

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Melody L. James, Susan S. Barden, T. Scott Beck, Appellate Panel

WCC File No. 0800660

Cindy Ella Dozier, Employee, Appellant,

v.

American Red Cross, Employer, and Sedgwick CMS, Carrier, Respondents.

**SUPPLEMENTAL
RECORD ON APPEAL**

Stephen B. Samuels
SAMUELS LAW FIRM, LLC
1320 Richland Street
Columbia, SC 29201
(803) 779-4000

ATTORNEY FOR APPELLANT

Wesley J. Shull, Esquire
WILLSON JONES CARTER & BAXLEY, P.A.
872 S. Pleasantburg Drive
Greenville, SC 29607
(864) 272-2660

ATTORNEY FOR RESPONDENTS

RECEIVED

SEP 11 2013

SC Court of Appeals

INDEX TO RECORD ON APPEAL

I. PLEADINGS

Claimant's Form 30 with Attachment (December 30, 2009)	600
Claimant's Brief to the SC Workers' Compensation Commission (March 5, 2010)	602
Claimant's Form 30 and Attachment (May 31, 2012)	605

II. EXHIBITS

Claimant's 2009 APA Submissions:

1. Correspondence of Dr. Blake H. Moore (August 20, 2008 - July 30, 2009)	608
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Claimant's 2012 APA Submissions

1. Dr. Lisa Manusco Correspondence (September 16, 2009)	613
2. Dr. George Bitting Questionnaire (April 6, 2009)	614

Defendants' 2012 APA Submissions

1. James Myers Vocational Evaluation (September 26, 2011)	615
2. FirstChoice Healthcare, P.C. Health History Questionnaire (January 26, 2009)	617

III. CERTIFICATE OF COUNