief Complaint:

HPI
- MOI: 7am today pt. was walking up stairs from parking lot into UPAC Tanglewood Nursing Home when she slipped on 1st stair & injured (R) FA & hand

(R) paraspinal muscles c PTP & midline Pain.
(R) Distal FA palmar aspect c large abrasion, inflam./PTP/Pain c grip. Mild inflam of digits 2/3/4/5 of (R) hand.

☐ CBC
☐ EKG
☐ FBS
☐ Flu
☐ Heme
☐ Hgb A1C
☐ H. Pylori
☐ KOH
☐ Microalb
☐ Mono
☐ Strep
☐ U/A
☐ U Preg
☐ Wet Prep
☒ X-Ray

nto
n/Breasts

ction
oulizer
cedure
s - Send Out

(R) Forearm
(R) hand.
T-spine.

ESSMENT / DIAGNOSIS: Contusions
1. Abrasions (R) arm 2. Back Pain 3. (R) arm pain.

lient Care Instructions Discussed:
estyle Modification
eventative Recommendation(s)
escriptions / OTC Meds
le Effects Discussed
o Return: RTO x1d
/orse: RTO x2d
ot better: X 7 days for Re-check.
Follow-Up:
ER if:

Referrals, Tests, Treatments
1. X-rays: (R) hand, (R) FA, T-spine > 0 fx.
2. Sling (R) arm

Rx.
1. Soma 350mg tid. #30
2. Naproxen Na+ 550mg bid. #20
3. Ultram 50mg q6h prn #20

PSR Notes: NEW

Off Work / School

M.D., D.O. (P.A.) F.N.P.

I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Doctors Care and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine or health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Doctors Care. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with Doctors Care Notice of Privacy Practices.
I authorize payment of medical benefits to Doctors Care physicians or their designee for services rendered.

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or Authorized Person's Signature: Date: 3/11/11

Workers Compensation patients: I hereby authorize Doctors Care to speak to a rehabilitation specialist, my employer, my insurance carrier or other professionals involved in my care or rehabilitation, regarding my records and the treatment I have received or will receive.

Authorized Person's Signature: Date: 3/11/11

Return To Work Form

Doctors Care

☐ 850 Aiken Mall Drive, Aiken, SC 29803 (803) 648-1464
☐ 511 Beltline Blvd., Columbia, SC 29205 (803) 782-4051
☐ 1060 Highway 1, South Lugoff, SC 29078 (803) 438-9759
☐ 977 Knox Abbott Drive, Cayce, SC 29033 (803) 794-0476
☐ 7653 Garners Ferry Road, Columbia, SC 29209 (803) 783-2661
☐ 1736 St. Matthews Road, Orangeburg, SC 29116 (803) 536-0613

☐ 4416 Forest Drive, Suite A, Columbia, SC 29206 (803) 738-9522
☐ 247 Columbia Avenue, Lexington, SC 29072 (803) 359-5533
☐ 1029 York Street NE, Aiken, SC 29801 (803) 648-4119
☐ 10040 Two Notch Road, Columbia, SC 29223 (803) 788-1153
☑ 4214 Hardscrabble Road, Columbia, SC 29223 (803) 736-8955
☐ 100 Jimmy Love Lane, Columbia, SC 29212 (803) 772-5030
☐ 2475 Broad Street, Sumter, SC 29150 (803) 778-6555
☐ 2836 Augusta Road, W. Columbia, SC 29169 (803) 939-0545
☐ 3240 Sunset Blvd., West Columbia, SC 29169 (803) 796-4251
☐ 1520 Knox Avenue, N. Augusta, SC 29841 (803) 279-4120

Name: Gayle Ramey Arrival Time: 9:50 Discharge Time: _____

Date: 3.11.11 Company Name:: _____

WORK STATUS: (Check Appropriate Boxes)

☐ 1. May perform full duty activities as of _____ without accommodations.

☐ 2. Off duty due to work-related condition.

Estimated return to work date with modified duty: _____

Estimated return to work date for full duty: _____

RETURN FOR RE-EVALUATION AT THIS LOCATION ON _____ **Time:** _____

☑ 3. May work with the following accommodations as of: _____

- ☑ No lifting more than 10 lbs.
- ☐ No operation of hazardous or fast-moving machinery, no driving.
- ☑ Ground level work only, no ladders or heights.
- ☑ No repetitive bending, stooping, squatting, pushing, jerking, twisting, or bouncing.
- ☑ No continuous standing ~~and/or sitting.~~ >30min in duration per hour.
- ☑ Minimal walking or climbing (including stairs)
- ☑ Limited use of Back.
- ☑ No overhead lifting.
- ☑ No high repetitive hand activities for extended periods of time.
- ☑ No use of (R) arm

☐ 4. Has reached Maximum Medical Improvement (MMI)

☑ 5. Return for re-evaluation at this office on 3/18/2011 Time: _____

Additional Comments:

PATIENT DISCHARGE INSTRUCTIONS:

Diagnosis: (1) (R) arm injury (2) Back injury Medications: ☑ as directed ☐ as needed

Wound or Injury Care: ☐ keep dry and clean ☐ do not remove dressing ☐ elevate extremity ☐ warm soaks

☐ ice every _____ ☐ apply heat every _____ ☐ wear elastic support/immobilizer/keep taped

☐ home exercise instructions given ☐ follow instructions sheet given ☐ bed rest for _____

REFERRAL: If a referral is made for physical therapy, or to another physician, please complete this section:

To: _____ Date: _____ Time: _____

For: _____

Address: _____

I understand the above instructions and what to do for my follow-up care. I have received a copy of these instructions for myself and for my employer.

Employee Signature: Gayle Ramey Date: 3/11/11

Provider Signature: PA-C Date: 3/11/2011

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medical affiliates

Workers' Compensation Policy & Procedure

Patient to Receive a Copy

All Work-Related Patients please read the following, and present this to your supervisor. You have Three (3) Payment Options.

1. EMPLOYER FILES TO THEIR WORKERS' COMPENSATION INSURANCE CARRIER

Your employer may file this visit/claim with their workers' compensation insurance carrier

- A Workers' Compensation Authorization Form must accompany the patient or must be faxed or emailed to the Doctors Care Office today, if during normal business hours, or the very next business day. A copy of this form can be found at www.doctorscare.com or at any Doctors Care office.
- A First Report of Injury must accompany the patient, or be sent to the Doctors Care office within three (3) business days and must be sent to the workers' compensation insurance carrier as well.
- The First Report of Injury is essential to file the claim. Once the First Report of Injury is submitted, we will file the claim to the workers' compensation insurance carrier.

2. EMPLOYER PAYS BILL ITSELF

Your employer may pay the bill within 10 business days without filing the claim.

- Please submit payment in the envelope provided for the services rendered within ten (10) business days of the visit.

3. PATIENT PAYS BILL

IF OPTIONS 1 or 2 ARE NOT COMPLETED, THE PATIENT WILL BE RESPONSIBLE FOR THE PAYMENT OF SERVICES RENDERED.

Patient will be given the following items upon departure.

1. A statement with the current account balance.
2. An envelope in which the Employer may use to pay the bill without filing a workers' compensation insurance claim.
3. A copy of this policy and procedure outline.

Patient Acknowledgement

I have been informed of the Doctors Care Policy and Procedure on all Work-Related Injuries. I understand that I will be personally responsible for the payment of services, if options 1 or 2 are not completed within 10 business days.

Carla Rainey — Patient's Printed Name

3/11/11 — Date

[signature] — Patient or Authorized Person's Signature

Tonya Shepard — Supervisor's Name

LPAC Tanglewood — Employer

803-337-3211 — Supervisor Phone #

[WKC-F004-(12-07)]

ASSESSMENT

Doctors Care

EXAM ROOM TIME 915 | CHECKOUT TIME | TICKET NO. 3144305

ACCOUNT NUMBER	DATE	TIME	
471935	03/14/11 MONDAY	09:03am	KILLIAN, MICHAEL

INSURANCE BALANCE $353.00
ACCOUNT BALANCE $353.00
CURRENT CHARGES
AMOUNT PAID
NEW BALANCE
CASH | CHECK | M.O. | C.C.

NAME & ADDRESS
RAMEY, GAYLA
[redacted]
[redacted]
[redacted]

DOB: 01/02/1961 (50 years)
GENDER: F
IBG:
CELL:
RELATION: SELF
WRK:
INSURED: RAMEY, GAYLA
INS: WC/ESIS/ACE
REASON: KILLIAN WKC FOLLOW UP
NICKNAME:
COPAY:

Personal Hx
Family Hx: DM -, HTN -
Social Hx: Alcohol —, Tobacco +

ROS (/ or O): Fatigue, Wt. Loss, Fever, Chills, Nasal Congestion, Sinus Pain, Sore Throat, CP, SOB, Cough, Sputum, Wheezing, ABD Pain, N, V, D, Constip., Dysuria, Freq., Urgency, Back Pain, Pelvic Pain, Vag. D/C, Headache, Syncope, Rash
☑ All others negative M.K

Allergies: NKDA
Medications: HCTZ, Lexapro
☑ Med List Reviewed M.K

v. chart rev., no sig chg ____ Above Hx reviewed M.K

T	BP	Pulse	Resp	Temp
4	124/82	76	16	98.2

☐ Pulse Ox ____ ☐ LMP ____
☐ Chaperone ____ ☐ Tetanus UP

PHYSICAL: (see reverse) Omit if N/A
(if amt., O if abnml. & give details)
General
HEENT
Neck
Nodes
Lungs
CV
Abd
Back → ⊖SLR → mild PTP of (L) paraspinal muscles.
Ext
GU
Neuro → +2 Patellar reflexes
Skin/Breasts → Contusion/Abrasion (R) hand c mild ecchymosis

I.V.
Injection
Nebulizer
Procedure
Labs - Send Out

Chief Complaint:
HPI
- x 3/11/2011 - DOI: Pt. slipped going up wooden stairs @ work place.
- Pt. st. very improved, No (R) arm.

☐ CBC
☐ EKG
☐ FBS
☐ Flu
☐ Heme
☐ Hgb A1C
☐ H. Pylori
☐ KOH
☐ Microalb
☐ Mono
☐ Strep
☐ U/A
☐ U Preg
☐ Wet Prep
☐ X-Ray

ASSESSMENT / DIAGNOSIS:
① Back Pain ② Rt. arm abrasion/Contusion

Referrals, Tests, Treatments Rx:
- None -
Pt. to cont. P.O. meds as Rx.

PSR Notes: ESTAB

Patient Care Instructions Discussed:
Lifestyle Modification
Preventative Recommendation(s)
Prescriptions / OTC Meds
Side Effects Discussed
Date to Return:
If worse: PRN x 1d
If not better: PRN x 2d
For Follow-Up: 3/18/2011
Go to ER if:

Off Work / School

M.D., D.O., P.A., F.N.P.

I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Doctors Care and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Doctors Care. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with Doctors Care Notice of Privacy Practices.
I authorize payment of medical benefits to Doctors Care physicians or their designee for services rendered.

Patient or Authorized Person's Signature: [signature] Date: 3/14/11

345 112

Return To Work Form

☐ 850 Aiken Mall Drive, Aiken, SC 29803 (803) 648-1464
☐ 511 Beltline Blvd., Columbia, SC 29205 (803) 782-4051
☐ 1060 Highway 1, South Lugoff, SC 29078 (803) 438-9759
☐ 977 Knox Abbott Drive, Cayce, SC 29033 (803) 794-0476
☐ 7653 Garners Ferry Road, Columbia, SC 29209 (803) 783-2661
☐ 1736 St. Matthews Road, Orangeburg, SC 29116 (803) 536-0613
☐ 4416 [illegible] Drive, Suite A, Columbia, SC 29206 (803) 738-9522
☐ 247 C[illegible]a Avenue, Lexington, SC 29072 (803) 359-5533
☐ 1029 York Street NE, Aiken, SC 29801 (803) 648-4119
☐ 10040 Two Notch Road, Columbia, SC 29223 (803) 788-1153
☑ 4214 Hardscrabble Road, Columbia, SC 29223 (803) 736-8955
☐ 100 Jimmy Love Lane, Columbia, SC 29212 (803) 772-5030
☐ 2475 Broad Street, Sumter, SC 29150 (803) 778-6555
☐ 2836 Augusta Road, W. Columbia, SC 29170 (803) 939-0545
☐ 3240 Sunset Blvd., West Columbia, SC 29169 (803) 796-4251
☐ 1520 Knox Avenue, N. Augusta, SC 29841 (803) 279-4120

Name: Gayla Ramey Arrival Time: 9 Discharge Time: 935

Date: 3.14.11 Company Name:

WORK STATUS: (Check Appropriate Boxes)

☐ 1. May perform full duty activities as of _____ without accommodations.

☐ 2. Off duty due to work-related condition.

Estimated return to work date with modified duty: _____

Estimated return to work date for full duty: _____

RETURN FOR RE-EVALUATION AT THIS LOCATION ON _____ **Time:** _____

☐ 3. May work with the following accommodations as of: _____

☑ No lifting more than 10 lbs.

☐ No operation of hazardous or fast-moving machinery, no driving.

☑ Ground level work only, no ladders or heights.

☑ No repetitive bending, stooping, squatting, ~~pushing, jerking, twisting,~~ or ~~bouncing~~.

☐ No continuous standing and/or sitting.

☐ Minimal walking or climbing (including stairs)

☑ Limited use of Back

☐ No overhead lifting.

☐ No high repetitive hand activities for extended periods of time.

☐ No use of _____

☐ 4. Has reached Maximum Medical Improvement (MMI)

☑ 5. Return for re-evaluation at this office on 3/18/2011 Time: _____

Additional Comments:

PATIENT DISCHARGE INSTRUCTIONS:

Diagnosis: Back Injury @ Arm Injury Medications: ☐ as directed ☐ as needed

Wound or Injury Care: ☐ keep dry and clean ☑ do not remove dressing ☐ elevate extremity ☐ warm soaks

☐ ice every _____ ☐ apply heat every _____ ☐ wear elastic support/immobilizer/keep taped

☐ home exercise instructions given ☐ follow instructions sheet given ☐ bed rest for _____

REFERRAL: If a referral is made for physical therapy, or to another physician, please complete this section:

To: _____ Date: _____ Time: _____

For: _____

Address: _____

I understand the above instructions and what to do for my follow-up care. I have received a copy of these instructions for myself and for my employer.

Employee Signature: _____ Date: _____

Provider Signature: [signature] PA846 Date: 3/14/11

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Apr. 20. 2011 9:34AM

UCI medical affiliates

Doctors Care Radiology Form

X-Ray Interpretation and Review

Date: 3-11-11

X-Ray #: 0375 Office: RV

Patient Name: Tayla Ramey Patient ID: 471935 DOB: 1-2-[redacted] Age: 20

Requesting Provider: Killian Sex: F

Operator's Signature: E. Herman Pregnancy Status: —

History:

Films Taken:

- ☐ Abdomen, 1V, 74000
- ☐ Abdomen, 3V, 74022
- ☐ Ankle, 3V, 73610
- ☐ C-Spine, 3V, 72040
- ☐ C-Spine, 5V, 72050
- ☐ Chest, 1V, 71010
- ☐ Chest, 2V, 71020
- ☐ Clav, 2V, 73000
- ☐ Coccyx, 2V, 72220
- ☐ Elbow, 2V, 73070
- ☐ Elbow, 4V, 73080
- ☐ Femur, 2V, 73550
- ☐ Finger, 3V, 73140
- ☐ Foot, 2V, 73620
- ☐ Foot, 3V, 73630
- ☐ Foot FB, 2V, 73620
- ☑ Forearm, 2V, 73090
- ☐ Hand, 2V, 73120
- ☑ Hand, 3V, 73130
- ☐ Hip, 2V, 73510
- ☐ Humerus, 2V, 73060
- ☐ Knee, 2V, 73560
- ☐ Knee & Sun, 3+1, 73564
- ☐ Knee & Tun, 3+1, 73564
- ☐ LS-Spine, 3V, 72100
- ☐ Mandible, 3V, 70100
- ☐ Nasal, 3V, 70160
- ☐ Neck ST, 2V, 70360
- ☐ Oscalcis, 2V, 73650
- ☐ Pelvis, 1V, 72170
- ☐ Ribs, 4V, 71101
- ☐ Ribs-Bilat, 4-5V, 71111
- ☐ Sacrum, 2V, 72220
- ☐ Scapula, 2V, 73010
- ☐ Shoulder AC, 2V, 73050
- ☐ Shoulder, 2V, 73030
- ☐ Sinuses, 2V, 70210
- ☐ Sinuses, 3V, 70220
- ☐ Skull, 2V, 70250
- ☐ Skull, 4V, 70260
- ☑ T-Spine, 2V, 72070
- ☐ Thumb, 3V, 73140
- ☐ Tib & Fib, 2V, 73590
- ☐ Toes, 3V, 73660
- ☐ Wrist, 2V, 73100
- ☐ Wrist w/ Nav, 3-5, 73110
- ☐ Add View, 1V, 70001

# of Views: 7 Code:

☐ Unlisted X-Ray Description:

Doctors Care Practitioner Interpretation:

① ® hand: ⊖Fx.

②. T-spine: ⊖Fx.

Practitioner Signature: M. Killian

Right or Left Extremity: ☑ R ☐ L

Lead Shielding Used: ☑ Y ☐ N

Is Patient Pregnant: ☐ Y ☑ N

Circle # of Films Taken: 1 2 3 4 (5)

Questions for Radiologist

Do you agree with practitioner's initial impression?	☑ Yes	☐ No
Do you consider the x-ray(s) normal?	☑ Yes	☐ No
Do you see significant findings not noted by practitioner?	☐ Yes	☐ No

If high risk, please notify office immediately by phone and fax.

Additional Practitioner Questions:

Radiologists Response

Agree. Also Forearm neg.

Radiologist Name: C.S. Zaiyi Date of Review: 3/14/11

Radiologist Signature: C. Zaiyi Doctors Care Office Notified (Phone/Fax/Other):

Doctors Care Follow-Up

Report Reviewed By Doctors Care Practitioner: ☑ Signature: 3/15/11 Date:

Further action required? ☐ Yes ☑ No

Patient notified? ☐ Yes ☐ No

If yes to either question, follow up steps initiated (describe):

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Doctors Care

4 EXAM ROOM TIME 8:41 CHECKOUT TIME TICKET NO.

ACCOUNT NUMBER	DATE	TIME		
471935	03/18/11 FRIDAY	08:36am	DC RIDGEVIEW,	2150167

NAME & ADDRESS
RAMEY, GAYLA
[redacted]
[redacted]
WRK:
INSURED: RAMEY, GAYLA
INS: WC/ESIS/ACE
REASON: -
NICKNAME:

$25

DOB: 01/02/1961 (50 years)
GENDER: F

IBG:
CELL:

RELATION: OTHER

COPAY:

INSURANCE BALANCE	$614.00
ACCOUNT BALANCE	$614.00
CURRENT CHARGES	
AMOUNT PAID	
NEW BALANCE	

CASH	CHECK	M.O.	C.C.

Improving

Personal Hx: A ___ N ___
Family Hx: DM +, HTN +
Social Hx: Alcohol ___, Tobacco +

ROS (/ or O): Fatigue, Wt. Loss, Fever, Chills, Nasal Congestion, Sinus Pain, Sore Throat, CP, SOB, Cough, Sputum, Wheezing, ABD Pain, N, V, D, Constip., Dysuria, Freq., Urgency, Back Pain, Pelvic Pain, Vag. D/C, Headache, Syncope, Rash
☐ All others negative

Allergies: NKDA

Medications:
HCTZ
Levastatin
☐ Med List Reviewed SF

Prev. chart rev., no sig chg ___ Above Hx reviewed SF

T	BP		Pulse	Resp	Temp
43	150	72	80	16	98.1

☐ Pulse Ox ___ ☐ LMP ___
☐ Chaperone ___ ☐ Tetanus DTD

PHYSICAL: (see reverse) Omit if N/A
(✓ if nml., O if abnml. & give details)
✓ General
✓ HEENT
O Neck
✓ Nodes
✓ Lungs
✓ CV
✓ Abd
✓ Back
✓ Ext
✓ GU
✓ Neuro
✓ Skin/Breasts
✓ I.V.
✓ Injection
✓ Nebulizer
✓ Procedure
✓ Labs - Send Out

O tenderness cervical spine
mild tenderness lateral @ cervical spine ecs Full neck ROM
UE strength=bilat
O shoulder pain
O thoracic spine pain
healing abrasion R elbow

Chief Complaint: DOI 3/11/11

HPI c/o O/ slight (R) lateral neck / trapezius pulling otherwise denies complaints
mid back feels appr
85% improved
ROM c no discomfort
Soma causes pt to be SO sedated to work

☐ CBC
☐ EKG
☐ FBS
☐ Flu
☐ Heme
☐ Hgb A1C
☐ H. Pylori
☐ KOH
☐ Microalb
☐ Mono
☐ Strep
☐ U/A
☐ U Preg
☐ Wet Prep
☐ X-Ray

ASSESSMENT / DIAGNOSIS: thoracic/cervical strain resolving

☐ Patient Care Instructions Discussed:
☐ Lifestyle Modification
☐ Preventative Recommendation(s)
☐ Prescriptions / OTC Meds
☒ Side Effects Discussed
Date to Return:
☐ If worse: ASAP
☐ If not better: 3-5 days
☒ For Follow-Up: 1 week - 10 days
Go to ER if:

Referrals, Tests, Treatments

Continue naproxen

if allok next week consider d/c pt

PSR Notes:
99214 ESTAB

Off Work / School

Staff: P. Herman RN Signature M.D., D.O., P.A., F.N.P.

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Doctors Care and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Doctors Care.
2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Doctors Care Notice of Privacy Practices.
3. I authorize payment of medical benefits to Doctors Care physicians or their designee for services rendered.

Patient or Authorized Person's Signature: [signature] Date: 3/18/11

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4. Workers Compensation patients: I hereby authorize Doctors Care to speak to a rehabilitation specialist, my employer, my insurance carrier or other professionals involved in my care or rehabilitation, regarding my medical records and the treatment I have received or will receive.

Patient or Authorized Person's Signature: [signature] 348 Date: 3/18/11

APP - 416

Return To Work Form

☐ 850 Aiken Mall Drive, Aiken, SC 29803 (803) 648-1464
☐ 511 Beltline Blvd., Columbia, SC 29205 (803) 782-4051
☐ 1060 Highway 1, South Lugoff, SC 29078 (803) 438-9759
☐ 977 Knox Abbott Drive, Cayce, SC 29033 (803) 794-0476
☐ 7653 Garners Ferry Road, Columbia, SC 29209 (803) 783-2661
☐ 1736 St. Matthews Road, Orangeburg, SC 29116 (803) 536-0613
☐ 4416 Forest Drive, Suite A, Columbia, SC 29206 (803) 738-9522
☐ 247 Columbia Avenue, Lexington, SC 29072 (803) 359-5533
☐ 1029 York Street NE, Aiken, SC 29801 (803) 648-4119
☐ 10040 Two Notch Road, Columbia, SC 29223 (803) 788-1153
☐ 4214 Hardscrabble Road, Columbia, SC 29223 (803) 736-8955
☐ 100 Jimmy Love Lane, Columbia, SC 29212 (803) 772-5030
☐ 2475 Broad Street, Sumter, SC 29150 (803) 778-6555
☐ 2836 Augusta Road, W. Columbia, SC 29169 (803) 939-0545
☐ 3240 Sunset Blvd., West Columbia, SC 29169 (803) 796-4251
☐ 1520 Knox Avenue, N. Augusta, SC 29841 (803) 279-4120

Name: Gayla Kamen Arrival Time: [redacted] Discharge Time: [redacted]

Date: 3.18.11 Company Name::

WORK STATUS: (Check Appropriate Boxes)

☒ 1. May perform full duty activities as of 3/18/11 without accommodations.

☐ 2. Off duty due to work-related condition.

Estimated return to work date with modified duty:

Estimated return to work date for full duty: Time:

RETURN FOR RE-EVALUATION AT THIS LOCATION ON

☐ 3. May work with the following accommodations as of:

- ☐ No lifting more than _____ lbs.
- ☐ No operation of hazardous or fast-moving machinery, no driving.
- ☐ Ground level work only, no ladders or heights.
- ☐ No repetitive bending, stooping, squatting, pushing, jerking, twisting, or bouncing.
- ☐ No continuous standing and/or sitting.
- ☐ Minimal walking or climbing (including stairs)
- ☐ Limited use of
- ☐ No overhead lifting.
- ☐ No high repetitive hand activities for extended periods of time.
- ☐ No use of

☐ 4. Has reached Maximum Medical Improvement (MMI)

☒ 5. Return for re-evaluation at this office on ~~3-23~~ SF 3-25-11 Time:

Additional Comments: Pt does have mild neck discomfort. She may need re-eval soon if continues. She has normal ~~comfortable~~ full active ROM

PATIENT DISCHARGE INSTRUCTIONS: mid back pain, resolve at

Diagnosis: cervical strain, ~~tbi~~ sacrum pain Medications: ☒ as directed ☐ ~~as~~ as needed

Wound or Injury Care: ☐ keep dry and clean ☐ do not remove dressing ☐ elevate extremity ☐ warm soaks

☐ ice every _____ ☒ apply heat every 6 hrs ☐ wear elastic support/immobilizer/keep taped

☐ home exercise instructions given ☐ follow instructions sheet given ☐ bed rest for

REFERRAL: If a referral is made for physical therapy, or to another physician, please complete this section:

To: Date: Time:

For:

Address:

I understand the above instructions and what to do for my follow-up care. I have received a copy of these instructions for myself and for my employer.

Employee Signature: [redacted] Date:

Provider Signature: [redacted] Date: 3/18/11

4 EXAM ROOM TIME 10:46 — CHECKOUT TIME 1241

Doctors Care

ACCOUNT NUMBER	DATE	TIME		TICKET NO.
471935	03/24/11	10:40am	DC RIDGEVIEW, Gillian	2160573

THURSDAY

IE & ADDRESS
RAMEY, GAYLA
16[redacted]
[redacted]
WRK:
INSURED: RAMEY, GAYLA
INS: WC/ESIS/ACE
REASON: WC FOLLOW UP
NICKNAME:

DOB: 01/02/1961 (50 years)
GENDER: F
IBG:
CELL:
RELATION: OTHER
COPAY:

INSURANCE BALANCE	$755.00
ACCOUNT BALANCE	$755.00
CURRENT CHARGES	
AMOUNT PAID	
NEW BALANCE	

CASH	CHECK	M.O.	C.C.

more stiffness in Neck

onal Hx — Family Hx: DM, HTN — Social Hx: Alcohol, Tobacco

dent? ☐ yes ☐ no If yes, which state: ____
of Accident: ____
chart rev., no sig chg.: ____ Above Hx rev.: M.K.

ROS (/ or O): ~~Fatigue~~, ~~Dizzy~~, ~~Weak~~, ~~VA Loss~~, ~~Fever~~, ~~Chills~~, ~~Nasal Congestion~~, ~~Sinus Pain~~, ~~Ear Pain~~, ~~Sore Throat~~, ~~SOB~~, ~~CP~~, ~~Cough~~, ~~Sputum~~, ~~Wheeze~~, ~~ABD Pain~~, ~~N~~, ~~V~~, ~~D~~, ~~Constip~~, ~~Dysuria~~, ~~Freq.~~, ~~Urgency~~, ~~Back Pain~~, Pelvic Pain, Vag. D/C, ~~Headache~~, ~~Syncope~~, ~~Rash~~ M.K ☐ All others negative

Allergies: NKDA

Medications:
HCTZ
Lovastatin
☑ Meds/Allergies Reviewed M.K.

	HT	BMI	BP	PULSE	RESP	TEMP	
3	5'7½"		110/78	72	110	98.0	☐ LMP ☐ Tetanus UTD

/SICAL: (see reverse) Omit if N/A
if nml., O if abnml. & give details)
General
HEENT
Neck
Nodes
Lungs
CV
Abd
Back → Palpable muscle spasm. Ⓡ
Ext
GU Ⓡ trapezius.
Neuro
Skin/Breasts
Chaperone ____
I.V.
Injection
Nebulizer
Procedure
Pulse Ox ____

Chief Complaint:

HPI
① DOI = 3/11/2011 - Pt slipped on ~~wooden~~ stairs @ work
② X 13d c Ⓡ shoulder pain c radiation to neck & back. No radiation to Ⓡ arm
③ Healing abrasion Ⓡ arm.

☐ CBC
☐ EKG
☐ FBS
☐ Flu
☐ Heme
☐ Hgb A1C
☐ H. Pylori
☐ KOH
☐ Microalb
☐ Mono
☐ Strep
☐ Tetanus
☐ U/A
☐ U Preg
☐ Wet Prep
☑ X-Ray C-spine. #0444
☐ Labs - Send Out

AGNOSIS: ① Muscle Spasm ② Spondylolisthesis ③ Neck pain

Patient Care Instructions Discussed
Lifestyle Modification
Preventative Recommendation(s)
Prescriptions / OTC Meds
Side Effects Discussed
Follow-Up: X 7d.
eturn:
Worsening symptoms: RTO
If not better: RTO x 7d.
o to ER if:

Crutches/Splints/Supplies ☐ Given ☐ Recommended

① Phys. therapy initiation this visit.

Rx: ① Naprox. Nat 500mg bid #30
② Soma 350mg tid. #30.

PSR Notes: ESTAB

Off Work / School

aff: G Herman RT — M. Gillian M.D., D.O., P.A., F.N.P.

I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Doctors Care and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine d other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Doctors Care. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with Doctors Care Notice of Privacy Practices.
I authorize payment of medical benefits to Doctors Care physicians or their designee for services rendered.

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atient or Authorized Person's Signature: Date: 3/24/11

Workers Compensation patients: I hereby authorize Doctors Care to speak to a rehabilitation specialist, my employer, my insurance carrier or other professionals involved in my care or rehabilitation, regarding my edical records and the treatment I have received or will receive.

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atient or Authorized Person's Signature: Date: 3/24/11

Return To Work Form

Doctors Care

- 850 Aiken Mall Drive, Aiken, SC 29803 (803) 648-1464
- 511 Beltline Blvd., Columbia, SC 29205 (803) 782-4051
- 1060 Highway 1, South Lugoff, SC 29078 (803) 438-9759
- 977 Knox Abbott Drive, Cayce, SC 29033 (803) 794-0476
- 7653 Garners Ferry Road, Columbia, SC 29209 (803) 783-2661
- 1736 St. Matthews Road, Orangeburg, SC 29116 (803) 536-0613
- 7936 Broad River Road, Irmo, SC 29116 (803) 749-2508
- 4500 Forest Drive, Suite A, Columbia, SC 29206 (803) 738-9522
- 247 Columbia Avenue, Lexington, SC 29072 (803) 359-5533
- 1029 York Street NE, Aiken, SC 29801 (803) 648-4119
- 10040 Two Notch Road, Columbia, SC 29223 (803) 788-1153
- 4214 Hardscrabble Road, Columbia, SC 29223 (803) 736-8955
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- 2836 Augusta Road, W. Columbia, SC 29170 (803) 939-0545
- 3240 Sunset Blvd., West Columbia, SC 29169 (803) 796-4251
- 1520 Knox Avenue, N. Augusta, SC 29841 (803) 279-4120

Name: G. Ramey Arrival Time: 1030 Discharge Time: 1241

Date: 3.24.11 Company Name::

WORK STATUS: (Check Appropriate Boxes)

☐ 1. May perform full duty activities as of _____ without accommodations.

☐ 2. Off duty due to work-related condition.

Estimated return to work date with modified duty: _____

Estimated return to work date for full duty: _____

RETURN FOR RE-EVALUATION AT THIS LOCATION ON _____ **Time:** _____

☑ 3. May work with the following accommodations as of: 3/24/2011

- ☑ No lifting more than 10 lbs.
- ☐ No operation of hazardous or fast-moving machinery, no driving.
- ☑ Ground level work only, no ladders or heights.
- ☑ No repetitive bending, stooping, squatting, pushing, jerking, twisting, or bouncing.
- ☐ No continuous standing and/or sitting.
- ☐ Minimal walking or climbing (including stairs)
- ☑ Limited use of back / neck.
- ☐ No overhead lifting.
- ☐ No high repetitive hand activities for extended periods of time.
- ☐ No use of _____

☐ 4. Has reached Maximum Medical Improvement (MMI) Time: _____

☑ 5. Return for re-evaluation at this office on 3/31/2011

Additional Comments:

PATIENT DISCHARGE INSTRUCTIONS:

Diagnosis: ① Neck pain ② Back pain ③ Muscle spasm Medications: ☐ as directed ☐ as needed

Wound or Injury Care: ☐ keep dry and clean ☐ do not remove dressing ☐ elevate extremity ☐ warm soaks

☐ ice every _____ ☐ apply heat every _____ ☐ wear elastic support/immobilizer/keep taped

☐ home exercise instructions given ☐ follow instructions sheet given ☐ bed rest for _____

REFERRAL: If a referral is made for physical therapy, or to another physician, please complete this section:

To: Physical Therapy Date: _____ Time: _____

For: _____

Address: _____

I understand the above instructions and what to do for my follow-up care. I have received a copy of these instructions for myself and for my employer.

Employee Signature: _____ **Date:** 3/24/11

Provider Signature: _____ **Date:** 3/24/2011

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APP-419

[MED-F014-(01-11)]

medical affiliates

Workers' Compensation Policy & Procedure

Patient to Receive a Copy

All Work-Related Patients please read the following, and present this to your supervisor. You have Three (3) Payment Options.

1. EMPLOYER FILES TO THEIR WORKERS' COMPENSATION INSURANCE CARRIER

Your employer may file this visit/claim with their workers' compensation insurance carrier

- A Workers' Compensation Authorization Form must accompany the patient or must be faxed or emailed to the Doctors Care Office today, if during normal business hours, or the very next business day. A copy of this form can be found at www.doctorscare.com or at any Doctors Care office.
- A First Report of Injury must accompany the patient, or be sent to the Doctors Care office within three (3) business days and must be sent to the workers' compensation insurance carrier as well.
- The First Report of Injury is essential to file the claim. Once the First Report of Injury is submitted, we will file the claim to the workers' compensation insurance carrier.

2. EMPLOYER PAYS BILL ITSELF

Your employer may pay the bill within 10 business days without filing the claim.

- Please submit payment in the envelope provided for the services rendered within ten (10) business days of the visit.

3. PATIENT PAYS BILL

IF OPTIONS 1 or 2 ARE NOT COMPLETED, THE PATIENT WILL BE RESPONSIBLE FOR THE PAYMENT OF SERVICES RENDERED.

Patient will be given the following items upon departure.

1. A statement with the current account balance.
2. An envelope in which the Employer may use to pay the bill without filing a workers' compensation insurance claim.
3. A copy of this policy and procedure outline.

Patient Acknowledgement

I have been informed of the Doctors Care Policy and Procedure on all Work-Related Injuries. I understand that I will be personally responsible for the payment of services, if options 1 or 2 are not completed within 10 business days.

Gayla Ramey — Patient's Printed Name

3/24/11 — Date

Patient or Authorized Person's Signature

& Tonya Shepard DHS — Supervisor's Name

uPAC - Tanglewood — Employer

803-337-3211 — Supervisor Phone #

[WKC-F004-(12-07)]

tci medical affiliates

Doctors Care Radiology Form

X-Ray Interpretation and Review

Date: 3-24-11

X-Ray #: 07444 Office: RV

Patient Name: Gayla Ramsey

Patient ID: 10435 DOB: 2-61 Age: 50

Requesting Provider: Killian

Pregnancy Status: Neck stiffness Sex: F

Operator's Signature:

History: Injury 3-11-11

Films Taken:

- ☐ Abdomen, 1V, 74000
- ☐ Abdomen, 3V, 74022
- ☐ Ankle, 3V, 73610
- ☒ C-Spine, 3V, 72040
- ☐ C-Spine, 5V, 72050
- ☐ Chest, 1V, 71010
- ☐ Chest, 2V, 71020
- ☐ Clav, 2V, 73000
- ☐ Coccyx, 2V, 72220
- ☐ Elbow, 2V, 73070
- ☐ Elbow, 4V, 73080
- ☐ Femur, 2V, 73550
- ☐ Finger, 3V, 73140
- ☐ Foot, 2V, 73620
- ☐ Foot, 3V, 73630
- ☐ Foot- FB, 2V, 73620
- ☐ Forearm, 2V, 73090
- ☐ Hand, 2V, 73120
- ☐ Hand, 3V, 73130
- ☐ Hip, 2V, 73510
- ☐ Humerus, 2V, 73060
- ☐ Knee, 2V, 73560
- ☐ Knee & Sun, 3+1, 73564
- ☐ Knee & Tun, 3+1, 73564
- ☐ LS-Spine, 3V, 72100
- ☐ Mandible, 3V, 70100
- ☐ Nasal, 3V, 70160
- ☐ Neck-ST, 2V, 70360
- ☐ Oscalcis, 2V, 73650
- ☐ Pelvis, 1V, 72170
- ☐ Ribs, 4V, 71101
- ☐ Ribs-Bilat, 4-5V, 71111
- ☐ Sacrum, 2V, 72220
- ☐ Scapula, 2V, 73010
- ☐ Shoulder AC, 2V, 73050
- ☐ Shoulder, 2V, 73030
- ☐ Sinuses, 2V, 70210
- ☐ Sinuses, 3V, 70220
- ☐ Skull, 2V, 70250
- ☐ Skull, 4V, 70260
- ☐ T-Spine, 2V, 72070
- ☐ Thumb, 3V, 73140
- ☐ Tib & Fib, 2V, 73590
- ☐ Toes, 3V, 73660
- ☐ Wrist, 2V, 73100
- ☐ Wrist w/ Nav, 3-5, 73110
- ☐ Add View, 1V, 70001

# of Views: 3 Code:

☐ Unlisted X-Ray Description:

Doctors Care Practitioner Interpretation:

1. Spondylolisthesis of C-4 on C-5
2. DJD

Practitioner Signature:

Right or Left Extremity: ☐ R ☐ L

Lead Shielding Used: ☒ Y ☐ N

Is Patient Pregnant: ☐ Y ☒ N

Circle # of Films Taken: 1 2 3 4 5

Questions for Radiologist

Do you agree with practitioner's initial impression?	☒ Yes	☐ No
Do you consider the x-ray(s) normal?	☐ Yes	☒ No
Do you see significant findings not noted by practitioner? If high risk, please notify office immediately by phone and fax.	☐ Yes	☐ No

Additional Practitioner Questions

Radiologists Response:

1) Grade I Ant. Subluxation c C4-5. Recommend Ct c flex + extension views to assess for stability. DDD

Radiologist Name: C. Davis MD

Date of Review: 3/27/11 @ C4-5

Radiologist Signature:

Doctors Care Office Notified (Phone/Fax/Other):

Doctors Care Follow-Up

Date: 3/28/2011

Report Reviewed By Doctors Care Practitioner: Signature:

Further action required? ☒ Yes ☐ No

Patient notified? ☐ Yes ☐ No

If yes to either question, follow up steps initiated (describe):

1). Sched. MRI of C-spine (No contrast) Dr. Killian

medical affiliates

Workers' Compensation Policy & Procedure

Patient to Receive a Copy

All Work-Related Patients please read the following, and present this to your supervisor. You have Three (3) Payment Options.

1. EMPLOYER FILES TO THEIR WORKERS' COMPENSATION INSURANCE CARRIER

Your employer may file this visit/claim with their workers' compensation insurance carrier

- A Workers' Compensation Authorization Form must accompany the patient or must be faxed or emailed to the Doctors Care Office today, if during normal business hours, or the very next business day. A copy of this form can be found at www.doctorscare.com or at any Doctors Care office.
- A First Report of Injury must accompany the patient, or be sent to the Doctors Care office within three (3) business days and must be sent to the workers' compensation insurance carrier as well.
- The First Report of Injury is essential to file the claim. Once the First Report of Injury is submitted, we will file the claim to the workers' compensation insurance carrier.

2. EMPLOYER PAYS BILL ITSELF

Your employer may pay the bill within 10 business days without filing the claim.

- Please submit payment in the envelope provided for the services rendered within ten (10) business days of the visit.

3. PATIENT PAYS BILL

IF OPTIONS 1 or 2 ARE NOT COMPLETED, THE PATIENT WILL BE RESPONSIBLE FOR THE PAYMENT OF SERVICES RENDERED.

Patient will be given the following items upon departure.

1. A statement with the current account balance.
2. An envelope in which the Employer may use to pay the bill without filing a workers' compensation insurance claim.
3. A copy of this policy and procedure outline.

Patient Acknowledgement

I have been informed of the Doctors Care Policy and Procedure on all Work-Related Injuries. I understand that I will be personally responsible for the payment of services, if options 1 or 2 are not completed within 10 business days.

Gayla Ramey — Patient's Printed Name

4/1/11 — Date

Patient or Authorized Person's Signature

Supervisor's Name

Employer

Supervisor Phone #

[WKC-F004-(12-07)]

10/6

4 EXAM ROOM TIME 943 — CHECKOUT TIME — TICKET NO. 2170970

ACCOUNT NUMBER	DATE	TIME
471935	04/01/11 FRIDAY	08:44am

DC RIDGEVIEW,

NAME & ADDRESS
RAMEY, GAYLA
[redacted]
WRK:
INSURED: RAMEY, GAYLA
INS: WC/ESIS/ACE
REASON: WKC FOLLOW UP
NICKNAME:

DOB: 01/02/1961 (50 years)
GENDER: F
IBG:
CELL:
RELATION: OTHER
COPAY:

INSURANCE BALANCE	$755.00
ACCOUNT BALANCE	$755.00
CURRENT CHARGES	
AMOUNT PAID	
NEW BALANCE	

CASH | CHECK | M.O. | C.C.

Personal Hx: DM — HTN —
Family Hx: DM — HTN —
Social Hx: Alcohol — Tobacco —
Accident? ☐ yes ☐ no If yes, which state:
Date of Accident: Above Hx rev.: SF
Prev. chart rev., no sig chg.:

ROS (/ or O): Fatigue, Dizzy, Weak, Wt. Loss, Fever, Chills, Nasal Congestion, Sinus Pain, Ear Pain, Sore Throat, SOB, CP, Cough, Sputum, Wheeze, ABD Pain, N, V, D, Constip., Dysuria, Freq., Urgency, Back Pain, Pelvic Pain, Vag. D/C, Headache, Syncope, Rash ☐ All others negative

Allergies: NKDA

Medications: HCTZ Levastatin SF
☐ Meds/Allergies Reviewed

WT	HT	BMI	BP	PULSE	RESP	TEMP	☐ LMP ☐ Tetanus
145			124/84	68	16	97.9	UTD

Chief Complaint: DOI 3/11/11

PHYSICAL: (see reverse) Omit if N/A
(✓ if nml., O if abnml. & give details).
☐ General
☐ HEENT
☐ Neck
☐ Nodes
☐ Lungs
☐ CV
☐ Abd
☐ Back
☐ Ext
☐ GU
☐ Neuro
☐ Skin/Breasts
☐ Chaperone
☐ I.V.
☐ Injection
☐ Nebulizer
☐ Procedure
☐ Pulse Ox

(+) tender cervical spine & palpable muscle spasm
ROM cervical spine decreased

HPI pt having trouble finding a comfortable position while in bed re: neck pain. Had MRI of cervical spine yesterday. results (P) yet. has not started PT has not taking much Flexeril. pt laid off from work since 3/11/11 re: bicycle thrown

☐ CBC
☐ EKG
☐ FBS
☐ Flu
☐ Heme
☐ Hgb A1C
☐ H. Pylori
☐ KOH
☐ Microalb
☐ Mono
☐ Strep
☐ Tetanus
☐ U/A
☐ U Preg
☐ Wet Prep
☐ X-Ray
☐ Labs - Send

DIAGNOSIS:
(1) Cervical Spine Trapezius Strain
(2) DDD c-spine / Spondylolisthesis

PSR Notes: EST

☐ Patient Care Instructions Discussed
☐ Lifestyle Modification
☐ Preventative Recommendation(s)
☐ Prescriptions / OTC Meds
☐ Side Effects Discussed
☐ Follow-Up: 1 week
Return:
☐ Worsening symptoms:
☐ If not better: 3-5 days
Go to ER if:

Crutches/Splints/Supplies ☐ Given ☐ Recommended

(1) PT- pt to start
(2) Cont anti inflammatory
(3) light duty

Off Work / School

Staff: [signature] M.D., D.O., P.A., F.N.P.

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Doctors Care and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Doctors Care.
2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Doctors Care Notice of Privacy Practices.
3. I authorize payment of medical benefits to Doctors Care physicians or their designee for services rendered.

Patient or Authorized Person's Signature: [signature] Date: 4/1/11

4. Workers Compensation patients: I hereby authorize Doctors Care to speak to a rehabilitation specialist, my employer, my insurance carrier or other professionals involved in my care or rehabilitation, regarding medical records and the treatment I have received or will receive.

Patient or Authorized Person's Signature: Date:

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APP 423

Return To Work Form

Your Neighborhood Medical Center
Doctors Care

- ☐ 850 Aiken Mall Drive, Aiken, SC 29803 (803) 648-1464
- ☐ 511 Beltline Blvd., Columbia, SC 29205 (803) 782-4051
- ☐ 1060 Highway 1, South Lugoff, SC 29078 (803) 438-9759
- ☐ 977 Knox Abbott Drive, Cayce, SC 29033 (803) 794-0476
- ☐ 7653 Garners Ferry Road, Columbia, SC 29209 (803) 783-2661
- ☐ 1736 St. Matthews Road, Orangeburg, SC 29116 (803) 536-0613
- ☐ 7936 Broad River Road, Irmo, SC 29116 (803) 749-2508
- ☐ 4500 Forest Drive, Suite A, Columbia, SC 29206 (803) 738-9522
- ☐ 247 Columbia Avenue, Lexington, SC 29072 (803) 359-5533
- ☐ 1029 York Street NE, Aiken, SC 29801 (803) 648-4119
- ☐ 10040 Two Notch Road, Columbia, SC 29223 (803) 788-1153
- ☑ 4214 Hardscrabble Road, Columbia, SC 29223 (803) 736-8955
- ☐ 100 Jimmy Love Lane, Columbia, SC 29212 (803) 772-5030
- ☐ 2475 Broad Street, Sumter, SC 29150 (803) 778-6555
- ☐ 2836 Augusta Road, W. Columbia, SC 29170 (803) 939-0545
- ☐ 3240 Sunset Blvd., West Columbia, SC 29169 (803) 796-4251
- ☐ 1520 Knox Avenue, N. Augusta, SC 29841 (803) 279-4120

Name: Gayla Ramey Arrival Time: 845 Discharge Time: [redacted]

Date: 4/1/11 Company Name:: [redacted]

WORK STATUS: (Check Appropriate Boxes)

☐ 1. May perform full duty activities as of _____ without accommodations.

☐ 2. Off duty due to work-related condition.

Estimated return to work date with modified duty: _____

Estimated return to work date for full duty: _____

RETURN FOR RE-EVALUATION AT THIS LOCATION ON _____ **Time:** _____

☐ 3. May work with the following accommodations as of: 4/1/11

- ☒ No lifting more than 15 lbs.
- ☐ No operation of hazardous or fast-moving machinery, no driving.
- ☒ Ground level work only, no ladders or heights.
- ☒ No repetitive bending, stooping, squatting, pushing, jerking, twisting, or bouncing.
- ☐ No continuous standing and/or sitting.
- ☐ Minimal walking or climbing (including stairs)
- ☐ Limited use of _____
- ☒ No overhead lifting.
- ☐ No high repetitive hand activities for extended periods of time.
- ☐ No use of _____

☐ 4. Has reached Maximum Medical Improvement (MMI)

☒ 5. Return for re-evaluation at this office on 4/8/11 Time: _____

Additional Comments:

PATIENT DISCHARGE INSTRUCTIONS:

Diagnosis: cervical spine strain/neck pain Medications: ☒ as directed ☒ as needed

Wound or Injury Care: ☐ keep dry and clean ☐ do not remove dressing ☐ elevate extremity ☐ warm soaks

☐ ice every _____ ☒ apply heat every 6 hrs ☐ wear elastic support/immobilizer/keep taped

☐ home exercise instructions given ☐ follow instructions sheet given ☐ bed rest for _____

REFERRAL: If a referral is made for physical therapy, or to another physician, please complete this section:

To: _____ Date: _____ Time: _____

For: _____

Address: _____

I understand the above instructions and what to do for my follow-up care. I have received a copy of these instructions for myself and for my employer.

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Employee Signature: Gayla Ramey Date: 4/1/11

Provider Signature: Sarah Fortune 356 Date: 4/1/11

(MED-P014-(01-11))

medical affiliates

Workers' Compensation Policy & Procedure

Patient to Receive a Copy

[redacted]

All Work-Related Patients please read the following, and present this to your supervisor. You have Three (3) Payment Options.

1. EMPLOYER FILES TO THEIR WORKERS' COMPENSATION INSURANCE CARRIER

Your employer may file this visit/claim with their workers' compensation insurance carrier

- A Workers' Compensation Authorization Form must accompany the patient or must be faxed or emailed to the Doctors Care Office today, if during normal business hours, or the very next business day. A copy of this form can be found at www.doctorscare.com or at any Doctors Care office.
- A First Report of Injury must accompany the patient, or be sent to the Doctors Care office within three (3) business days and must be sent to the workers' compensation insurance carrier as well.
- The First Report of Injury is essential to file the claim. Once the First Report of Injury is submitted, we will file the claim to the workers' compensation insurance carrier.

2. EMPLOYER PAYS BILL ITSELF

Your employer may pay the bill within 10 business days without filing the claim.

- Please submit payment in the envelope provided for the services rendered within ten (10) business days of the visit.

3. PATIENT PAYS BILL

IF OPTIONS 1 or 2 ARE NOT COMPLETED, THE PATIENT WILL BE RESPONSIBLE FOR THE PAYMENT OF SERVICES RENDERED.

Patient will be given the following items upon departure.

1. A statement with the current account balance.
2. An envelope in which the Employer may use to pay the bill without filing a workers' compensation insurance claim.
3. A copy of this policy and procedure outline.

Patient Acknowledgement

I have been informed of the Doctors Care Policy and Procedure on all Work-Related Injuries. I understand that I will be personally responsible for the payment of services, if options 1 or 2 are not completed within 10 business days.

Gayla Ramey — 4/1/11
Patient's Printed Name — Date

[redacted] — Supervisor's Name
Patient or Authorized Person's Signature

Employer — Supervisor Phone #

[WKC-F004-(12-07)]

Apr. 20. 2011 9:31AM NO. 3330 P. 1

4 EXAM ROOM TIME 11 45 — Doctors Care — CHECKOUT TIME — TICKET NO. 2178057

ACCOUNT NUMBER	DATE	TIME	
471935	04/08/11 FRIDAY	11:46am	DC RIDGEVIEW,

NAME & ADDRESS: RAMEY, GAYLA [redacted]

[redacted]

WRK:
INSURED: RAMEY, GAYLA
INS: WC/ESIS/ACE
REASON: WC FOLLOW UP
NICKNAME:

DOB: 01/02/1961 (50 years)
GENDER: F

IBG:
CELL:

RELATION: OTHER

COPAY: WC

INSURANCE BALANCE	$896.00
ACCOUNT BALANCE	$896.00
CURRENT CHARGES	
AMOUNT PAID	
NEW BALANCE	

CASH	CHECK	M.O.	C.C.

Personal Hx: DM ___ HTN ___
Family Hx: DM ___ HTN ✓
Social Hx: Alcohol ___ Tobacco ✓

Accident? ☐ yes ☐ no If yes, which state: ___
Date of Accident: ___
Prev. chart rev., no sig chg.: ___ Above Hx rev.: M.K.

ROS (/ or O): ~~Fatigue~~, ~~Dizzy~~, ~~Weak~~, ~~Wt. Loss~~, ~~Fever~~, ~~Chills~~, ~~Nasal Congestion~~, Sinus Pain, Ear Pain, Sore Throat, SOB, CP, Cough, Sputum, Wheeze, ABD Pain, N, V, D, Constip., Dysuria, Freq., Urgency, Back Pain, Pelvic Pain, Vag. D/C, Headache, Syncope, Rash M.K. ☑ All others negative

Allergies: NKDA

Medications: HCTZ Levastatin

☑ Meds/Allergies Reviewed M.K.

VT	HT	BMI	BP	PULSE	RESP	TEMP	
146			128/74	68	14	98.1	☐ LMP ___ ☐ Tetanus ___

PHYSICAL: (see reverse) Omit if N/A
(✓ if nrml., O if abnrml. & give details)
✓ General
✓ HEENT
✓ Neck
✓ Nodes
✓ Lungs
✓ CV
✓ Abd
✓ Back
✓ Ext
✓ GU
✓ Neuro
✓ Skin/Breasts
✓ Chaperone ___
✓ I.V.
✓ Injection
✓ Nebulizer
✓ Procedure
✓ Pulse Ox ___

Chief Complaint:

HPI - XDOI: 3/11/2011 → Pt. Slipped on wooden stairs
- ⓐ MRI of C-spine ≈ 4/4/2011
  - ⓐ disc protrusion C3-C4
  - Chronic degen. disc changes
  - No spinal stenosis
- 784.0 - Sparring into neural foramina C-3 to C-6.

ⓐ PTP & Musc. Spasm
ⓑ Trapeezius Muscles.
H/A Pain & ☐ palp. of ⓑ Trapeezius distribution.

723.1 — 738.4

☐ CBC
☐ EKG
☐ FBS
☐ Flu
☐ Heme
☐ Hgb A1C
☐ H. Pylori
☐ KOH
☐ Microalb
☐ Mono
☐ Strep
☐ Tetanus
☐ U/A
☐ U Preg
☐ Wet Prep
☐ X-Ray
☐ Labs - Send Out

DIAGNOSIS:
0. Neck pain: ⓐ H/A (tension). ⓑ Spondylolisthesis

✓ Patient Care Instructions Discussed
✓ Lifestyle Modification
✓ Preventative Recommendation(s)
✓ Prescriptions / OTC Meds
✓ Side Effects Discussed
✓ Follow-Up: X 1-3d ⓐ Ortho M.D. ⓑ Re-Initiate Phys. Therap.

Return:
✓ Worsening symptoms: E.R.
✓ If not better: Ortho MD
Go to ER if:

Crutches/Splints/Supplies ☐ Given ☐ Recommended

Rx: ⓐ Naproxen Na+ 550mg #20.
ⓑ Medrol Dose Pak 4mg #21
ⓒ Ultram 50mg ☐ PRN pain.

PSR Notes: 99214 141 ESTAB

Off Work / School: VL

Staff: [signature] M.D., D.O., P.A., F.N.P.

I (print) hereby consent to any and all health care treatment and diagnostic procedures provided by Doctors Care and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Doctors Care. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Doctors Care Notice of Privacy Practices.
I authorize payment of medical benefits to Doctors Care physicians or their designee for services rendered.

Patient or Authorized Person's Signature: [signature] Date: 4/8/11

Workers Compensation patients: I hereby authorize Doctors Care to speak to a rehabilitation specialist, employer, my insurance carrier or other professionals involved in my care or rehabilitation, regarding my medical records and the treatment I have received or will receive. 11-1-11

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APP - 426

Doctors Care

Retu.. To Work Form

- 850 Aiken Mall Drive, Aiken, SC 29803 (803) 648-1464
- 511 Beltline Blvd., Columbia, SC 29205 (803) 782-4051
- 1060 Highway 1, South Lugoff, SC 29078 (803) 438-9759
- 977 Knox Abbott Drive, Cayce, SC 29033 (803) 794-0476
- 7653 Garners Ferry Road, Columbia, SC 29209 (803) 783-2661
- 1736 St Matthews Road, Orangeburg, SC 29116 (803) 536-0613
- 7936 Broad River Road, Irmo, SC 29116 (803) 749-2508
- 4500 Drive, Suite A, Columbia, SC 29206 (803) 738-9522
- 247 C ia Avenue, Lexington, SC 29072 (803) 359-5533
- 1029 York Street NE, Aiken, SC 29801 (803) 648-4119
- 10040 Two Notch Road, Columbia, SC 29223 (803) 788-1153
- 4214 Hardscrabble Road, Columbia, SC 29223 (803) 736-8955
- 100 Jimmy Love Lane, Columbia, SC 29212 (803) 772-5030
- 2475 Broad Street, Sumter, SC 29150 (803) 778-6555
- 2836 Augusta Road, W. Columbia, SC 29169 (803) 939-0545
- 3240 Sunset Blvd., West Columbia, SC 29169 (803) 796-4251
- 1520 Knox Avenue, N. Augusta, SC 29841 (803) 279-4120

Name: Gayle Ramey Arrival Time: 1100 Discharge Time:

Date: 4.8.11 Company Name:

WORK STATUS: (Check Appropriate Boxes)

- ☐ 1. May perform full duty activities as of _____ without accommodations.
- ☐ 2. Off duty due to work-related condition.
  - Estimated return to work date with modified duty: _____
  - Estimated return to work date for full duty: _____ Time: _____
  - **RETURN FOR RE-EVALUATION AT THIS LOCATION ON** 4/8/2011
- ☑ 3. May work with the following accommodations as of: _____
  - ☑ No lifting more than 15 lbs.
  - ☐ No operation of hazardous or fast-moving machinery, no driving.
  - ☑ Ground level work only, no ladders or heights.
  - ☑ No repetitive bending, stooping, squatting, pushing, jerking, twisting, or bouncing.
  - ☐ No continuous standing and/or sitting.
  - ☑ Minimal walking or climbing (including stairs)
  - ☑ Limited use of Neck
  - ☑ No overhead lifting.
  - ☐ No high repetitive hand activities for extended periods of time.
  - ☐ No use of _____
- ☐ 4. Has reached Maximum Medical Improvement (MMI) _____ Time: _____
- ☑ 5. Return for re-evaluation at this office on 4/18/2011 if unable to be seen by Ortho. MD

Additional Comments:

PATIENT DISCHARGE INSTRUCTIONS:

Diagnosis: ① Neck pain ② Spondylolisthesis Medications: ☑ as directed ☐ as needed

Wound or Injury Care: ☐ keep dry and clean ☐ do not remove dressing ☐ elevate extremity ☐ warm soaks

☐ Ice every _____ ☐ apply heat every _____ ☐ wear elastic support/immobilizer/keep taped

☐ home exercise instructions given ☐ follow instructions sheet given ☐ bed rest for _____

REFERRAL: If a referral is made for physical therapy, or to another physician, please complete this section:

To: Ortho M.D. Date: _____ Time: _____

For: _____

Address: _____

I understand the above instructions and what to do for my follow-up care. I have received a copy of these instructions for myself and for my employer.

Employee Signature: Gayle Ramey Date: 4/8/11

Date: 12/9/2011

Return To Work Form

☐ 850 Aiken Mall Drive, Aiken, SC 29803 (803) 648-1464
☐ 511 Beltline Blvd., Columbia, SC 29205 (803) 782-4051
☐ 1060 Highway 1, South Lugoff, SC 29078 (803) 438-9759
☐ 977 Knox Abbott Drive, Cayce, SC 29033 (803) 794-0476
☐ 7653 Garners Ferry Road, Columbia, SC 29209 (803) 783-2661
☐ 1736 St. Matthews Road, Orangeburg, SC 29116 (803) 536-0613
☐ 7936 Broad River Road, Irmo, SC 29116 (803) 749-2508
☐ 4500 Forest Drive, Suite A, Columbia, SC 29206 (803) 738-9522
☐ 247 Columbia Avenue, Lexington, SC 29072 (803) 359-5533
☐ 1029 York Street NE, Aiken, SC 29801 (803) 648-4119
☐ 10040 Two Notch Road, Columbia, SC 29223 (803) 788-1133
☐ 4814 Hardscrabble Road, Columbia, SC 29223 (803) 736-8955
☐ 100 Jimmy Love Lane, Columbia, SC 29212 (803) 772-5030
☐ 2475 Broad Street, Sumter, SC 29150 (803) 778-6555
☐ 2836 Augusta Road, W. Columbia, SC 29170 (803) 939-0545
☐ 3240 Sunset Blvd., West Columbia, SC 29169 (803) 796-4251
☐ 1520 Knox Avenue, N. Augusta, SC 29841 (803) 279-4120

Name: Gayla Ramey Arrival Time: 1100 Discharge Time: _____

Date: 4.8.11 Company Name: _____

WORK STATUS: (Check Appropriate Boxes)

☐ 1. May perform full duty activities as of _____ without accommodations.

☐ 2. Off duty due to work-related condition.

Estimated return to work date with modified duty: _____

Estimated return to work date for full duty: _____

RETURN FOR RE-EVALUATION AT THIS LOCATION ON _____ Time: _____

☐ 3. May work with the following accommodations as of: _____

- ☐ No lifting more than _____ lbs.
- ☐ No operation of hazardous or fast-moving machinery, no driving.
- ☐ Ground level work only, no ladders or heights.
- ☐ No repetitive bending, stooping, squatting, pushing, jerking, twisting, or bouncing.
- ☐ No continuous standing and/or sitting.
- ☐ Minimal walking or climbing (including stairs)
- ☐ Limited use of _____
- ☐ No overhead lifting.
- ☐ No high repetitive hand activities for extended periods of time.
- ☐ No use of _____

All restrictions as previously spoken

☐ 4. Has reached Maximum Medical Improvement (MMI) Time: _____

☐ 5. Return for re-evaluation at this office on _____

Additional Comments:

PATIENT DISCHARGE INSTRUCTIONS:

Diagnosis: _____ Medications: ☐ as directed ☐ as needed

Wound or Injury Care: ☐ keep dry and clean ☐ do not remove dressing ☐ elevate extremity ☐ warm soaks

☐ ice every _____ ☐ apply heat every _____ ☐ wear elastic support/immobilizer/keep taped

☐ home exercise instructions given ☐ follow instructions sheet given ☐ bed rest for _____

REFERRAL: If a referral is made for physical therapy, or to another physician, please complete this section:

To: _____ Date: _____ Time: _____

For: _____

Address: _____

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I understand the above instructions and what to do for my follow-up care. I have received a copy of these instructions for myself and for my employer.

Employee Signature: Gayla Ramey Date: 4/8/11

Provider Signature: _____ Date: _____

[MED-F014-(01-11)]

medical affiliates

Workers' Compensation Policy & Procedure

Patient to Receive a Copy

Doctors Care

All Work-Related Patients please read the following, and present this to your supervisor. You have Three (3) Payment Options.

1. EMPLOYER FILES TO THEIR WORKERS' COMPENSATION INSURANCE CARRIER

Your employer may file this visit/claim with their workers' compensation insurance carrier

- A Workers' Compensation Authorization Form must accompany the patient or must be faxed or emailed to the Doctors Care Office today, if during normal business hours, or the very next business day. A copy of this form can be found at www.doctorscare.com or at any Doctors Care office.
- A First Report of Injury must accompany the patient, or be sent to the Doctors Care office within three (3) business days and must be sent to the workers' compensation insurance carrier as well.
- The First Report of Injury is essential to file the claim. Once the First Report of Injury is submitted, we will file the claim to the workers' compensation insurance carrier.

2. EMPLOYER PAYS BILL ITSELF

Your employer may pay the bill within 10 business days without filing the claim.

- Please submit payment in the envelope provided for the services rendered within ten (10) business days of the visit.

3. PATIENT PAYS BILL

IF OPTIONS 1 or 2 ARE NOT COMPLETED, THE PATIENT WILL BE RESPONSIBLE FOR THE PAYMENT OF SERVICES RENDERED.

Patient will be given the following items upon departure.

1. A statement with the current account balance.
2. An envelope in which the Employer may use to pay the bill without filing a workers' compensation insurance claim.
3. A copy of this policy and procedure outline.

Patient Acknowledgement

I have been informed of the Doctors Care Policy and Procedure on all Work-Related Injuries. I understand that I will be personally responsible for the payment of services, if options 1 or 2 are not completed within 10 business days.

Cinda Ramey — Patient's Printed Name

4/8/11 — Date

Patient or Authorized Person's Signature

Josephine Elkins — Supervisor's Name

UPAC Tanglewood (Separated) — Employer

803-337-3211 — Supervisor Phone #

[WKC-F004-(12-07)]

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CAMDEN OPEN MRI

CAMDEN OPEN MRI
1202-A Mill Street
Camden, SC 29020

Phone: 1-803-432-0470
Fax: 1-803-432-0570

Patient: Gayla Ramey
Account #: 000294
DOB: 1/2/1961
Physician: Dr. Killian
Workers/Comp

PRELIMINARY REPORT

History: pain

CERVICAL SPINE MRI 3-31-11

Dislocation?

Multiple sequences reveal disc dislocation at all levels. The vertebral body heights, signals and alignment are normal. There is a small left disc protrusion at C3-4. On the right there is a small to moderate disc osteophyte complex at C3-4, C4-5 and C5-6. There are some degenerative facet joint changes at C3-4, C4-5 and C5-6 which are moderate. No spinal stenosis or definite myelopathy is seen. There is some mild to moderate spurring of the uncovertebral joints into the right and left (right greater than left) C3-4, C4-5 and C5-6 neural foramina.

IMPRESSION: DISC PROTRUSIONS AS DESCRIBED ABOVE, CHRONIC DEGENERATIVE DISC AND FACET JOINT CHANGES, NO SPINAL STENOSIS, SOME SPURRING INTO THE NEURAL FORAMINA FROM THE UNCOVERTEBRAL JOINTS AS DESCRIBED ABOVE.

Donald J. Copley, MD
Camden Radiology Associates

DJC/js

4/15/11

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Palmetto Spine & Sports Medicine, p.a.

Palmetto Spine Sports Medicine, P.A.

Timothy M. Zgleszewski, M.D.
Board Certified
- *Physiatry*
- *Pain Medicine*
- *Independent Medical Examiner*

Non-Operative Spine Care • Interventional Pain Medicine • Electrodiagnostics • Musculoskeletal Medicine

INDEPENDENT MEDICAL EXAMINATION

EXAMINEE:	Gayla Ramey
DATE OF EXAM:	July 19, 2011
DATE OF BIRTH:	January 2, 1961
DATE OF INJURY:	March 11, 2011
REFERRAL ORGANIZATION:	Calhoun Law Firm
REFERRING INDIVIDUAL:	Mark R. Calhoun, Esq.
EVALUATING PHYSICIAN:	Timothy M. Zgleszewski, M.D.
LOCATION OF EVALUATION:	Columbia, SC

Ms. Ramey was referred for an Independent Medical Evaluation at the request of the above agent. The IME process was explained to the examinee, and the examinee understands that no patient/ treating physician relationship exists and that a report will be sent to the requesting agent. Analysis is based upon the subjective complaints, history given by the examinee, review of medical records, tests provided to me and objective clinical findings on physical examination. History was provided by the examinee. Approximately 30 minutes were spent with the examinee. This included taking a history and performing a detailed physical examination. An additional 85 minutes were spent reviewing medical information and preparation of this report. As routinely performed in my medical practice, today's history was formulated by direct patient interview and, when available, medical records that from time to time are utilized for specific detail and accuracy of events regarding the mechanism of injury and the treatment rendered to the individual being evaluated.

HISTORY: Ms. Ramey is a 50 year old female who states she was involved in a work accident that occurred on or about March 11, 2011 while employed by UPAC Tanglewood, working a Nurse. The examinee states the injury occurred when she slipped on some wooden steps landing on her left hip and right upper extremity. She reports having discoloration of the left buttock post fall. The examinee states that she had immediate mid back, neck, and right wrist pain at the time of the injury. She states that she developed an intermittent stabbing sensation of the low back a few days later. She reports continued pain at the site of her wrist hematoma, and reports that there is a scar that has excess skin growth. The examinee also indicates that her neck pain is greater than her low back pain. She states that she has not received any treatment to date.

The examinee states the pain is located in the right and left low back. It does not radiate into the legs. The pain is described

as an achy, stabbing, sharp, and burning sensation. Aggravating factors include standing, walking, changes of position, forward bending, and twisting. Alleviating factors include over the counter medications. The examinee's current low back pain averages around 2/10 on the pain scale. At times it flares up to 9/10 on the pain scale.

The examinee states the pain is located in the right and left mid back. It does not radiate into the chest or ribs. The pain is described as a throbbing and achy sensation. Aggravating factors include forward bending, backward bending, pushing and pulling, as well as lying on her stomach. Alleviating factors include lying on her back. The examinee's mid back pain averages around 2/10 on the pain scale. At times it flares up to 5/10 on the pain scale.

The examinee states the pain is located in the right and left neck. It radiates into the right arm. The pain extends down to the shoulders. The pain is described as a throbbing, popping, achy, and stabbing sensation. The examinee states the pain is deep. Aggravating factors include forward neck bending, backward neck bending, lateral flexion to the left and right, pushing, pulling, lying on her stomach, side lying, coughing, sneezing, twisting of the neck, and reaching. The examinee's current neck pain averages around 2/10 on the pain scale. At times it flares up to 5/10 on the pain scale.

The examinee has not had any interventional spinal procedures in the past. The examinee has not gone through physical therapy. The examinee has not had chiropractic care. The examinee is taking Naproxen, Ibuprofen, Advil, and Soma for the pain with some reduction of her discomfort. The examinee's diagnostic testing includes x-rays and a Cervical MRI performed to date.

CURRENT MEDICATIONS: Zocor, HCTZ, Naproxen, Ibuprofen, Advil, and Soma

ALLERGIES: No Known Drug Allergies

PAST MEDICAL HISTORY: Bronchitis

PAST SURGICAL HISTORY: None

SOCIAL HISTORY: The examinee is a one and a half pack a day smoker and a non-drinker. She consumes an average amount of caffeinated beverages per day. She is married with four children. The examinee's highest level of education completed is an Associates Degree with some college.

FAMILY HISTORY: Non-contributory

WORK HISTORY: The examinee states that she has not worked since March 20, 2011.

REVIEW OF SYSTEMS: Non-contributory

GENERAL APPEARANCE: Physical examination reveals a well-developed and well-nourished slender female in a minimal to moderate amount of pain. Grooming, nutrition, and body habitus are otherwise normal for her age. The examinee is alert and oriented to time, place, and person with normal mood and affect.

Gait and station is nonantalgic. The examinee is able to raise up on her heels and toes. Inspection of the upper and lower extremities demonstrates no edema with intact radial and pedal pulses. Inspection of the low back demonstrates a normal lordosis. There is no lumbar shift present on today's examination. There are no prior surgical incisions at the lumbosacral spine. Range of motion of the lumbosacral spine is painful. Pain is increased with forward bending and extension. Range of motion of the hips is normal. There is negative simulated axial compression testing, negative simulated axial rotation testing, negative regional testing, and negative distraction testing. Overall today's Waddell's testing is negative.

On palpation, there is tenderness and spasms in the bilateral lumbar paraspinals. There is no generalized tenderness over the Greater Trochanters. There are no trigger points at the lumbosacral spine today. There is tightness noted in the bilateral piriformis muscles. There is tenderness over the bilateral PSIS's. There is a negative Fortin Finger test bilaterally. There is a positive Patrick's Test bilaterally. There are negative neural tension signs in both legs in the seated slumped position. There is a negative Straight Leg Raise Test bilaterally.

Inspection of the mid back demonstrates a normal thoracic curvature. There are no prior surgical incisions at the thoracic

spine. Range of motion of the thoracic spine is painful. Pain is increased with extension. There are trigger points located in the upper thoracic paraspinal muscles. Examination of the thoracic spine reveals no spinous process tenderness. There are mild spasms noted in the bilateral upper thoracic paraspinal muscles. Bilateral lower extremity motor examination was normal today. Bilateral lower extremity sensory examination was normal to soft touch and pinprick. Deep tendon reflexes of the bilateral patella and Achilles are normal and symmetric.

Inspection of the cervical spine demonstrates a normal cervical lordosis. There are no prior surgical incisions at the cervical spine. Range of motion of the cervical spine is painful. Pain is increased with extension as well as right and left lateral rotation. On palpation, there is tenderness and spasms in the bilateral cervical paraspinals. There is tenderness in the bilateral cervical facet joints. There is no tenderness over the bilateral Greater Occipital Nerves. There are trigger points located in the bilateral scalene, upper trapezius, and cervical paraspinal muscles with a positive twitch response. There is tightness noted in the bilateral upper trapezius muscles. There are negative neural tension signs in both arms in the median, ulnar, and radial biases. Bilateral upper extremity motor examination was normal. Bilateral upper extremity sensory examination was normal to soft touch and pinprick. Deep tendon reflexes of the bilateral biceps, triceps, and brachioradialis are normal and symmetric.

DIAGNOSTIC TESTING/MEDICAL RECORDS:

1. Doctors Care
2. Camden Open MRI

DIAGNOSES:

1. Cervical pain
2. Probable cervical facet joint dysfunction/pain and or aggravation of pre-existing cervical degenerative disc disease
3. Thoracic pain
4. Probable thoracic facet joint dysfunction/pain
5. Low back pain
6. Probable sacroiliac joint dysfunction/pain

DISCUSSION: After reviewing today's history, physical examination, review of the medical records, and provided diagnostic testing, the examinee has the above diagnoses. It is my medical opinion that the above diagnoses are causally related to the work accident in question. The mechanism of injury described is consistent with the above diagnoses. It is my medical opinion that the examinee is not currently at Maximal Medical Improvement (MMI).

The cause of the examinee's low back pain is coming from the examinee's bilateral sacroiliac joint based on the mechanism of injury as well as physical examination today with positive maneuvers for bilateral sacroiliac joint pain. The bilateral sacroiliac joints have not been tested to date.

The examinee will require rehabilitation therapy to address the low back pain, but will require further diagnostic testing and treatment as outlined below prior to the initiation of rehabilitation therapy.

The examinee will require diagnostic sacroiliac joint (SI) injections to the bilateral SI joints under fluoroscopic guidance utilizing a pain diary. If positive, she will need to proceed with therapeutic SI joint injections with corticosteroids. If no long term benefit is obtained, then she will need to proceed with radiofrequency ablation of the involved SI joints.

The examinee is a candidate for Deepwave Treatment/Percutaneous Electrical Nerve Stimulation (PENS) secondary to the low back pain. The examinee will require six in office treatments; and if successful, she will possibly require a home unit. Deepwave Treatment will most probably tend to increase the examinee's functional ability as well as to lessen her discomfort and the need for pain medications, thus enhancing the examinee's overall quality of life. We are able to provide the above treatment here at Palmetto Spine & Sports Medicine, P.A.

The examinee will require oral pain medications to control her low back pain. These medications would include narcotic pain medications, nerve type pain medications (i.e. neurontin), and the non-steroidal anti-inflammatory medications.

Ms. Ramey is not currently at Maximal Medical Improvement (MMI). If Ms. Ramey is deemed to be at MMI, then based on the AMA Guides to the Evaluation of Permanent Impairment 5th Edition, secondary to the bilateral SI joint dysfunction and pain, the examinee has a 5% impairment to the back/spine. This is based on page 428, Table 15-19.

The examinee's thoracic (mid back) pain is most probably coming from the bilateral upper thoracic facet joints. This is based on the mechanism of injury, review of the medical records, as well as the positive finding on physical examination today, including muscle spasms over the bilateral upper thoracic paraspinals, tenderness over the bilateral upper thoracic facet joints, and increased pain with extension. The thoracic facet joints have not been tested to date.

The examinee will require rehabilitation therapy to address the thoracic pain, but will require further diagnostic testing and treatment as outlined below prior to the initiation of rehabilitation therapy.

The examinee will require diagnostic lumbar facet nerve blocks to the bilateral upper thoracic facet joints under fluoroscopic guidance utilizing a pain diary. If positive, she will need to proceed with therapeutic facet joint injections with corticosteroids. If no long term benefit is obtained, then she will need to proceed with radiofrequency ablation to the medial branches of the involved facet joints.

The examinee is a candidate for Deepwave Treatment/Percutaneous Electrical Nerve Stimulation (PENS) secondary to the thoracic pain. The examinee will require six in office treatments; and if successful, she will possibly require a home unit. Deepwave Treatment will most probably tend to increase the examinee's functional ability as well as to lessen her discomfort and the need for pain medications, thus enhancing the examinee's overall quality of life. We are able to provide the above treatment here at Palmetto Spine & Sports Medicine, P.A.

The examinee will require oral pain medications to control her thoracic pain. These medications would include narcotic pain medications, nerve type pain medications (i.e. neurontin), and the non-steroidal anti-inflammatory medications.

Ms. Ramey is not currently at Maximal Medical Improvement (MMI). If Ms. Ramey is deemed to be at MMI, then based on the AMA Guides to the Evaluation of Permanent Impairment 5th Edition, the examinee is considered to be DRE Thoracic Category II, 8% impairment to the back/spine.

The examinee's cervical (neck) pain is most probably coming from the bilateral cervical facet joints. This is based on the mechanism of injury, review of the medical records, as well as the positive findings on physical examination today, including muscle spasms and tenderness over the bilateral cervical facet joints, and increased pain on extension of the neck. The cervical facet joints have not been tested to date. The other possibility would be an aggravation of the pre-existing degenerative disc disease.

The examinee will require rehabilitation therapy to address the neck pain, but will require further diagnostic testing and treatment as outlined below prior to the initiation of rehabilitation therapy.

The examinee will require diagnostic cervical facet nerve blocks to the bilateral C4-5, C5-6, and C6-7 facet joints under fluoroscopic guidance utilizing a pain diary. If positive, she will need to proceed with therapeutic facet joint injections with corticosteroids. If no long term benefit is obtained, then she will need to proceed with radiofrequency ablation to the medial branches of the involved facet joints. If this does not relieve her pain, then she would require a surgical consultation.

The examinee will require trigger point injections the bilateral scalene, upper trapezius, and cervical parapsinal muscles.

The examinee is a candidate for Deepwave Treatment/Percutaneous Electrical Nerve Stimulation (PENS) secondary to the neck pain. The examinee will require six in office treatments; and if successful, she will possibly require a home unit. Deepwave Treatment will most probably tend to increase the examinee's functional ability as well as to lessen her discomfort and the need for pain medications, thus enhancing the examinee's overall quality of life. We are able to provide the above treatment here at Palmetto Spine & Sports Medicine, P.A.

The examinee will require oral pain medications to control her neck pain. These medications would include narcotic pain medications, nerve type pain medications (i.e. neurontin), and the non-steroidal anti-inflammatory medications.

Ms. Ramey is not currently at Maximal Medical Improvement (MMI). If Ms. Ramey is deemed to be at MMI, then based on the AMA Guides to the Evaluation of Permanent Impairment 5th Edition, the examinee is considered to be DRE Cervical Category II, 8% impairment to the back/spine.

If needed, I could assume the care of this examinee to carry out the above.

The examinee may not return to work in my medical opinion until the above additional diagnostic testing and treatment is rendered. In my medical opinion, the examinee would be at risk for further injury if she returns to work before the additional diagnostic testing and treatment is rendered.

Recommendations regarding the examinee's ability to work, or participate in activities of daily living and other opinions provided in this report are given totally independent of the requesting agent. If any new medical records are provided, the above recommendations and opinions may change. These recommendations and opinions are based upon reasonable degree of medical certainty.

At the conclusion of the examination, the examinee was asked whether or not there was any information that was not asked that she wanted to include in this report. The answer to this question was no.

The above diagnostic and treatment recommendations will most probably tend to lessen the examinee's period of disability and impairment and prevent regression of her condition. The above recommendations and opinions are made with a reasonable degree of medical certainty and are made independent of the requesting agent.

"I certify and affirm that the foregoing report is true to the best of my knowledge under penalty of perjury."

Thank you for allowing me to complete this IME of Gayla Ramey. I believe I have answered all questions asked of me. If there are any further inquiries, please do not hesitate to contact me in writing.

Timothy M. Zgleszewski, M.D.
Board Certified Physical Medicine Rehabilitation
Sub Specialty Board Certified, Pain Medicine
Fellowship Trained Interventional Spine/Pain Medicine

cc: Mark R. Calhoun, Esq.
Phone#: (803) 957-8401
Fax#: (803) 957-4709

Electronically signed by Timothy M. Zgleszewski, M.D. on 07/25/2011 at 12:33:00 PM

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EXHIBITS

1) Deposition Transcript of Linda Burr scheduled for August 3, 2011

2) Claimants Wage Record Subpoenaed on April 6, 2011

CALHOUN LAW FIRM

MARK R. CALHOUN
ATTORNEY AT LAW

OFFICE: 803-957-8401
TELECOPIER: 803-957-4709

714 EAST MAIN STREET
LEXINGTON, S.C. 29072

April 6, 2011

Unity HealthPost Acute Care of Tanglewood
Attn: Personnel Department
213 Tanglewood Court
Ridgeway, SC 29130

Re: Gayla Ramey
DOB: 01/02/1961
Date of Injury: 03/11/2011

Dear Sir/Madam:

Enclosed please find a *subpoena duces tecum* for all **Personnel File and Wage Records** on the above Claimant. If these records are provided by the request date by U.S. mail your personal appearance is not necessary. Please notice that we are requesting all records. All records should be sent to my street address.

The Subpoena will allow/require you to release this information to us.

If you have any questions, please do not hesitate to contact my office.

Sincerely,

Mark R. Calhoun

MRC/mcm
enclosure

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803)737-5700

WCC File #
Carrier File #
Carrier Code #
Employer FEIN

Gayla Ramey [redacted]
Claimant's Name SSN

[redacted] [redacted]
Address City State Zip

Home Phone # Work Phone #

Unity HealthPost Acute Care of Tanglewood
Employer's Name

213 Tanglewood Court Ridgeway, SC 29130
Address City State Zip

American Zurich Insurance Company
Insurance Carrier

Mark R. Calhoun (803) 957-8401
Preparer's Name Phone #

TO: Unity HealthPost Acute Care of Tanglewood- Personnel Department

☐ **YOU ARE COMMANDED** to appear before the above named Commission at the place, date and time specified below to testify in the above case.

PLACE OF TESTIMONY: ROOM:

DATE AND TIME:

☐ **YOU ARE COMMANDED** to appear at the place, date and time specified below to testify at the taking of a deposition in the above case.

PLACE OF DEPOSITION: DATE AND TIME:

☒ **YOU ARE COMMANDED** to produce and permit inspection and copying of the following documents or objects in your possession, custody or control at the place, date and time specified below (list documents or objects):

PLACE: 714 East Main Street. Lexington, SC 29072 DATE AND TIME: 04/13/2011 at 5:00pm

ANY AND ALL PERSONNEL RECORDS AND WAGE RECORDS ON THE ABOVE CLAIMANT.

☐ **YOU ARE COMMANDED** to permit inspection of the following premises at the date and time specified below.

PREMISES: DATE AND TIME:

THIS SUBPOENA SHALL REMAIN IN EFFECT UNTIL YOU ARE GRANTED PERMISSION TO DEPART BY THE COMMISSIONER OR AN OFFICER ACTING ON BEHALF OF THE COMMISSIONER QUESTIONS CONCERNING THIS SUBPOENA SHOULD BE ADDRESSED TO THE ISSUING OFFICER.

MJ GA (803) 957-8401 04/06/2011
ISSUING OFFICER'S SIGNATURE AND TITLE PHONE # DATE

Serve this form according to R.67-21213. Refer to R.67-212 and R.67-214 for additional information. Procedural questions may be addressed to the Judicial Department (803/737-5675).

WCC FORM # 27 REV. DATE 3/96

SUBPOENA
APP - 441

Archived Time Card Report

Includes one single employee.

Ramey, Gayla

Location	Heritage Healthcare Ridgew	SSN	[redacted]
Department	6100 RN CERTIFIED	Class	Ridgeway
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277482		

03/07/10 to 03/20/10

Date	In	Out	In	Out	Hours	Schedule	Exceptions
03/07/10	8:33a	3:19p			6:15	Unsch.	Unsch.
03/07/10	10:48p	7:51a			8:30	Unsch.	Unsch.
03/07/10					14:45	REGULAR	
03/09/10	6:56a	4:46p			9:15	Unsch.	Unsch.
03/09/10					9:15	REGULAR	
03/10/10	6:50a	3:54p			8:45	Unsch.	Unsch.
03/10/10					8:45	REGULAR	
03/11/10	6:51a	3:44p			8:30	Unsch.	Unsch.
03/11/10					3.5000	MEALS	
03/11/10					1:15	OVERTIME	
03/12/10	8:48a	3:50p			7:15	REGULAR	
03/12/10					8:30	Unsch.	Unsch.
03/15/10	6:54a	3:56p			8:30	OVERTIME	
03/15/10					8:30	Unsch.	Unsch.
03/16/10	6:56a	3:43p			8:30	REGULAR	
03/16/10					8:15	Unsch.	Unsch.
03/17/10	6:54a	2:52p			8:15	REGULAR	
03/17/10					7:15	Unsch.	Unsch.
03/18/10	6:54a	2:57p			7:15	REGULAR	
03/18/10					7:30	Unsch.	Unsch.
03/20/10	6:54a	3:17p			7:30	REGULAR	
03/20/10	11:01p	8:29a	8:52a	3:35p	7:45	Unsch.	Unsch.
03/20/10					15:30	Unsch.	Unsch.
03/20/10					14:45	OVERTIME	
					8:30	REGULAR	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	80:00	25.0400	2003.2000
027-6100-01	OVERTIME	24:30	37.5600	920.2200
027-6100-01	MEALS	0:00	0.0000	3.5000

Supervisor Edits

MELANIES 03/23/10 11:45a AUTHORIZED PERIOD BEGINNING 03/07/10 AND SECURED
LYNDAB 03/22/10 3:15p CREDIT 3.5000 MEALS 027-6100-01 03/11/10

Gayla Ramey
$57,156.93 ÷ 52 = 1,099.17
X 66.6% =
$ 732.04

Archived Time Card Report

Includes one single employee.

Ramey, Gayla [redacted]

Location	Heritage Healthcare Ridgew	SSN	[redacted]
Department	6100 RN CERTIFIED	Class	Ridgeway
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277462		

03/21/10 to 04/03/10

Date	In	Out	In	Out	Hours	Schedule	Exceptions
03/22/10	11:00p	3:32p			15:30	Unsch.	Unsch.
03/22/10					15:30	REGULAR	
03/24/10	6:55a	3:17p			7:45	Unsch.	Unsch.
03/24/10					3.5000	MEALS	
03/24/10					7:45	REGULAR	
03/25/10	6:56a	4:03p			8:30	Unsch.	Unsch.
03/25/10					8:30	REGULAR	
03/26/10	6:48a	3:36p			8:15	Unsch.	Unsch.
03/26/10					8:15	REGULAR	
03/29/10	6:59a	3:47p			8:15	Unsch.	Unsch.
03/29/10					8:15	REGULAR	
03/30/10	6:53a	3:19p			7:45	Unsch.	Unsch.
03/30/10					7:45	REGULAR	
03/31/10	7:01a	3:37p			8:00	Unsch.	Unsch.
03/31/10					8:00	REGULAR	
04/01/10	7:00a	4:21p			8:45	Unsch.	Unsch.
04/01/10					8:45	REGULAR	
04/03/10	6:47a	11:31a	12:03p	11:19p	15:30	Unsch.	Unsch.
04/03/10					8:15	OVERTIME	
04/03/10					7:15	REGULAR	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	80:00	25.0400	2003.2000
027-6100-01	OVERTIME	8:15	37.5600	309.8700
027-6100-01	MEALS	0:00	0.0000	3.5000

Supervisor Edits

MELANIES 04/06/10 11:34a AUTHORIZED PERIOD BEGINNING 03/21/10 AND SECURED
LYNDAB 04/05/10 9:27p CREDIT 3.5000 MEALS 027-6100-01 03/24/10

Archived Time Card Report

Includes one single employee.

Ramey, Gayla [redacted]

Location	Heritage Healthcare Ridgew	SSN	[redacted]
Department	6100 RN CERTIFIED	Class	Ridgeway
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277482		

04/04/10 to 04/17/10

Date	In	Out	In	Out	Hours	Schedule	Exceptions
04/04/10	7:06a	3:53p			8:30	Unsch.	Unsch.
04/04/10					8:30	REGULAR	
04/06/10	6:53a	3:05p			7:30	Unsch.	Unsch.
04/06/10					7:30	REGULAR	
04/07/10	6:58a	3:00p			7:30	Unsch.	Unsch.
04/07/10					7:30	REGULAR	
04/08/10	6:30a	4:11p			9:15	Unsch.	Unsch.
04/08/10					9:15	REGULAR	
04/09/10	6:23a	3:23p			8:30	Unsch.	Unsch.
04/09/10	10:52p	7:17a			8:00	Unsch.	Unsch.
04/09/10					9:15	OVERTIME	
04/09/10					7:15	REGULAR	
04/12/10	6:53a	11:15a	11:29a	5:06p	9:30	Unsch.	Unsch.
04/12/10					3.5000	MEALS	
04/12/10					9:30	REGULAR	
04/13/10	6:55a	11:10p			15:15	Unsch.	Unsch.
04/13/10					15:15	REGULAR	
04/14/10	6:54a	11:41a	12:02p	8:43p	13:15	Unsch.	Unsch.
04/14/10					13:15	REGULAR	
04/15/10	6:54a	3:24p			8:00	Unsch.	Unsch.
04/15/10					6:00	OVERTIME	
04/15/10					2:00	REGULAR	
04/17/10	6:57a	3:31p			8:00	Unsch.	Unsch.
04/17/10					8:00	OVERTIME	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	80:00	25.0400	2003.2000
027-6100-01	OVERTIME	23:15	37.5600	873.2700
027-6100-01	MEALS	0:00	0.0000	3.5000

Supervisor Edits

MELANIES 04/20/10 11:40a AUTHORIZED PERIOD BEGINNING 04/04/10 AND SECURED
LYNDAB 04/19/10 7:32p ADD PUN 04/07/10 3:00p
LYNDAB 04/19/10 6:01p CREDIT 3.5000 MEALS 027-6100-01 04/12/10

Archived Time Card Report

Includes one single employee.

Ramey, Gayla [redacted]

Location	Heritage Healthcare Ridgew	SSN	[redacted]
Department	6100 RN CERTIFIED	Class	Ridgeway
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277482		

04/18/10 to 05/01/10

Date	In	Out	In	Out	Hours	Schedule	Exceptions
04/18/10	6:52a	3:36p			8:15	Unsch.	Unsch.
04/18/10					8:15	REGULAR	
04/20/10	6:26a	3:18p			8:15	Unsch.	Unsch.
04/20/10					8:15	REGULAR	
04/21/10	6:21a	11:05p			15:45	Unsch.	Unsch.
04/21/10					15:45	REGULAR	
04/22/10	6:58a	10:59a	11:11a	3:05p	7:30	Unsch.	Unsch.
04/22/10					3.5000	MEALS	
04/22/10					7:30	REGULAR	
04/23/10	6:52a	3:32p			8:15	Unsch.	Unsch.
04/23/10					8:00	OVERTIME	
04/23/10					0:15	REGULAR	
04/26/10	7:05a	3:30p			8:00	Unsch.	Unsch.
04/26/10					8:00	REGULAR	
04/27/10	6:57a	3:18p			7:45	Unsch.	Unsch.
04/27/10					7:45	REGULAR	
04/28/10	6:58a	3:03p			7:30	Unsch.	Unsch.
04/28/10					3.5000	MEALS	
04/28/10					7:30	REGULAR	
04/29/10	6:59a	3:42p			8:15	Unsch.	Unsch.
04/29/10					8:15	REGULAR	
05/01/10	6:29a	3:29p			8:30	Unsch.	Unsch.
05/01/10					8:30	REGULAR	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	80:00	25.0400	2003.2000
027-6100-01	OVERTIME	8:00	37.5600	300.4800
027-6100-01	MEALS	0:00	0.0000	7.0000

Supervisor Edits

MELANIES 05/04/10 11:39a AUTHORIZED PERIOD BEGINNING 04/18/10 AND SECURED
LYNDAB 05/03/10 4:40p CREDIT 3.5000 MEALS 027-6100-01 04/22/10
LYNDAB 05/03/10 5:04p CREDIT 3.5000 MEALS 027-6100-01 04/28/10

Archived Time Card Report

Includes one single employee.

Ramey, Gayla [redacted]

Location	Heritage Healthcare Ridgew	SSN	[redacted]
Department	6100 RN CERTIFIED	Class	Ridgeway
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277482		

05/02/10 to 05/15/10

Date	In	Out	In	Out	Hours	Schedule	Exceptions
05/02/10	6:55a	11:18a	11:37a	3:27p	8:00	Unsch.	Unsch.
05/02/10	11:02p	12:18a	12:46a	7:12a	7:45	Unsch.	Unsch.
05/02/10					15:45	REGULAR	
05/04/10	6:52a	3:25p			8:15	Unsch.	Unsch.
05/04/10					8:15	REGULAR	
05/05/10	6:51a	10:29a	11:03a	3:25p	8:15	Unsch.	Unsch.
05/05/10					8:15	REGULAR	
05/06/10	6:51a	3:29p			8:15	Unsch.	Unsch.
05/06/10					0:30	OVERTIME	
05/06/10					7:45	REGULAR	
05/07/10	7:03a	7:30a	8:31a	3:00p	7:00	Unsch.	Unsch.
05/07/10					7:00	OVERTIME	
05/08/10	10:47p	11:33a	11:47a	3:09p	15:30	Unsch.	Unsch.
05/09/10					15:30	REGULAR	
05/11/10	7:05a	3:44p			8:15	Unsch.	Unsch.
05/11/10	10:43p	10:18a	10:54a	3:01p	15:15	Unsch.	Unsch.
05/11/10					23:30	REGULAR	
05/13/10	7:06a	3:21p			7:45	Unsch.	Unsch.
05/13/10					6:45	OVERTIME	
05/13/10					1:00	REGULAR	
05/15/10	7:30a	3:21p			7:15	Unsch.	Unsch.
05/15/10					7:15	OVERTIME	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	80:00	25.0400	2003.2000
027-6100-01	OVERTIME	21:30	37.5600	807.5400

Supervisor Edits

MELANIES 05/18/10 9:53a AUTHORIZED PERIOD BEGINNING 05/02/10 AND SECURED
LYNDAB 05/14/10 4:21p ADD PUN 05/07/10 3:00p

Archived Time Card Report

Includes one single employee.

Ramey, Gayla [redacted]

Location	Heritage Healthcare Ridgew	SSN	[redacted] Ridgeway
Department	6100 RN CERTIFIED	Class	
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277482		

05/16/10 to 05/29/10

Date	In	Out	In	Out	Hours	Schedule	Exceptions
05/16/10	7:02a	9:45a	10:29a	10:50p	14:30	Unsch.	Unsch.
05/16/10					14:30	REGULAR	
05/17/10	7:24a	10:40p			14:15	Unsch.	Unsch.
05/17/10					14:15	REGULAR	
05/18/10	7:00a	3:00p			7:30	Unsch.	Unsch.
05/18/10					7:30	REGULAR	
05/19/10	6:59a	3:38p			8:15	Unsch.	Unsch.
05/19/10					4:30	OVERTIME	
05/19/10					3:45	REGULAR	
05/20/10	7:00a	10:28a	10:43a	3:49p	8:15	Unsch.	Unsch.
05/20/10					8:15	OVERTIME	
05/21/10	5:58a	11:00a	11:28a	3:26p	8:00	Unsch.	Unsch.
05/21/10					8:00	OVERTIME	
05/23/10	10:47p	3:35p			15:45	Unsch.	Unsch.
05/23/10					15:45	REGULAR	
05/25/10	6:55a	3:35p			8:00	Unsch.	Unsch.
05/25/10					8:00	REGULAR	
05/26/10	7:14a	8:11a			1:00	Unsch.	Unsch.
05/26/10					1:00	REGULAR	
05/27/10	1:58p	2:32p			0:30	Unsch.	Unsch.
05/27/10					0:30	REGULAR	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	65:15	25.0400	1633.8600
027-6100-01	OVERTIME	20:45	37.5600	779.3701

Supervisor Edits

LYNDAB 05/17/10 1:04p ADD PUN 05/16/10 10:50p (Power out.)
MELANIES 06/01/10 9:51a AUTHORIZED PERIOD BEGINNING 05/16/10 AND SECURED
LYNDAB 05/21/10 2:13p ADD PUN 05/18/10 7:00a

Archived Time Card Report

Includes one single employee.

Ramey, Gayla [redacted]

Location	Heritage Healthcare Ridgew	SSN	[redacted]
Department	6100 RN CERTIFIED	Class	Ridgeway
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277482		

05/30/10 to 06/12/10

Date	In	Out	In	Out	Hours	Schedule	Exceptions
05/31/10					8:00	PTO	
06/01/10					8:00	PTO	
06/02/10					8:00	PTO	
06/03/10					8:00	PTO	
06/04/10					8:00	PTO	
06/07/10	7:00a	3:47p			8:15	Unsch.	Unsch.
06/07/10					8:15	REGULAR	
06/08/10	6:56a	4:07p			8:30	Unsch.	Unsch.
06/08/10					8:30	REGULAR	
06/09/10	6:57a	4:40p			9:15	Unsch.	Unsch.
06/09/10					9:15	REGULAR	
06/10/10	6:49a	4:04p			8:45	Unsch.	Unsch.
06/10/10					8:45	REGULAR	
06/11/10	6:36a	10:25a	10:44a	3:58p	9:00	Unsch.	Unsch.
06/11/10					3:45	OVERTIME	
06/11/10					5:15	REGULAR	
06/12/10	6:59a	3:18p			7:45	Unsch.	Unsch.
06/12/10					7:45	OVERTIME	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	40:00	25.0400	1001.6000
027-6100-01	OVERTIME	11:30	37.5600	431.9400
027-6100-01	PTO	40:00	25.0400	1001.6000

Supervisor Edits

MELANIES 06/15/10 9:03a AUTHORIZED PERIOD BEGINNING 05/30/10 AND SECURED
LYNDAB 06/13/10 1:25p CREDIT 8:00 PTO 027-6100-01 05/31/10
LYNDAB 06/13/10 1:25p CREDIT 8:00 PTO 027-6100-01 06/01/10
LYNDAB 06/13/10 1:25p CREDIT 8:00 PTO 027-6100-01 06/02/10
LYNDAB 06/13/10 1:25p CREDIT 8:00 PTO 027-6100-01 06/03/10
LYNDAB 06/13/10 1:24p CREDIT 8:00 PTO 027-6100-01 06/04/10

Archived Time Card Report

Includes one single employee.

Ramey, Gayla [redacted]

Location	Heritage Healthcare Ridgew	SSN	[redacted]		
Department	6100 RN CERTIFIED	Class	Ridgeway		
Cost Center	GENERAL	Hire Date	07/24/02		
Badge	0	Rate	25.0400		
ID Number	650277482				

05/13/10 to 06/26/10

Date	In	Out	In	Out	Hours	Schedule	Exceptions
05/13/10	7:01a	4:10p			8:45	Unsch.	Unsch.
05/13/10	10:46p	8:06a			8:45	Unsch.	Unsch.
06/13/10					17:30	REGULAR	
06/15/10	6:39a	3:29p			8:15	Unsch.	Unsch.
06/15/10					8:15	REGULAR	
06/16/10	7:01a	3:38p			8:15	Unsch.	Unsch.
06/16/10					8:15	REGULAR	
06/17/10	6:40a	4:51p			9:30	Unsch.	Unsch.
06/17/10					3:30	OVERTIME	
06/17/10					6:00	REGULAR	
06/18/10	7:02a	3:53p			8:30	Unsch.	Unsch.
06/18/10					8:30	OVERTIME	
06/21/10	6:55a	3:53p			8:30	Unsch.	Unsch.
06/21/10					8:30	REGULAR	
06/22/10	6:48a	4:58p			9:45	Unsch.	Unsch.
06/22/10					9:45	REGULAR	
06/23/10	8:59a	9:56a	10:12a	1:12p	5:45	Unsch.	Unsch.
06/23/10					5:45	REGULAR	
06/24/10	6:57a	3:33p			8:00	Unsch.	Unsch.
06/24/10					8:00	REGULAR	
06/26/10	7:11a	11:51a	12:03p	4:03p	8:15	Unsch.	Unsch.
06/26/10					0:15	OVERTIME	
06/26/10					8:00	REGULAR	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	80:00	25.0400	2003.2000
027-6100-01	OVERTIME	12:15	37.5600	460.1100

Supervisor Edits

MELANIES 05/28/10 9:02a AUTHORIZED PERIOD BEGINNING 06/13/10 AND SECURED

Archived Time Card Report

Includes one single employee.

Ramey, Gayla [redacted]

Location	Heritage Healthcare Ridgew	SSN	[redacted]
Department	6100 RN CERTIFIED	Class	Ridgeway
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277462		

06/27/10 to 07/10/10

Date	In	Out	In	Out	Hours	Schedule	Exceptions
06/27/10	7:02a	3:40p			8:15	Unsch.	Unsch.
06/27/10					8:15	REGULAR	
06/29/10	6:46a	3:39p			8:30	Unsch.	Unsch.
06/29/10					8:30	REGULAR	
06/30/10	6:59a	10:43a	11:20a	3:54p	8:30	Unsch.	Unsch.
06/30/10					8:30	REGULAR	
07/01/10	7:10a	11:58a			4:45	Unsch.	Unsch.
07/01/10					4:45	REGULAR	
07/02/10	7:17a	3:30p			7:45	Unsch.	Unsch.
07/02/10					7:45	REGULAR	
07/03/10	7:01a	9:55a	10:34a	3:34p	7:45	Unsch.	Unsch.
07/03/10					5:30	OVERTIME	
07/03/10					2:15	REGULAR	
07/04/10	10:42p	9:53a	10:05a	3:38p	16:00	Unsch.	Unsch.
07/04/10					16:00	REGULAR	
07/06/10					8:00	PTO	
07/07/10					8:00	PTO	
07/08/10	6:54a	3:59p			8:30	Unsch.	Unsch.
07/08/10					8:30	REGULAR	
07/10/10	6:51a	11:28a	12:04p	3:28p	8:15	Unsch.	Unsch.
07/10/10					8:15	REGULAR	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	72:45	25.0400	1821.6600
027-6100-01	OVERTIME	5:30	37.5600	206.5800
027-6100-01	PTO	16:00	25.0400	400.6400

Supervisor Edits

MELANIES 07/13/10 10:11a AUTHORIZED PERIOD BEGINNING 06/27/10 AND SECURED
LYNDAB 07/12/10 5:09p CREDIT 8:00 PTO 027-6100-01 07/06/10
LYNDAB 07/12/10 5:09p CREDIT 8:00 PTO 027-6100-01 07/07/10

Archived Time Card Report

Includes one single employee.

Ramey, Gayla [redacted] Location: Heritage Healthcare Ridgew SSN: [redacted] Ridgeway
Department: 6100 RN CERTIFIED Class: 07/24/02
Cost Center: GENERAL Hire Date: 25.0400
Badge: 0 Rate:
ID Number: 850277482

07/11/10 to 07/24/10

Date	In	Out	In	Out	Hours	Schedule	Exceptions
07/11/10	7:02a	3:27p			8:00	Unsch.	Unsch.
07/11/10					8:00	REGULAR	
07/13/10	6:59a	3:51p			8:15	Unsch.	Unsch.
07/13/10					8:15	REGULAR	
07/14/10	6:59a	3:58p			8:30	Unsch.	Unsch.
07/14/10					8:30	REGULAR	
07/15/10	7:03a	3:26p			8:00	Unsch.	Unsch.
07/15/10					8:00	REGULAR	
07/16/10	6:58a	3:40p			8:15	Unsch.	
07/16/10					1:00	OVERTIME	
07/16/10					7:15	REGULAR	
07/19/10	6:54a	10:32a	11:23a	3:28p	7:45	Unsch.	Unsch.
07/19/10					7:45	REGULAR	
07/20/10	6:58a	3:40p			8:15	Unsch.	Unsch.
07/20/10					8:15	REGULAR	
07/21/10	6:57a	3:31p			8:00	Unsch.	Unsch.
07/21/10					8:00	REGULAR	
07/22/10	6:58a	11:04a	11:19a	3:23p	8:00	Unsch.	Unsch.
07/22/10					8:00	REGULAR	
07/24/10	6:54a	11:28a	11:47a	4:03p	8:30	Unsch.	Unsch.
07/24/10					0:30	OVERTIME	
07/24/10					8:00	REGULAR	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	80:00	25.0400	2003.2000
027-6100-01	OVERTIME	1:30	37.5600	56.3400

Supervisor Edits

MELANIES 07/27/10 1:11p AUTHORIZED PERIOD BEGINNING 07/11/10 AND SECURED
LYNDAS 07/26/10 2:44p ADD PUN 07/20/10 3:40p

Archived Time Card Report

Includes one single employee.

Ramey, Gayla [redacted]

Location	Heritage Healthcare Ridgew	SSN	[redacted]
Department	6100 RN CERTIFIED	Class	Ridgeway
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277482		

07/25/10 to 08/07/10

Date	In	Out	In	Out	Hours	Schedule	Exceptions
07/25/10	7:02a	3:08p			7:45	Unsch.	Unsch.
07/25/10					7:45	REGULAR	
07/26/10	7:10a	3:46p			8:00	Unsch.	Unsch.
07/26/10					8:00	REGULAR	
07/27/10	6:55a	3:27p			8:00	Unsch.	Unsch.
07/27/10					8:00	REGULAR	
07/28/10	6:58a	3:49p			8:15	Unsch.	Unsch.
07/28/10					8:15	REGULAR	
07/29/10	6:58a	2:56p			7:30	Unsch.	Unsch.
07/29/10	11:00p	8:15a			8:45	Unsch.	Unsch.
07/29/10					8:15	OVERTIME	
07/29/10					8:00	REGULAR	
08/02/10	6:55a	4:30p			9:00	Unsch.	Unsch.
08/02/10					9:00	REGULAR	
08/03/10	7:00a	11:30p			15:30	Unsch.	Unsch.
08/03/10					15:30	REGULAR	
08/04/10	7:10a	2:08p			6:30	Unsch.	Unsch.
08/04/10					6:30	REGULAR	
08/05/10	7:00a	3:30p			8:00	Unsch.	Unsch.
08/05/10					8:00	REGULAR	
08/06/10	7:00a	3:30p			8:00	Unsch.	Unsch.
08/06/10					7:00	OVERTIME	
08/06/10					1:00	REGULAR	
08/07/10	7:00a	3:30p			8:00	Unsch.	Unsch.
08/07/10					8:00	OVERTIME	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	80:00	25.0400	2003.2000
027-6100-01	OVERTIME	23:15	37.5600	873.2700

Supervisor Edits

LYNDAB 08/10/10 10:12a DEL PUN 07/25/10 3:09p
MELANIES 08/10/10 12:01p AUTHORIZED PERIOD BEGINNING 07/25/10 AND SECURED
LYNDAB 08/03/10 9:49a ADD PUN 07/29/10 11:00p (Time clock down)
LYNDAB 08/03/10 9:50a ADD PUN 07/30/10 8:15a
LYNDAB 08/03/10 10:16a ADD PUN 08/02/10 6:55a (Time clock down)
LYNDAB 08/03/10 10:16a ADD PUN 08/02/10 4:30p
LYNDAB 08/09/10 2:46p ADD PUN 08/03/10 7:00a (Time clock down)
LYNDAB 08/09/10 2:47p ADD PUN 08/03/10 11:30p (Time clock down)
LYNDAB 08/09/10 2:53p ADD PUN 08/04/10 7:10a (Time clock down)
LYNDAB 08/09/10 2:54p ADD PUN 08/04/10 2:08p (Time clock down)
LYNDAB 08/09/10 3:46p ADD PUN 08/05/10 7:00a (Time clock down)
LYNDAB 08/09/10 3:46p ADD PUN 08/06/10 3:30p (Time clock down)
LYNDAB 08/09/10 3:24p ADD PUN 08/06/10 7:00a (Time clock down)
LYNDAB 08/09/10 3:25p ADD PUN 08/06/10 3:30p (Time clock down)
LYNDAB 08/09/10 3:36p ADD PUN 08/07/10 7:00a (Time clock down)
LYNDAB 08/09/10 3:37p ADD PUN 08/07/10 3:30p (Time clock down)

Archived Time Card Report

Includes one single employee.

Ramey, Gayla [redacted]

Location	Heritage Healthcare Ridgew	SSN	[redacted]
Department	6100 RN CERTIFIED	Class	Ridgeway
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277482		

08/08/10 to 08/21/10

Date	In	Out	In	Out	Hours	Schedule	Exceptions
08/08/10	7:00a	3:30p			8:00	Unsch.	Unsch.
08/08/10					8:00	REGULAR	
08/10/10	6:45a	3:30p			8:15	Unsch.	Unsch.
08/10/10					8:15	REGULAR	
08/11/10	6:50a	4:25p			9:15	Unsch.	Unsch.
08/11/10					9:15	REGULAR	
08/12/10	10:45p	7:30a			8:15	Unsch.	Unsch.
08/12/10					8:15	REGULAR	
08/14/10	7:40a	3:50p			7:30	Unsch.	Unsch.
08/14/10					1:15	OVERTIME	
08/14/10					6:15	REGULAR	
08/16/10	6:50a	3:30p			8:15	Unsch.	Unsch.
08/16/10					8:15	REGULAR	
08/17/10	6:50a	3:50p			8:30	Unsch.	Unsch.
08/17/10					8:30	REGULAR	
08/18/10	7:00a	3:30p			8:00	Unsch.	Unsch.
08/18/10					8:00	REGULAR	
08/19/10	7:00a	3:15p			7:45	Unsch.	Unsch.
08/19/10					7:45	REGULAR	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	72:30	25.0400	1815.4000
027-6100-01	OVERTIME	1:15	37.5600	46.9500

Supervisor Edits

LYNDAB 08/09/10 3:10p ADD PUN 08/08/10 7:00a (Time clock down)
LYNDAB 08/09/10 3:11p ADD PUN 08/08/10 3:30p (Time clock down)
MELANIES 08/24/10 9:13a AUTHORIZED PERIOD BEGINNING 08/08/10 AND SECURED
LYNDAB 08/20/10 11:51a ADD PUN 08/10/10 6:45a (Time clock down)
LYNDAB 08/20/10 11:51a ADD PUN 08/10/10 3:30p (Time clock down)
LYNDAB 08/20/10 11:51a ADD PUN 08/11/10 6:50a (Time clock down)
LYNDAB 08/20/10 11:51a ADD PUN 08/11/10 4:25p (Time clock down)
LYNDAB 08/20/10 11:49a ADD PUN 08/12/10 10:45p (Time clock down)
LYNDAB 08/20/10 11:50a ADD PUN 08/13/10 7:30a (Time clock down)
LYNDAB 08/20/10 11:50a ADD PUN 08/14/10 7:40a (Time clock down)
LYNDAB 08/20/10 11:50a ADD PUN 08/14/10 3:50p (Time clock down)
LYNDAB 08/20/10 11:49a ADD PUN 08/16/10 6:50a (Time clock down)
LYNDAB 08/20/10 11:49a ADD PUN 08/16/10 3:30p (Time clock down)
LYNDAB 08/20/10 11:52a ADD PUN 08/17/10 6:50a (Time clock down)
LYNDAB 08/20/10 11:52a ADD PUN 08/17/10 3:50p (Time clock down)
LYNDAB 08/20/10 11:52a ADD PUN 08/18/10 7:00a (Time clock down)
LYNDAB 08/20/10 11:52a ADD PUN 08/18/10 3:30p (Time clock down)
LYNDAB 08/23/10 9:09a ADD PUN 08/19/10 7:00a (Time clock down)
LYNDAB 08/23/10 9:10a ADD PUN 08/19/10 3:15p (Time clock down)

Archived Time Card Report

Includes one single employee.

Ramey, Gayla [redacted]

Location	Heritage Healthcare Ridgew	SSN	[redacted]
Department	6100 RN CERTIFIED	Class	Ridgeway
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277482		

08/22/10 to 09/04/10

Date	In	Out	In	Out	Hours	Schedule	Exceptions
08/22/10	7:00a	7:10p			11:45	Unsch.	Unsch.
08/22/10					11:45	REGULAR	
08/25/10	6:50a	7:15p			12:00	Unsch.	Unsch.
08/25/10					12:00	REGULAR	
08/26/10	7:05a	10:30a	11:00a	7:20p	11:45	Unsch.	Unsch.
08/26/10					11:45	REGULAR	
08/30/10	7:00a	7:30p			12:00	Unsch.	Unsch.
08/30/10					12:00	REGULAR	
09/01/10	6:55a	7:35p			12:00	Unsch.	Unsch.
09/01/10					12:00	REGULAR	
09/02/10	2:11p	2:28p			0:15	Unsch.	Unsch.
09/02/10					0:15	REGULAR	
09/04/10	7:00a	11:21a	12:15p	7:24p	11:30	Unsch.	Unsch.
09/04/10					11:30	REGULAR	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	71:15	25.0400	1784.1000

Supervisor Edits

LYNDAB 08/23/10 10:54a ADD PUN 08/22/10 7:00a (Time clock down)
LYNDAB 08/23/10 10:54a ADD PUN 08/22/10 7:10p (Time clock down)
MELANIES 09/07/10 12:01p AUTHORIZED PERIOD BEGINNING 08/22/10 AND SECURED
LYNDAB 08/30/10 1:30p ADD PUN 08/25/10 6:50a (Time clock down)
LYNDAB 08/30/10 1:30p ADD PUN 08/25/10 7:15p (Time clock down)
LYNDAB 08/30/10 1:31p ADD PUN 08/26/10 7:05a (Time clock down)
LYNDAB 08/30/10 1:32p ADD PUN 08/26/10 10:30a (Time clock down)
LYNDAB 08/30/10 1:32p ADD PUN 08/26/10 11:00a (Time clock down)
LYNDAB 08/30/10 1:32p ADD PUN 08/26/10 7:20p (Time clock down)
LYNDAB 08/31/10 2:40p ADD PUN 08/30/10 7:00a (Time clock down)
LYNDAB 08/31/10 2:40p ADD PUN 08/30/10 7:30p (Time clock down)
LYNDAB 09/06/10 8:22a ADD PUN 09/01/10 6:55a (Time clock down)

Archived Time Card Report

Includes one single employee.

Ramey, Gayla [redacted]

Location	Heritage Healthcare Ridgew	SSN	[redacted]
Department	6100 RN CERTIFIED	Class	Ridgeway
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277482		

09/05/10 to 09/18/10

Date	In	Out	In	Out	Hours	Schedule	Exceptions
09/05/10	6:56a	7:27p			12:00	Unsch.	Unsch.
09/05/10					12:00	REGULAR	
09/06/10					397.5100	RETROPAY	
09/07/10	6:52a	7:32p			12:15	Unsch.	Unsch.
09/07/10					12:15	REGULAR	
09/08/10	6:54a	7:04p			11:30	Unsch.	Unsch.
09/08/10					11:30	REGULAR	
09/12/10	7:03a	12:15p	12:27p	3:13p	7:45	Unsch.	Unsch.
09/12/10					7:45	REGULAR	
09/13/10	6:55a	10:48a	11:16a	7:24p	12:00	Unsch.	Unsch.
09/13/10					12:00	REGULAR	
09/14/10	6:58a	10:56a	11:40a	6:56p	11:15	Unsch.	Unsch.
09/14/10					11:15	REGULAR	
09/17/10	6:57a	11:01a	12:01p	7:25p	8:00	PTO	Unsch.
09/18/10					11:30	Unsch.	
09/18/10					2:30	OVERTIME	
09/18/10					9:00	REGULAR	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	75:45	25.0400	1898.7800
027-6100-01	OVERTIME	2:30	37.5600	93.9000
027-6100-01	RETROPAY	0:00	0.0000	397.5100
027-6100-01	PTO	8:00	25.0400	200.3200

Supervisor Edits

MELANIES 09/21/10 9:44a AUTHORIZED PERIOD BEGINNING 09/05/10 AND SECURED
MELANIES 09/21/10 9:56a AUTHORIZED PERIOD BEGINNING 09/06/10 AND SECURED
LYNDAB 09/20/10 6:22p CREDIT 397.5100 RETROPAY 027-6100-01 09/06/10 (left off from prev. payperiod)
LYNDAB 09/20/10 6:21p CREDIT 8:00 PTO 027-6100-01 09/17/10

Archived Time Card Report

Includes one single employee.

Ramey, Gayla [redacted]

Location	Heritage Healthcare Ridgew	SSN	[redacted]
Department	6100 RN CERTIFIED	Class	Ridgeway
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277432		

09/19/10 to 10/02/10

Date	In	Out	In	Out	Hours	Schedule	Exceptions
09/19/10	7:12a	7:27p			11:45	Unsch.	Unsch.
09/19/10					11:45	REGULAR	
09/22/10	6:58a	10:40a	11:00a	7:11p	11:45	Unsch.	Unsch.
09/22/10					11:45	REGULAR	
09/23/10	6:46a	11:42a			4:30	Unsch.	Unsch.
09/23/10					4:30	REGULAR	
09/24/10	6:52a	11:33a	11:58a	7:38p	12:30	Unsch.	Unsch.
09/24/10					0:30	OVERTIME	
09/24/10					12:00	REGULAR	
09/27/10	7:13a	10:26a	10:57a	7:57p	12:15	Unsch.	Unsch.
09/27/10					12:15	REGULAR	
09/29/10	6:58a	10:28a	10:57a	7:45p	12:15	Unsch.	Unsch.
09/29/10					12:15	REGULAR	
10/02/10	7:13a	9:52a	10:35a	7:05p	11:00	Unsch.	Unsch.
10/02/10					11:00	REGULAR	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	75:30	25.0400	1890.5200
027-6100-01	OVERTIME	0:30	37.5600	18.7800

Supervisor Edits

MELANIES 10/05/10 9:38a AUTHORIZED PERIOD BEGINNING 09/19/10 AND SECURED
LYNDAB 10/01/10 9:49a ADD PUN 09/29/10 10:57a

Archived Time Card Report

Includes one single employee.

Ramey, Gayla [redacted]

Location	Heritage Healthcare Ridgew	SSN	[redacted]
Department	6100 RN CERTIFIED	Class	Ridgeway
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277482		

10/03/10 to 10/16/10

Date	In	Out	In	Out	Hours	Schedule	Exceptions
10/03/10	6:55a	2:04p	2:59p	7:16p	11:15	Unsch.	Unsch.
10/03/10					11:15	REGULAR	
10/06/10	6:55a	10:45a	11:22a	5:25p	10:00	Unsch.	Unsch.
10/06/10					10:00	REGULAR	
10/07/10	6:50a	10:30a	11:12a	10:33p	14:30	Unsch.	Unsch.
10/07/10					14:30	REGULAR	
10/08/10	6:52a	4:05p			8:45	Unsch.	
10/08/10					4:30	OVERTIME	
10/08/10					4:15	REGULAR	Unsch.
10/09/10	10:41a	1:10p			2:30	Unsch.	
10/09/10					2:30	OVERTIME	Unsch.
10/12/10	6:53a	7:18p			11:45	Unsch.	
10/12/10					11:45	REGULAR	Unsch.
10/13/10	6:55a	10:26a	11:07a	7:19p	11:30	Unsch.	
10/13/10					11:30	REGULAR	Unsch.
10/16/10	7:05a	10:26a	10:51a	7:26p	12:00	Unsch.	
10/16/10					12:00	REGULAR	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	75:15	25.0400	1884.2600
027-6100-01	OVERTIME	7:00	37.5600	262.9200

Supervisor Edits

MELANIES 10/19/10 9:08a AUTHORIZED PERIOD BEGINNING 10/03/10 AND SECURED
LYNDAB 10/14/10 1:42p ADD PUN 10/06/10 11:15a (Forgot)
LYNDAB 10/14/10 1:42p DEL PUN 10/06/10 11:15a
LYNDAB 10/14/10 1:43p ADD PUN 10/06/10 10:45a
LYNDAB 10/14/10 1:41p ADD PUN 10/07/10 7:00a (Forgot)
LYNDAB 10/14/10 1:41p DEL PUN 10/07/10 7:00a

Archived Time Card Report

Includes one single employee.

Ramey, Gayla [redacted]

Location	Heritage Healthcare Ridgew	SSN	[redacted]
Department	6100 RN CERTIFIED	Class	Ridgeway
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277482		

11/14/10 to 11/27/10

Date	In	Out	In	Out	Hours	Schedule	Exceptions
11/14/10	6:53a	11:10a	11:35a	3:36p	8:00	Unsch.	Unsch.
11/14/10					8:00	REGULAR	
11/17/10	6:57a	11:13a	11:29a	3:41p	8:15	Unsch.	Unsch.
11/17/10					8:15	REGULAR	
11/18/10	6:55a	7:16p			11:45	Unsch.	Unsch.
11/18/10					11:45	REGULAR	
11/19/10	7:01a	11:12a	11:33a	12:25p	11:15	Unsch.	Unsch.
	1:25p	7:30p			11:15	REGULAR	
11/19/10					14:30	Unsch.	Unsch.
11/23/10	7:00a	12:18p	1:13p	11:07p	12:00	PTO	
11/23/10					14:30	REGULAR	
11/23/10					12:15	Unsch.	Unsch.
11/27/10	7:06a	1:59p	2:17p	7:48p	12:15	REGULAR	
11/27/10							

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	66:00	25.0400	1652.6400
027-6100-01	PTO	12:00	25.0400	300.4800

Supervisor Edits

LOREY 11/30/10 9:02a AUTHORIZED PERIOD BEGINNING 11/14/10 AND SECURED
LYNDAB 11/29/10 3:36p CREDIT 12:00 PTO 027-6100-01 11/23/10

Archived Time Card Report

Includes one single employee.

Ramey, Gayla

Location	Heritage Healthcare Ridgew	SSN	[redacted]
Department	6100 RN CERTIFIED	Class	Ridgeway
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277482		

11/28/10 to 12/11/10

Date	In	Out	In	Out	Hours	Schedule	Exceptions
11/28/10	7:05a	9:45a	10:23a	4:06p	8:15	Unsch.	Unsch.
11/28/10					8:15	REGULAR	
11/30/10	6:57p	7:34a			12:00	Unsch.	Unsch.
11/30/10					12:00	REGULAR	
12/02/10	6:59a	7:53p			12:30	Unsch.	Unsch.
12/02/10					12:30	REGULAR	
12/03/10	7:09a	10:31a	11:02a	2:18p	6:30	Unsch.	
12/03/10					6:30	REGULAR	
12/06/10					8:00	PTO	Unsch.
12/11/10	6:49a	11:23p			15:45	Unsch.	
12/11/10					15:45	REGULAR	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	55:00	25.0400	1377.2000
027-6100-01	PTO	8:00	25.0400	200.3200

Supervisor Edits

LOREY 12/14/10 10:40a AUTHORIZED PERIOD BEGINNING 11/28/10 AND SECURED
LYNDAB 12/13/10 2:54p CREDIT 8:00 PTO 027-6100-01 12/06/10

Archived Time Card Report

Includes one single employee.

Ramey, Gayla [redacted]

Location	Heritage Healthcare Ridgew	SSN	[redacted]
Department	6100 RN CERTIFIED	Class	Ridgeway
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277482		

12/12/10 to 12/25/10

Date	In	Out	In	Out	Hours	Schedule	Exceptions
12/12/10					400.6400	RETROPAY	
12/14/10	7:00a	3:07p			7:30	Unsch.	Unsch.
12/14/10					7:30	REGULAR	
12/15/10	7:02a	3:02p			7:30	Unsch.	Unsch.
12/15/10					7:30	REGULAR	
12/16/10	7:04a	7:17p			11:45	Unsch.	Unsch.
12/16/10					11:45	REGULAR	
12/18/10	6:52a	10:45a	11:20a	6:57p	11:45	Unsch.	Unsch.
12/18/10					11:45	REGULAR	
12/20/10	6:48p	6:30a			13:15	Unsch.	Unsch.
12/20/10					13:15	REGULAR	
12/23/10	6:59a	2:38p	3:31p	7:39p	11:45	Unsch.	Unsch.
12/23/10					11:45	REGULAR	
12/25/10	7:18a	9:32a	9:59a	3:23p	7:45	Unsch.	Unsch.
12/25/10					8:00	HOLIDAY	
12/25/10					7:45	REGULAR	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	71:15	25.0400	1784.1000
027-6100-01	HOLIDAY	8:00	25.0400	200.3200
027-6100-01	RETROPAY	0:00	0.0000	400.6400

Supervisor Edits

LYNDAB 12/27/10 1:56p CREDIT 400.6400 RETROPAY 027-6100-01 12/12/10 (left off from prev. payperiod)
LOREY 12/28/10 9:18a AUTHORIZED PERIOD BEGINNING 12/12/10 AND SECURED
LYNDAB 12/27/10 10:30a CREDIT 8:00 HOLIDAY 027-6100-01 12/25/10

Archived Time Card Report

Includes one single employee.

Ramey, Gayla

Location	Heritage Healthcare Ridgew	SSN	[redacted]
Department	6100 RN CERTIFIED	Class	Ridgeway
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277482		

12/26/10 to 01/08/11

Date	In	Out	In	Out	Hours	Schedule	Exceptions
12/26/10					8:00	PTO	
12/27/10	7:03a	9:42a	10:08a	12:37p	5:00	Unsch.	Unsch.
12/27/10					5:00	REGULAR	
12/29/10	6:50a	3:18p	5:35p	7:31p	10:30	Unsch.	Unsch.
12/29/10					10:30	REGULAR	
12/30/10	6:53a	3:16p			7:45	Unsch.	Unsch.
12/30/10					7:45	REGULAR	
01/01/11	6:45a	10:54a	11:41a	6:55p	11:30	Unsch.	Unsch.
01/01/11					11:30	REGULAR	
01/02/11	6:57a	10:04a	10:38a	3:15p	7:45	Unsch.	Unsch.
01/02/11					7:45	REGULAR	
01/04/11					4:00	PTO	
01/05/11	7:03a	7:50p			12:15	Unsch.	Unsch.
01/05/11					12:15	REGULAR	
01/06/11	7:09a	2:10p	3:03p	7:36p	11:30	Unsch.	Unsch.
01/06/11					11:30	REGULAR	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	66:15	25.0400	1658.3000
027-6100-01	PTO	12:00	25.0400	300.4800

Supervisor Edits

LYNDAB 01/10/11 12:33p CREDIT 8:00 PTO 027-6100-01 12/26/10
LOREY 01/13/11 6:29a AUTHORIZED PERIOD BEGINNING 12/26/10 AND SECURED
LYNDAB 01/10/11 12:33p CREDIT 4:00 PTO 027-6100-01 01/04/11

Archived Time Card Report

Includes one single employee.

Ramey, Gayla [redacted]

Location	Heritage Healthcare Ridgew	SSN	[redacted]
Department	6100 RN CERTIFIED	Class	Ridgeway
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277482		

01/09/11 to 01/22/11

Date	In	Out	In	Out	Hours	Schedule	Exceptions
01/09/11	6:59a	9:53a	10:23a	7:18p	11:45	Unsch.	Unsch.
01/09/11					11:45	REGULAR	
01/13/11	6:59a	7:36p			12:00	Unsch.	Unsch.
01/13/11					12:00	REGULAR	
01/14/11	7:11a	11:19a	11:50a	3:20p	7:30	Unsch.	Unsch.
01/14/11					7:30	REGULAR	
01/17/11	6:55a	7:25p			12:00	Unsch.	Unsch.
01/17/11					12:00	REGULAR	
01/19/11	7:02a	7:24p			12:00	Unsch.	Unsch.
01/19/11					12:00	REGULAR	
01/21/11	7:03a	10:46a	11:36a	8:13p	12:30	Unsch.	Unsch.
01/21/11					12:30	REGULAR	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	67:45	25.0400	1696.4600

Supervisor Edits

LOREY 01/25/11 8:12p AUTHORIZED PERIOD BEGINNING 01/09/11 AND SECURED

Archived Time Card Report

Includes one single employee.

Ramey, Gayla [redacted]

Location	Heritage Healthcare Ridgew	SSN	[redacted]
Department	6100 RN CERTIFIED	Class	Ridgeway
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277482		

01/23/11 to 02/05/11

Date	In	Out	In	Out	Hours	Schedule	Exceptions
01/24/11	6:55a	12:16p	12:35p	7:46p	12:15	Unsch.	Unsch.
01/24/11					12:15	REGULAR	
01/25/11	6:58a	7:26p			12:00	Unsch.	Unsch.
01/25/11					12:00	REGULAR	
01/26/11	12:57p	3:13p			2:15	Unsch.	Unsch.
01/26/11					2:15	REGULAR	
01/29/11	7:00a	7:34p			12:00	Unsch.	Unsch.
01/29/11					12:00	REGULAR	
01/30/11	6:44a	7:37p			12:15	Unsch.	Unsch.
01/30/11					12:15	REGULAR	
02/02/11	7:06a	7:43p			12:15	Unsch.	Unsch.
02/02/11					12:15	REGULAR	
02/03/11	6:34a	7:25p			12:30	Unsch.	Unsch.
02/03/11					12:30	REGULAR	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	75:30	25.0400	1890.5200

Supervisor Edits

LOREY 02/08/11 9:06a AUTHORIZED PERIOD BEGINNING 01/23/11 AND SECURED

Archived Time Card Report

Includes one single employee.

Ramey, Gayla [redacted]

Location	Heritage Healthcare Ridgew	SSN	[redacted]
Department	6100 RN CERTIFIED	Class	Ridgeway
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277482		

02/06/11 to 02/19/11

Date	In	Out	In	Out	Hours	Schedule	Exceptions
02/07/11	7:19a	12:56p	1:11p	7:46p	12:00	Unsch.	Unsch.
02/07/11					12:00	REGULAR	
02/09/11	6:45a	7:51p			12:30	Unsch.	Unsch.
02/09/11					12:30	REGULAR	
02/11/11	6:51a	7:17p			12:00	Unsch.	Unsch.
02/11/11					12:00	REGULAR	
02/15/11	7:03a	7:30p			12:00	Unsch.	Unsch.
02/15/11					12:00	REGULAR	
02/16/11	6:53a	7:28p			12:00	Unsch.	Unsch.
02/16/11					12:00	REGULAR	
02/19/11	9:36a	8:23p			13:30	Unsch.	Unsch.
02/19/11					13:30	REGULAR	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	74:00	25.0400	1852.9600

Supervisor Edits

LOREY 02/22/11 9:26a AUTHORIZED PERIOD BEGINNING 02/05/11 AND SECURED

Archived Time Card Report

Includes one single employee.

Ramey, Gayla

Location	Heritage Healthcare Ridgew	SSN	[redacted]
Department	6100 RN CERTIFIED	Class	Ridgeway
Cost Center	GENERAL	Hire Date	07/24/02
Badge	0	Rate	25.0400
ID Number	650277482		

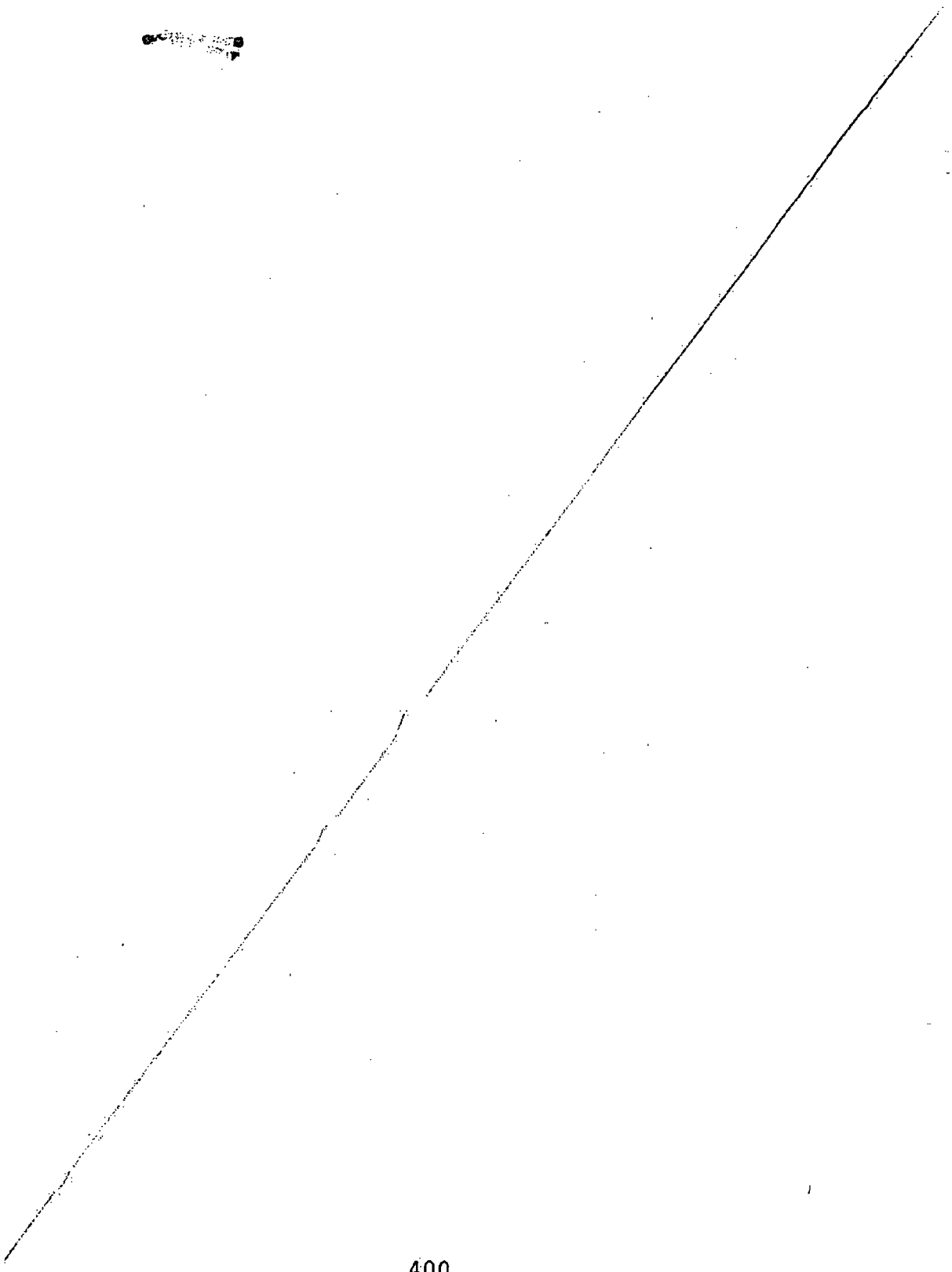
02/20/11 to 03/05/11

Date	In	Out	In	Out	Hours	Schedule	Exceptions
02/20/11	6:58a	7:32p			12:00	Unsch.	Unsch.
02/20/11					12:00	REGULAR	
02/23/11	6:37a	8:03p			13:00	Unsch.	Unsch.
02/23/11					13:00	REGULAR	
02/24/11	5:57a	7:43p			12:15	Unsch.	Unsch.
02/24/11					12:15	REGULAR	
02/27/11					4:00	PTO	
02/28/11					8:00	PTO	
03/01/11	6:47a	7:35p			12:15	Unsch.	Unsch.
03/01/11					12:15	REGULAR	
03/05/11	6:55a	7:58p			12:30	Unsch.	Unsch.
03/05/11					3.5000	MEALS	
03/05/11					12:30	REGULAR	

LOC-DEPT-COSTCEN	Pay Designation	Hours	Rate	Dollars
027-6100-01	REGULAR	62:00	25.0400	1552.4800
027-6100-01	MEALS	0:00	0.0000	3.5000
027-6100-01	PTO	12:00	25.0400	300.4800

Supervisor Edits

TKELLEY 03/09/11 8:59a AUTHORIZED PERIOD BEGINNING 02/20/11 AND SECURED
LYNDAB 03/07/11 6:23p CREDIT 4:00 PTO 027-6100-01 02/27/11
LYNDAB 03/07/11 2:11p CREDIT 8:00 PTO 027-6100-01 02/28/11
LYNDAB 03/07/11 5:56p CREDIT 3.5000 MEALS 027-6100-01 03/05/11



HEDRICK GARDNER
HEDRICK GARDNER KINCHELOE & GAROFALO LLP
ATTORNEYS AT LAW
CHARLOTTE · RALEIGH · WILMINGTON · COLUMBIA

April 19, 2011

Mark R. Calhoun
Mark R. Calhoun, Attorney At Law
714 East Main Street
Lexington, SC 29072

Reply to:
R. DANIEL ADDISON
Partner
P.O. Box 11267
Columbia, SC 29211
Direct: (803) 727-1201
Fax: (803) 727-1259
Email: daddison@hedrickgardner.com

RE: Gayla Ramey v. Unihealth Post Acute Care - Tanglewood
WCC File No: Unassigned
Claim No: 6817498209762 3
Our File No: 128L-00030

Dear Mark:

In response to your Subpoena dated April 6, 2011 and which was served on the employer, enclosed please find a copy of the personnel records regarding the above referenced workers' compensation case.

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

Very sincerely yours,

R. Daniel Addison

RDA/lb
Enclosures

PARTNER OCCURRANCE
SUPERVISORY INVESTIGATION REPORT

SECTION 1: OCCURRENCE DATA

PARTNER NAME: Gayla Ramey
JOB POSITION / TITLE: RN
JOB ASSIGNMENT: Nurse (charge) in Hall 10
ACTIVITY/JOB AT TIME OF OCCURRENCE: Had not started her assignment
LENGTH OF TIME ON THIS JOB:
DEPARTMENT: Nursery
LOCATION OF OCCURRENCE: Outside - back steps of Hall 10
DATE AND TIME OF ACCIDENT: 3/11/11 6:45 AM
DATE REPORTED BY PARTNER: 3/11/11
DATE AND TIME OF INVESTIGATION: 3/11/11 8:30 AM
NAME OF WITNESSES (N/A if None)
1. Barbara Davis and ~~Amy~~ 2. Amy Collins 3.
TYPE OF OCCURRENCE: (Mark Those Applicable)

FIRST AID	MEDICAL	LOSS TIME	NEAR MISS (NO INJURY)
☐	☑	☐	☐

SECTION 2: ANALYSIS OF FACTS AND ROOT CAUSE DETERMINATION

WORK BEING PERFORMED AT TIME OF OCCURRENCE (EQUIPMENT / MOVEMENT INVOLVED AT TIME OF OCCURRENCE, AS APPLICABLE):
Walking from the parking lot - stepped up on the wet step platform before getting to the steps and my foot slipped from under me causing me to hit my wrist and leave my wrist on the steel beside the stairs

ROOT CAUSE: DESCRIBE UNSAFE ACTS AND/OR PHYSICAL HAZARDS AT TIME OF OCCURRENCE:
Both the stairs were wet and slippery

SECTION 3: CORRECTIVE ACTION

INJURED PARTNER RECOMMENDATIONS:
Wood sides to be replaced or planed and treated

SUPERVISOR RECOMMENDATIONS:
I walked out to the area - small pool of water on the platform in question - slightly sloping - Staff has been tips on how to use

WHAT IMMEDIATE ACTION HAVE YOU TAKEN TO PREVENT A RECURRENCE OF THIS TYPE OF OCCURRENCE?
Reported to the appropriate personal.

DATE COMPLETED: 3/11/11
SUPERVISOR SIGNATURE: [signature]

SECTION 4: FOLLOW UP ACTIVITY

ACTION ITEM	RESPONSIBILITY	TARGET DATE	DATE COMPLETED
1. Sent to Doctors Care			
2.			
3.			
4.			

ACTION:
SATISFACTORY ☐ UNSATISFACTORY ☐ - IF UNSATISFACTORY, WHY?

Section 5: PARTNER INFORMATION (HR)

SOCIAL SECURITY #/AGE:	EMPLOYMENT DATE:	LOSS TIME	MINOR	OSHA 300 RECORDABLE?
401-98-7482,		☐	☐	☐

NAME OF DOCTOR: _____ NATURE OF INJURY: RT upper arm above wrist

PREPARED BY/DATE: SUPERVISOR	REVIEWED BY/DATE: SAFETY COMMITTEE	OCC. INJURY MANAGER	ADMINISTRATOR
[signature] 3/11/11	/	/	/

08/27/10

Acknowledgement of Transitional/Modified Duties

Date: 3/11/11

I Kayla Ramsey [redacted], understand my employer located at:: 713 Ranglewood Dr, City: Ridgeway, State: S.C., Zip: 29130: can provide me with transitional duty. I further understand that I may receive a reduction in pay while on transitional duty restrictions and can request disability benefits from our Workers' Compensation Insurance company.

I understand that I will be offered the following tasks while on transitional duty:

- Office Clerical: file paper work, answer phones, make copies, and other duties within my limitations.
- Laundry Tech: Folding of towels, face clothes, pillowcases, hanging of clothes, folding of clothe: and other duties within my limitations.
- Dietary Aide: roll silver wear, dessert trays, push food carts, serve meal trays, and other duties within my limitations.
- Janitorial: sweep, mop, take out trash, and other duties within my limitations.
- Nursing: One on One care with residents and patients, taking vital signs, etc.

In the event I have to attend a Doctor appointment, can not come in to work because of my injury, or have to leave early I understand I must contact my Supervisor, and I will not be compensated by my employer for any time lost. In addition, I understand that whenever possible, all appointments must be made around my work schedule.

I further; understand I must keep my Workers' Compensation Coordinator and manger informed of all Doctor and/or Physical Therapy appointments I have scheduled and that failure to do so may result in disciplinary actions.

Kayla Ramsey
Partners Signature

3/11/11
Date

Witness Signature

3/11/11
Date

Disability Benefits Waiver

I, Gayla Ramey, elect to use my Personal/Sick leave in lieu of Workers' Compensation disability benefits for the following reasons:

☑ During the Workers' Compensation waiting period.

☐ During my scheduled absence

When the Personal/Sick leave is exhausted, I understand that I must notify my manager so that the Workers' Compensation Disability Benefits can be in initiated.

I also understand that any and all absences I incur in connection with my Workers' Compensation case will concurrently be considered as Family and Medical Leave Act (FMLA) leave by the Company, and accordingly will be counted against the total amount of FMLA leave available to me annually.

Gayla Ramey
Partner Signature

3/11/11
Date:

Witness Signature

3/11/11
Date:

[redacted]

I Gayla Ramsey understand that I have the right to refuse medical coverage for my Workers Comp Injury on 3/11/11. I have been given the opportunity to ask any question pertaining to medical coverage for Workers Comp.

Gayla Ramsey 3/11/11
Partner's Signature and Date

Josephine Eldenia Eaglin Jr 3/11/11
Witness Signature and Date

GENERAL LIABILITY CLAIM NOTICE

Facility: Lutheran Acute Care Edgewood	**Date of Incident:** 3/11/11
Address: 213 Edgewood Court Ridgeway SC 29130	**Policy Number:**
Contact:	**Date Reported:** 3/11/11
Phone: 803 337 3212	
Claimant:	**SSI:** [redacted]
Address:	**Age:** 58 **Sex:** Female
Phone:	**Cell:**
Medical Attention Necessary: ☑ Yes ☐ NO **Ambulance:** ☐ **Self- Transported:** ☐	**Medical Center Taken to:**
Alleged Incident: (be specific)	**Time of Alleged Incident:**

" When I stepped up on the wet wooden platform before getting to the steps my feet slipped from under me causing me to hit my right arm causing injury. When I attempted to open door to come in the building the dotted piece to transfer from the site of injury above my wrist down through the tip of the thumb. Continue to ask that Lord to unleat present.

Witnesses: (include Job title)	Phone/Cell:
Barbara Davis CNA	803-337 3212 Hall 2N
Amy Collins CNA	803-337 3212 Hall 4N

Risk Management Notes:

Person Completing Report:	Date:
Josephine Edwards	3/11/11

AUTHORIZATION FOR MEDICAL RELEASE OF INFORMATION

Partner's Name: Gayla Ramey
(please print)

Address: [redacted]

Phone Number: [redacted] SSN: [redacted]

Description of Accident: "I was stepped upon the wet wooden platform before getting to the steps my feet slipped from under me causing me to hit my stomach and my wrist on the rail beside the stairs

I Gayla Ramey/ UPAC Tanglewood hereby authorize: , or its management representatives to be furnished any information and facts regarding this injury, including reports and records, results of diagnosis, treatment and prognosis, estimates of disability, and recommendations for further treatment. This information is to be used for the purposes of evaluating and handling my claim for injury as a result of an incident occurring on or about _____ and for no other purpose, now or in the future.

Gayla Ramey
Partner's Signature

3/11/11
Date

Witness: Signature

3/11/11
Date:

TRANSITIONAL DUTY EMPLOYMENT PLAN

To be completed upon the injured Partners return to work following an on-the-job injury

Name	Department
Gayla Ramey	Nursing
itle RN	Supervisor: [redacted]

nal Capacities/Restrictions No lifting more than 10 lbs Ground level work only	No Repetitive bending, stooping, squatting Limited use of back
Restrictions Begin: 3/14/11	Next Physician Visit:: 3/18/11 Next Review Date: 3/18/11

Plan Specifics

ibe the Job/Specific Task:

Abacus interviews
Chart audits
System check list
and other duties that fall within the above
Job duties restrictions listed above.

ibe Hours/day and days/week, including progression schedule:

M-F 8a-4:30p

3/14/11 - to come in at 3p - 11p to work reception today.

d Consideration: Will Always report to manager immediately, anything that causes an alteration in this plan.

Transitional Employment Plan has been reviewed and discussed with me to clarify any questions that I may . I have been provided with a copy of this plan and I understand my supervisor will retain a copy. I understand the purpose of these restrictions is to enable me to recover from my injury and that I am required to stay within estrictions noted above. Should I experience any difficulties while performing transitional duty work, I will ediately contact my supervisor.

er Signature:	Date:
Gayla Ramey	3/14/11

re reviewed and discussed this Transitional Employment Plan with the employee. In addition, I have provided a of this plan to the employee.

visor or Reviewing Manager Signature:	Date:
Manager in Attendance: Lynda C Burr HR Generalist	Date 3/14/11

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TANGLEWOOD
HEALTH CARE CENTER | POST OFFICE BOX 68 RIDGEWAY, SOUTH CAROLINA 29130 (803) 337-3211

Name of Employee Gayla Ramey

Address [redacted]

Telephone Number [redacted]

Social Security Number [redacted]

After 90 days of employment, you are eligible for health insurance and other insurance benefits if you work full time. When your employment terminates, then you become eligible for Cobra coverage if you were covered while employed at Tanglewood Health Care Center. Your employer pays for health insurance benefits for SINGLE coverage. Family/Dependent coverage is $96.46 per pay period. Your insurance becomes effective the 1st of the month following 90 days of full time employment.

HEALTH INSURANCE AND OTHER INSURANCE BENEFITS ARE AVAILABLE TO FULL TIME EMPLOYEES ONLY.

Other Insurance Benefits are listed below—Explanation of benefits for each plan is attached.

Dental
Eye Care (Vision)
Voluntary Life Insurance

**After 90 days of full time employment, employees may enroll in the 401k Plan. Please see Human Resources for additional information.

The above benefits have been discussed with me.

Gayla Ramey 2/24/02 Dept.
Signature of Employee Date

JURY DUTY

Employees who have completed their 90day period and are regular full-time or regular part-time employees are eligible for jury duty compensation. Upon submitting verification of jury duty the employer pays the difference between jury compensation and regular salary. Employee must return to work if dismissed from jury duty during work hours.

VACATION TIME:

Upon satisfactory completion of the appraisal period (90) days, all regular full-time employees who [redacted] weekly shall earn a vacation pay as follows:

Full-Time Employees
1 Years - 5 days
2-4 years- 10 days
5 years & up-15 days

All regular part-time employees who work twenty to thirty hours weekly shall earvacation pay as follows:

Part-Time Employees
1 year-2.5days
2-4 years-5 days
5 years & up-7.5 days

A vacation day shall equal the length of the day customarily worked. There will be no time carried from one year to year. The year being your Anniversary date to the next.

HOLIDAYS

Upon satisfactory of the appraisal period (90 days) the following six days will be recognized as Holidays:
New Years Day
Independance Day (4th of July)
Labor Day
Thanksgiving Day
Your Birthday
Christmas Day

Signature

7/24/02
Date

RELIANCE STANDARD
Life Insurance Company
a Delphi company

Instructions: Use this form only for cases that offer the employee the ability to purchase voluntary disability coverage. Type or print with ballpoint pen. The employee and the policyholder must each receive a copy of the completed Group Disability Enrollment Form.

Group Disability Enrollment Form

All sections must be completed to ensure accurate processing.

(1) Policyholder/Employer: UHS-Pruitt Corporation			(2) RSL Policy No.: VPS: 325226
(3) Location/Bill Group: 027	(4) Full-Time Employment Date: 7/24/2002		(5) Class: GEN
(6) Hours Per Week: 40	(7) Job Title: LPN HCC	(8) Base Salary: $47,132.80 ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly	
(9) Employee's Full Name: Last Ramey First Gayla MI			(10) Payroll Cycle I receive my paycheck: ☐ Weekly ☐ Monthly ☐ Bi-Weekly ☐ Other: ☐ Semi-Monthly
(11) Employee's Peoplesoft ID: 12984	(12) Gender: F		(13) Employee's Birth Date: 1/2/1961

Choose Only One (14) or (15)

(14) Request for Group Insurance Coverage

☐ I request to purchase a weekly STD benefit. Please check below the amount of benefit you wish to purchase: (Premium based upon salary listed above. Disability premium will change as salary changes.)

☐ 40% Coverage – Weekly Benefit Amount of: $362.56. Bi-Weekly Premium is: $14.06

☐ 50% Coverage - Weekly Benefit Amount of: $453.20. Bi-Weekly Premium is: $17.57

☑ 60% Coverage - Weekly Benefit Amount of: $543.84. Bi-Weekly Premium is: $21.06

Please see Premium Calculation Worksheet for Rates and Premiums.

I authorize my employer to deduct from my salary or wages the necessary premium for the coverage requested above. The signature below also verifies the accuracy of the information contained on this form.

(15) Declination of Group Insurance Coverage

☐ I have been offered and have declined to purchase the Group Disability Insurance Coverage. I understand that in the event I desire such insurance at a later date: (1) I will be required to furnish evidence of insurability at my own expense; and (2) Reliance Standard Life Insurance Company (RSL) will have the right to refuse my request.

I understand that any coverage will not become effective until and unless approved by RSL, and upon approval, any benefits payable are subject to the terms, conditions and limitations of the Group Disability Policy. I also understand that the amount of any payroll deduction may be adjusted based on underwriting changes or age changes that affect the rates charged.

Employee Signature — Date: 10/23/08

Please sign, date and return enrollment form to your Plan Administrator upon completion.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

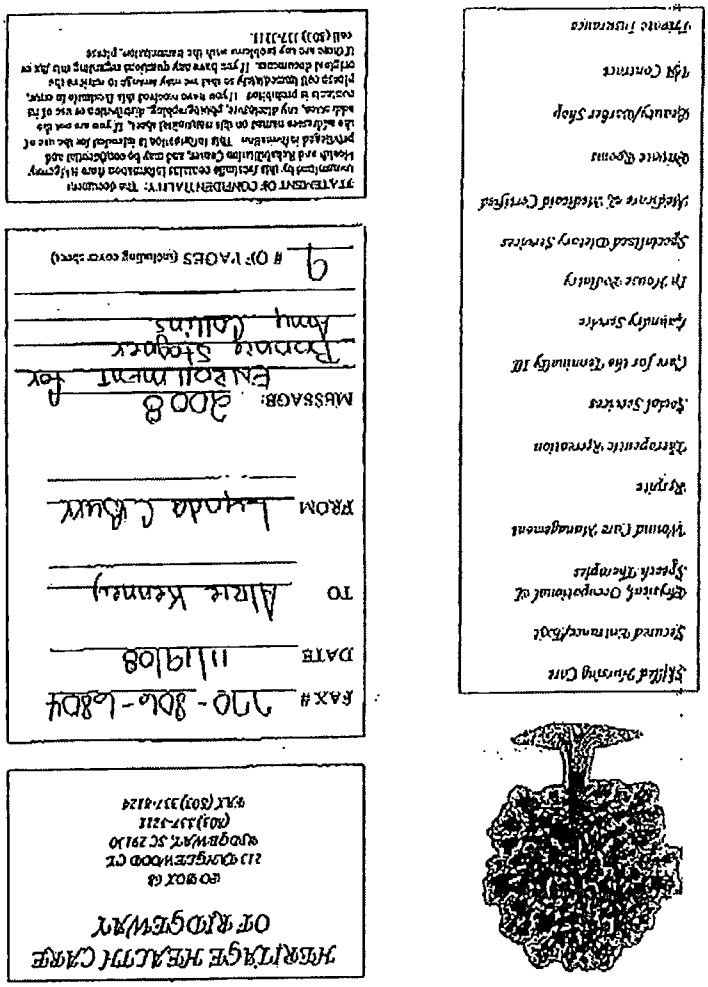
412

Message Confirmation Report

NOV-19-2008 12:08 PM WED

Fax Number :
Name :

Name/Number	:	17708066804
Page	:	9
Start Time	:	NOV-19-2008 12:03PM WED
Elapsed Time	:	05'46"
Mode	:	STD G3
Results	:	[O.K]



Lynda Burr

From: Claire Kaniewski
Sent: Tuesday, July 24, 2007 3:47 PM
To: Mal Keller
Cc: Lynda Burr
Subject: Gayla Ramey - Work Study Approval

Mal,
Please inform Gayla Ramey that her recent Work Study Application under the [redacted] has been approved by the ELT.

Thanks!
Claire

Claire Kaniewski
Human Resources
Generalist II
ckaniewski@uhs-pruitt.com

EDUCATION REIMBURSEMENT' OGRAM HR 7.101.00

Issue Date: September
Revised:

APPENDIX C
EDUCATION REIMBURSEMENT SUPPLEMENTAL APPLICATION
FOR FISCAL YEAR *JULY 1, 2008 TO JUNE 30, 2009*

Name: Gayla R. Ramey
Contact No: [redacted]
Email: [redacted]

Hire Date: 7-2-02
Job Title: LPN
Location: Ridgeway SC 29130

Degree/Certification: _____ Major/Course of Study: LPN to ADN transition
School/Institution Central Carolina Technical College
Acceptance date: 7/01/08 Anticipated date of graduation is: Summer 2009
Educational assistance is available to me through scholarship/grant: _____

Tuition Fees per Fiscal Yr	Book/Lab Fees per Fiscal Yr	Amount of Educational Assistance/Scholarship per Fiscal Year	Total Fees per Fiscal Yr
2805	1350		4155 Approx.

Supervisory Review and Approval

Supervisor's Signature: Shirley B. Powell Date: 7/29/08
Administrator's Signature: Pamela Duncan Date: 8-4-08

Employee Agreement

This supplemental application demonstrates my continued need for education reimbursement through the this fiscal year. I understand that I must maintain a grade of A, B, or C in each course in order to be eligible for a percentage of a refund for tuition, books, lab, and miscellaneous fees. I understand that there will not be any reimbursement if I fail the course. I will submit the necessary authorized grade reports, receipts and expense sheet within *8 weeks* of completion of each course to the Pruitt Corporation Human Resources Department, 1626 Jeurgens Court, Norcross, GA 30093. Educational assistance is available to me through other scholarship resources Therefore, my participation in the Education Reimbursement Program is only to the extent of tuition and fees not covered. I am acquainted with the requirements, policies and procedures for the Education Reimbursement Program and agree to comply with them.

This application is complete. My Supervisor and/or Administrator have reviewed and signed as approved.

Employee Signature: Gayla Ramey Date: 7/22/08

© 2004 Pruitt Corporation

Mailed 8/7/08 JB

Version 1.1

DESIGNATION OF BENEFICIARY

To the Trustees of Pruitt & Association,Inc Employee Profit Sharing (plan)

Pursuant of the provisions of the plan permitting the designation of a beneficiary or beneficiaries by a participant, I hereby designate the following person or persons as primary and secondary beneficiaries of my Account under the plan payable by reason of my death.

Primary Beneficiary

NAME: James W. Ramey RELATIONSHIP: Spouse

ADDRESS 3646 watson St Elgin SC 29045

Secondary Beneficiary

NAME: Loretta K. Todd RELATIONSHIP: Mother

ADDRESS: 1037 Rocky Branch LN Elgin SC 29045

I RESERVE THE RIGHT TO REVOKE OR CHANGE ANY BENEFICIARY DESIGNATION, I HEREBY REVOKE ALL PRIOR DESIGNATION (IF ANY) OF BENEFICIARIES AND SECONDARY BENEFICIARIES.

The trustees shall pay all sums payable under the plan by reason of my death to the primary beneficiary, if he or she survives me,and if no primary beneficiary survives me, then the trustees shall pay all amounts in accordance with section 8.02 of the plan.

NOTE: Unless the participant provides otherwise in completing this designation, the trustee shall pay all sums payable to more than one beneficiary equally to the living beneficiaries,subject however,to the requirements,if any of the qualified joint and survivor annuity provisions or of the qualified pretetirement survivor annuity provisions of ERSIA. The advisory committee will not accept the designation of beneficiary of married participant designating a primary beneficiary other than the participant's Accrued benefit is payable in the form of a qualified joint and survivor annuity or qualified pretretirement survivor annuity. Spouse consent is not required if the participant's spouse is the sole primary beneficiary.

Joy S. Goodwin, Chapter 13 Trustee
1813 Laurel Street
Columbia, SC 29201
Phone: (803) 779-5180 Fax: (803) 765-0167

August 09, 2010

RIDGEWAY HEALTH/REHABILITATION
PO BOX 68
ATTN PAYROLL
RIDGEWAY, SC 29130

RE: GAYLA R RAMEY

Case No.: 08-05867-dd

Dear Sir or Madam:

The pay order issued by the United States Bankruptcy Court directing you to withhold funds from the debtor's pay is herewith rescinded. This is due to one of the following situations: (1) the debtor is no longer enrolled in a chapter 13 wage earner plan due to completion, dismissal or conversion of the case, or (2) the debtor has made arrangements to submit his/her chapter 13 payments directly to the trustee's office.

Thank you for your prompt attention in this matter. Should you have any questions, please contact this office.

Sincerely,

Michelle Wilson
Case Administrator

CC: GAYLA R RAMEY
16 DUKE DRIVE
LUGOFF, SC 29078

Apr. 14. 2011 3:34PM

MSG Confirm

Date & Time : AUG-10-2010 03:43PM TUE
Fax Number : 803 337 8124
Fax Name :
Model Name : Dell 2335dn MFP

No	Name/Number	StartTime	Time	Mode	Page	Result
129	17708066881	08-10 03:42PM	00'10	ECM	001/001	O.K

Joy S. Goodwin, Chapter 13 Trustee
1513 Laurel Street
Columbia, SC 29201
Phone: (803) 779-5180 Fax: (803) 765-0167

August 09, 2010

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PO BOX 69
ATTN PAYROLL
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Thank you for your prompt attention in this matter. Should you have any questions, please contact this office.

Sincerely,

Michelle Wilson
Case Administrator

CC: GAYLA R RAMEY
16 DUKE DRIVE
LUGOFF, SC 29078

11/8 TS

RELIANCE STANDARD
Life Insurance Company
A DELPHI company

Instructions: *Use this form only for cases that offer the employee the ability to purchase voluntary disability coverage. Type or print with ballpoint pen. The employee and the policyholder must each receive a copy of the completed Group Disability Enrollment Form.*

Group Disability Enrollment Form

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(4) Full-Time Employment Date: 7/24/2002

(5) Class: GEN

(6) Hours Per Week: 40

(7) Job Title: LPN HCC

(8) Base Salary: $47,132.80 ☐ Hourly ☐ Monthly ☐ Weekly ☐ Yearly ☐ Bi-Weekly

(9) Employee's Full Name: Last Ramey First Gayla MI

(10) Payroll Cycle
I receive my paycheck:
☐ Weekly ☐ Monthly
☑ Bi-Weekly ☐ Other: _____
☐ Semi-Monthly

(11) Employee's Peoplesoft ID: 12984

(12) Gender: F

(13) Employee's Birth Date: 1/2/1961

Choose Only One (14) or (15)

(14) Request for Group Insurance Coverage

☐ I request to purchase a weekly STD benefit. Please check below the amount of benefit you wish to purchase: (Premium based upon salary listed above. Disability premium will change as salary changes.)

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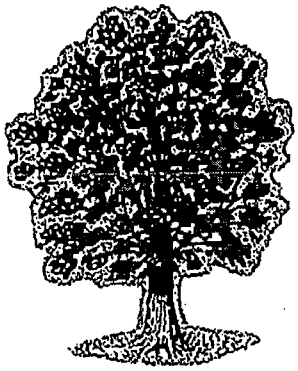
Employee Signature — Date: 10/23/08

Please sign, date and return enrollment form to your Plan Administrator upon completion.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.



HERITAGE HEALTH CARE OF RIDGEWAY

PO BOX 68
213 TANGLEWOOD CT
RIDGEWAY, SC 29130
(803) 337-3211
FAX (803) 337-8124

- Skilled Nursing Care
- Secured Entrance/Exit
- Physical, Occupational & Speech Therapies
- Wound Care Management
- Respite
- Therapeutic Recreation
- Social Services
- Care for the Terminally Ill
- Laundry Service
- In House Podiatry
- Specialized Dietary Services
- Medicare & Medicaid Certified
- Private Rooms
- Beauty/Barber Shop
- VA Contract
- Private Insurance

FAX # 770-806-6804

DATE 11/4/08

TO Arie Kennedy

FROM Lynda Burr

MESSAGE: Just got this one

1 # OF PAGES (including cover sheet)

STATEMENT OF CONFIDENTIALITY: The document transmitted by this facsimile contains information from Ridgeway Health and Rehabilitation Center, and may be confidential and privileged information. This information is intended for the use of the addressee named on this transmittal sheet. If you are not the addressee, any disclosure, photographing, distribution or use of its contents is prohibited. If you have received this facsimile in error, please call immediately so that we may arrange to retrieve the original documents. If you have any questions regarding this fax or if there are any problems with the transmission, please call (803) 337-3211.

Gayla Renee Ramey
Lugoff, SC 29078

License number: 207097
License type: RN
Original Issue Date: 09/16/2009
Expiration: 04/30/2012
Status: Active

Privilege To Practice: Multi-State

Individual listed above is in good standing with the SC Board of Nursing

April 19, 2010

As a recipient of the nursing scholarship, with a commitment to work for UHS-Pruitt, I am currently requesting a transfer to the Assistant Director of Nursing position. I feel that because the company offered the opportunity to me to pursue my degree, that they would support my request for advancement. I have supervised CNA's for the last 8 years at UPAC-Tanglewood, and have held other management positions in various places. I would like the opportunity to utilize my nursing skills while advancing with your company.

Thank you for your consideration,

Gayla Ramey

Gayla Ramey, RN

PRUITT CORPORATION
Committed to Caring

PEOPLESOFT

BLUE PARTNER MASTER FILE – CHANGE DATA

Only Changed Information Is Requested. Shaded Areas Are Required. DO NOT ENTER IF THE FIELD IS NOT CHANGING

PE 8/22/09

APPROVAL SIGNATURE: Pamela Duncan	EMPLOYEE ID: COMPANY #: 12984	EFFECTIVE DATE: 8/9/09
EMPLOYEE FIRST NAME: Gayla	EMPLOYEE MIDDLE NAME:	EMPLOYEE LAST NAME: Ramey
HOME ADDRESS STREET: APT # P.O. BOX		
CITY: STATE:	ZIP:	BENEFITS SERVICE DATE:
COUNTY:	PHONE NUMBERS: HOME WORK CELL PAGER	
EMAIL ADDRESS:	DEPARTMENT #:	JOB CODE: (SEE LIST)
PAY TYPE: (CIRCLE) HOURLY SALARIED	STATUS CHANGE TO: FULL TIME PART-TIME PRN	PAY RATE: HRLY 24.04 ANNUAL
FEDERAL TAX WITHHOLDING: W4 FORM ATTACHED	STATE TAX WITHHOLDING: STATE FORM ATTACHED (IF REQUIRED)	TRANSFER: FROM CO #_____ TO CO#_____

GENERAL DEDUCTIONS

TYPE	AMOUNT	GOAL
HEALTH PAC		
HOSPICE FOUNDATION		
PRUITT CARES		
LIFE INSURANCE		
UNIFORMS		
UNITED WAY		
SAVINGS		

TERMINATION

PTO PAYOUT: (CIRLCE) NO YES

OF HOURS_____

NOTE: PTO payouts must be processed in accordance to the PTO Policy.

REASON: (CIRCLE)

ATTENDANCE
DEATH
DID NOT START
EMPLOYER END OF PROBATION TIME
FAILURE TO RETURN FROM LEAVE
NOT ELIGIBLE FOR REHIRE
POSITION REDUCTION
RESIGNATION
RESIGNATION WITHOUT NOTICE
SERIOUS VIOLATION NOF RULES
UNSATISFACTORY PERFORMANCE
VIOLATION OF RULES

DIRECT DEPOSIT:

ATTACH SIGNED DOCUMENTATION

ADDITIONAL INFORMATION:

merit / retro amount owed $84.00

DOH: 7/24/02

Date: _____ Supervisor Signature: _____

Date: 8/20/09 Director of HR: Linda C Burr

PE 8/22/09 JB

UHS-PRUITT CORPORATION
JOB DESCRIPTION

Issued: 09/08
Revised:

JOB CODE: 0169

JOB TITLE: UNIT SUPERVISOR

DIVISION: HEALTHCARE CENTER DIVISION

Name: Gayla Ramey Date of Hire: 7/24/02

Center/Agency: Heritage Healthcare of Ridgeway Department: Nursing

Shift Assignment: _____ Duty Hours: _____

Attendance Requirements: Non-Exempt Status: May be required to work beyond normal working hours on weekends and holidays as necessary. Subject to callback during any emergency.

Accountability--Reports to: Administrator

Purpose: ☐ Job Description Notification ☐ 3-Month Performance Evaluation ☑ Annual Performance Evaluation

Performance Rating: 1=Not Met 2=Progressing 3= Met 4=Good 5=Exceeds Expectations

Essential Demonstration of UHS-Pruitt *"Committed To Caring"* Tenets:

1.	*C*hoose a positive, can-do attitude each and every day.	1 2 (3) 4 5
2.	*O*ur belief is "we should do it right because it is the right thing to do".	1 2 (3) 4 5
3.	*M*ake each day their day through your day.	1 2 (3) 4 5
4.	*M*aintain your focus on quality of care.	1 2 (3) 4 5
5.	*I*mprove yourself through education and training.	1 2 (3) 4 5
6.	*T*ake time to speak to everyone.	1 2 (3) 4 5
7.	*T*reat everyone with dignity and respect.	1 2 (3) 4 5
8.	*E*ach partner is responsible to know and support our organization's goals.	1 2 (3) 4 5
9.	*D*isplay pride in your work, your dress and your speech.	1 2 (3) 4 5
10.	*T*ake the extra step to make a difference.	1 2 (3) 4 5
11.	*O*ur mission is the principal belief of our organization. It must be known, owned, and embraced by all.	1 2 (3) 4 5
12.	*C*reate and maintain a clutter-free, clean and safe environment.	1 2 (3) 4 5
13.	*A*lways be an ambassador to those entrusted in our care.	1 2 (3) 4 5
14.	*R*espect the views and beliefs of others.	1 2 (3) 4 5
15.	*I*dentify opportunities to build teamwork.	1 2 (3) 4 5
16.	*N*ever accept being "average" always strive for "EXCELLENCE".	1 2 (3) 4 5
17.	*G*uests are special; treat everyone like one!	1 2 (3) 4 5

51/85

UHS-PRUITT CORPORATION
JOB DESCRIPTION

JOB CODE: 0169

Issued: 09/08
Revised:

JOB TITLE: UNIT SUPERVISOR

DIVISION: HEALTHCARE CENTER DIVISION

Job Description:

Assist the Director of Health Services in planning, organizing, developing and directing the day-to-day functions of the Nursing Services Department in accordance with current federal, state, and local regulations governing our center, and as may be directed by the Administrator, the Medical Director, and/or the Director of Health Services to provide appropriate care.

Essential Skill/Knowledge Functions:

1.	Operation of oxygen equipment including turning off and on, changing cylinder heads, cleaning/replacing humidifier, and others as necessary.	1	2	3	4	5
2.	Operation of suction machine (oral) including cleaning, selection of appropriates suction catheter, and storage.	1	2	3	4	5
3.	Operation and use of manual respirator.	1	2	3	4	5
4.	Location and use of emergency equipment supplies (box and/or crash cart etc.)	1	2	3	4	5
5.	Operation of whirlpool	1	2	3	4	5
6.	Operation of scales.	1	2	3	4	5
7.	Operation of glucose monitoring devices, calibration, and cleaning etc.	1	2	3	4	5
8.	Use of electronic thermometers (oral/rectal and ear)	1	2	3	4	5
9.	Delivery of medications (setting up, rotating, charting, ordering, giving to patient etc).	1	2	3	4	5
10.	Ordering and use of stock drugs	1	2	3	4	5
11.	Administration and documentation of insulin.	1	2	3	4	5
12.	Use and delivery of PRN medications.	1	2	3	4	5
13.	Use and delivery of topical treatment application (eye, ear, nose etc)	1	2	3	4	5
14.	Use delivery and documentation of narcotic medication	1	2	3	4	5
15.	Knowledge of procedures for receiving drugs from pharmacy	1	2	3	4	5
16.	Application of sterile dressings	1	2	3	4	5
17.	Operation and proper use of pressure reduction surfaces.	1	2	3	4	5
18.	Use of oral airway	1	2	3	4	5
19.	Knowledge of isolation procedures (when to implement etc.)	1	2	3	4	5
20.	Knowledge of location and proper use of personal protective equipment (gloves, masks, gowns, and aprons etc.)	1	2	3	4	5
21.	Delivery of enemas (S&S, and fleets)	1	2	3	4	5
22.	Insertion, irrigation and routine care of male/female catheters.	1	2	3	4	5
23.	Delivery of tube feedings (insertion, flushing, proper amounts etc.)	1	2	3	4	5
24.	Knowledge of procedures and ability to determine Advance Directive status for patients.	1	2	3	4	5
25.	Collection of lab specimens and interpreting results.	1	2	3	4	5
26.	IV implementation and administration	1	2	3	4	5
27.	Seizure precautions and administration of IV medication during a seizure.	1	2	3	4	5
28.	Knowledge of admissions discharges and transfer procedures.	1	2	3	4	5
29.	~~Documentation and billing of supplies used.~~	~~1~~	~~2~~	~~3~~	~~4~~	~~5~~
30.	Knowledge of procedure for sending a patient to the hospital.	1	2	3	4	5
31.	Knowledge of procedures to follow if unable to reach physician.	1	2	3	4	5
32.	Maintain effective lines of communication with attending physicians.	1	2	3	4	5
33.	Monitor physician services (documentation and visits etc.) in accordance with current regulations	1	2	3	4	5
34.	Maintain knowledge of documentation procedures including appropriate use of forms, timelines, and Medicare documentation.	1	2	3	4	5
35.	Maintain a working knowledge of current licensure standards and the survey process.	1	2	3	4	5
36.	Supervises Certified Nurse Assistant	1	2	3	4	5

105/175

UHS-PRUITT CORPORATION
JOB DESCRIPTION

Issued: 09/08
Revised:

JOB CODE: 0169
JOB TITLE: UNIT SUPERVISOR
DIVISION: HEALTHCARE CENTER DIVISION

Other Division or Job-Specific Essential Skill/Knowledge Functions: *(Partner and Supervisor to initial extra added functions)*

1.	_____	1 2 3 4 5
2.	_____	1 2 3 4 5
3.	_____	1 2 3 4 5

Partner Initials: _____; Supervisor Initials: RB

Essential Administrative Functions:

1.	Participate in center/agency surveys (Licensure / JCAHO) and any subsequently required reports.	1 2 (3) 4 5
2.	Attend and participate in continuing educational programs to keep abreast of changes in your field as well as to maintain current license/certification, as required.	1 2 (3) 4 5
3.	Attend and participate in mandatory in-services.	1 2 (3) 4 5
4.	Honor patients/residents' rights to fair and equitable treatment, self-determination, individuality, privacy, property and civil rights, including the right to wage complaints.	1 2 (3) 4 5
5.	Comply with corporate compliance program.	1 2 (3) 4 5
6.	Report job-related functions/tasks that involve occupational hazards including exposure to blood and body fluids and others as necessary.	1 2 (3) 4 5
7.	Follow established safety regulations, to include fire protection & prevention, smoking regulations, infection control, etc.	1 2 (3) 4 5
8.	Follow established safety procedures when performing tasks and/or working with equipment.	1 2 (3) 4 5
9.	Perform other related duties as necessary and as directed by supervisor.	1 2 (3) 4 5

Other Division or Job-Specific Essential Administrative Functions: *(Partner and Supervisor to initial extra added functions)*

1.	_____	1 2 (3) 4 5
2.	_____	1 2 3 4 5
3.	_____	1 2 3 4 5

Partner Initials: _____; Supervisor Initials: RB

27/45

UHS-PRUITT CORPORATION
JOB DESCRIPTION

JOB CODE: 0169
JOB TITLE: UNIT SUPERVISOR
DIVISION: HEALTHCARE CENTER DIVISION

Issued: 09/08
Revised:

Essential General Functions:

1.	Attendance – must maintain timely, regular attendance.	1	2	(3)	4	5
2.	Punctuality.	1	2	(3)	4	5
3.	Professional appearance.	1	2	(3)	4	5
4.	Communicates well with patients/residents/clients and family members providing warm and friendly greeting and an approachable attitude to families, visitors, patients/residents/clients and responds to expressed concerns while displaying a helpful, caring demeanor. Answers questions when appropriate in a professional manner.	1	2	(3)	4	5

12/20

OVERALL EVALUATION SCORE: 195 (Actual points scored) **Divided by** 325 (Total points possible*) = .60 % 15%

*(Functions that are "not applicable" to the position should not be counted as part of the total points possible or actual points scored.)

Supervisor's Comments Regarding Overall Job Performance:

Current % of Midpoint_____ **% Increase** 3% **New %of Midpoint**_____

Performance Evaluation Acknowledgment:

7/23/09
Date

Gayle Ramsey - CSR
Signature – Partner

7/17/09
Date

Patricia Stone, LPN
Signature – Departmental Supervisor

Current $ 23.34
+ .70 raise
24.04

August 18, 2009

Gayla talked with DHS and Pat. She decided to do a mixture of shifts. She prefers night shift but there is no availability at this time. I will consider her for a full time night shift as soon as it becomes available.

Gayla is aware that she may not have a full schedule due to her inability to take the only full time slot which on second shift.

Shirley Goodwin, RN

Signatures and dates

Gayla Ramey 8/18/09

PRUITT CORPORATION
Committed to Caring

PEOPLE Soft

BLUE PARTNER MASTER FILE – CHANGE DATA

Only Changed Information Is Requested. Shaded Areas Are Required. DO NOT ENTER IF THE FIELD IS NOT CHANGING

DOH: 2002

APPROVAL SIGNATURE:	EMPLOYEE ID: COMPANY #:	EFFECTIVE DATE: 9/20/09
EMPLOYEE FIRST NAME: Gayla	EMPLOYEE MIDDLE NAME:	EMPLOYEE LAST NAME: Ramey
HOME ADDRESS STREET: APT # P.O. BOX		
CITY: STATE:	ZIP:	BENEFITS SERVICE DATE:
COUNTY:	PHONE NUMBERS: HOME WORK CELL PAGER	
EMAIL ADDRESS:	DEPARTMENT #:	JOB CODE: (SEE LIST) (RN)
PAY TYPE: (CIRCLE) HOURLY SALARIED	STATUS CHANGE TO: FULL TIME PART-TIME PRN	PAY RATE: HRLY 25.04 ANNUAL_____
FEDERAL TAX WITHHOLDING: W4 FORM ATTACHED	STATE TAX WITHHOLDING: STATE FORM ATTACHED (IF REQUIRED)	TRANSFER: FROM CO #_____ TO CO#_____

GENERAL DEDUCTIONS

TYPE	AMOUNT	GOAL
HEALTH PAC		
HOSPICE FOUNDATION		
PRUITT CARES		
LIFE INSURANCE		
UNIFORMS		
UNITED WAY		
SAVINGS		

TERMINATION

PTO PAYOUT: (CIRLCE)
NO YES
OF HOURS_____

NOTE: PTO payouts must be processed in accordance to the PTO Policy.

REASON: (CIRCLE)
ATTENDANCE
DEATH
DID NOT START
EMPLOYER END OF PROBATION TIME
FAILURE TO RETURN FROM LEAVE
NOT ELIGIBLE FOR REHIRE
POSITION REDUCTION
RESIGNATION
RESIGNATION WITHOUT NOTICE
SERIOUS VIOLATION NOF RULES
UNSATISFACTORY PERFORMANCE
VIOLATION OF RULES

DIRECT DEPOSIT:
ATTACH SIGNED DOCUMENTATION

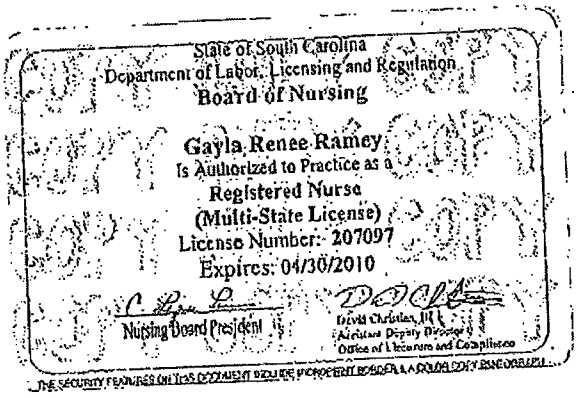
ADDITIONAL INFORMATION:
Passed State boards to become RN.

(Current rate $24.04)

Date: _____ Supervisor Signature: _____

Date: 9/29/09 Director of HR: Linda C Burr

PPE 10/3/09 LB


State of South Carolina
Department of Labor, Licensing and Regulation
Board of Nursing

Gayla Renee Ramey
Is Authorized to Practice as a
Registered Nurse
(Multi-State License)
License Number: 207097
Expires: 04/30/2010

Nursing Board President

David Christian, III
Assistant Deputy Director
Office of Licensure and Compliance

THE SECURITY FEATURES ON THIS DOCUMENT INCLUDE MICROPRINTING BORDER & A GOLD COPY WHEN COPIED

UNITED HOSPICE FOUNDATION INC

12984 PPE 12/12/09 JB

pruittcares

DEAR PARTNER:

The United Hospice Foundation / Pruitt Cares is a non-profit organization whose purpose is:

- to provide ministry and support within our communities,
- to assist with individual and organizational involvement in the communities where we live,
- provide end of life education (including Camp Cocoon),
- and work to make a difference by modeling our core values of *Committed to Caring.*

The PruittCares portion of this program will be used entirely for assistance. The foundation's administrative costs will not be funded by any of your charitable contributions.

You are invited to participate through voluntary, tax-deductible contributions. If you would like to help, please fill out the payroll deduction authorization below and *submit to payroll for completion.*

United Hospice Foundation / Pruitt Cares
PAYROLL DEDUCTION AUTHORIZATION
Please Print Clearly

Date: 11/18/09 Facility Name/Company #: _____

Name: Kayla Ramey

Beginning _____ (start date) please deduct $_____ from my payroll check each pay period (26 pay periods per year). I understand I may change this deduction amount twice a year, in January and July. I also understand I may stop this deduction at any time during the year.

I would like my contribution each pay period to be used for:

PruittCares	$ 1.00	(per pay period) and/or
United Hospice Foundation	$ _____	(per pay period) for a
Total	$ _____	(per pay period)

Name: Kayla Ramey Date: 11/18/09

Partner's Signature: Kayla Ramey

UniHealth Post-Acute Care
Tanglewood

HE 7/9/10 BB

EFFECTIVE JULY 9, 2010

TO: GAYLA RAMEY
FROM: ADMINISTRATION
RE: NURSE CALL

It is the expectation that all licensed nurses take their turn at Call. The nursing director or her designee will make rotating assignments for Call that begin at 5:00 PM on Fridays and end at 7:00 AM the following Monday.

Responsibilities include:

1. Pick up the pager in the nursing office prior to 5:00 PM on Friday (You are responsible for the pager and must return promptly on Monday.)

2. Receive/obtain a current copy of the nursing department staff with phone numbers.

3. Call List is to be posted at each nursing unit by the staffing coordinator.

4. When notified of a call-out by the facility, you are to either report to the facility to make calls for replacement or use your personal phone (at no reimbursement).

5. You are to keep a record of all calls made per shift per day and record staff name, number, reason for denial/refusal. (Turn in to Administrator on Monday).

6. If you are unable to secure staffing for the call-out, you are to verify with the DHS the plan for replacement.

NOTES FOR CLARIFICATION:

1. You do not take Call on your weekend to work, in case you have to provide the replacement.

2. You may swap Call with permission from the DHS and the staffing coordinator.

3. Anytime you report to the facility for Call related duties, you must clock in and clock out.

Committed to Caring

UNIFORM ORDER FORM – EMPLOYEE PURCHASES HR 19.104.00a

Issued: July, 2006
Revised:

Appendix A
UNIFORM ORDER FORM – EMPLOYEE PURCHASES

Date: May 19, 2010 Business Unit Name:
P.O. #: Employee Name: Cayla Ramey (First / Last)

Payment Method: Cash $_____ or Payroll Deduction ✓ (Maximum: 6 calendar weeks)

Department (Circle One): RN / LPN / CNA / Therapy / Dietary / Maintenance / Source Environmental Services / Pharmacy / Hospice / Home Health

COLORS: DG=DARK GREEN LG=LIGHT GREEN B=BURGUNDY T= TAN W=WHITE JG=JAZZY GREEN BK=BLACK

ITEM #	COLOR	SIZE

TUNICS AND WORK SHIRTS:			QTY	UNIT PRICE	TOTAL COST
7275	JG	XS S M L XL 2X 3X 4X			
7502	DG LG B T W	XS S M L XL 2X 3X 4X 5X	1 ea	14.50	29.00
8219	DG LG B T W	XS S M L XL 2X 3X 4X 5X			
SP60LT	TAN SOLID	XS S M L XL 2X 3X			
SP06WB	BLACK & WHITE CHECK	XS S M L XL 2X 3X 4X			
22073	DG	13 TO 18.5 Indicate size:			

PANTS: * Not Available in Petite or Tall ** Not Available in Tall				QTY	UNIT PRICE	TOTAL COST
7602	DG LG* B T W BK	XS S M L XL 2X 3X 4X 5X				
7602	Petite: XS S M L XL 2X 3X	Tall: XS S M L XL 2X		2	12.00	24.00
8322	DG T W BK	XS S M L XL 2X 3X				
8322	Petite: XS S M L XL 2X					
8520	DG LG** T W BK	XS S M L XL 2X 3X 4X 5X				
8520	Petite: XS S M L XL 2X	Tall: XS S M L XL 2X 3X				
PT20K	TAN	Waist:	Length:			
PT20SG	GREEN	Waist:	Length:			
5360	BLACK & WHITE CHECK	XS S M L XL 2X 3X				

WARM UPS:			QTY	UNIT PRICE	TOTAL COST
7473	JG	XS S M L XL 2X 3X 4X			
7525	DG LG B	XS S M L XL 2X 3X 4X 5X			
7551	DG B	XS S M L XL 2X 3X 4X 5X			

LAB JACKETS, LAB COATS, AND CHEF COATS:			QTY	UNIT PRICE	TOTAL COST
3230	Jacket	6 8 10 12 14 16 18 20			
3200	Jacket	32 34 36 38 40 42 44 46 48 50 52			
8058	Jacket	XS S M L XL 2X 3X 4X 5X			
1140	Jacket	32 34 36 38 40 42 44 46 48 50 52 54 56			
3155	Coat	4 6 8 10 12 14 16 18 20			
3132	Coat	32 34 36 38 40 42 44 46 48 50 52			
6520244	Chef Coat	32 34 36 38 40 42 44 46 48 50 52 54 56 58 60 62 64			

MISC:			QTY	UNIT PRICE	TOTAL COST

SUBTOTAL:		53.00
TAX:		3.44
TOTAL COST		56.44

Employee Signature: (To be signed when order is placed)
By signing, I agree to payroll deductions for my purchases:
X Cayla Ramey

I have received my order and understand that it is my responsibility to verify correctness (size, fit, color, logo, etc.). Items may only be returned in new condition on the same day that I take receipt. Once items leave the business unit they may be returned for quality issues only (within 30 days; exchange only). A twenty percent (20%) restocking fee will be charged for all returns except those relating to quality matters or vendor error.

By signing I acknowledge receipt and correctness of my order and acceptance of the return policy.

Employee Signature and Date: Cayla Ramey RN 5/13/10
(To be signed and dated when order is received and verified.)

FILE A COPY OF THIS FORM IN THE EMPLOYEE'S PERSONNEL FILE

12984

DOS 9/13/10 HR

3/18.90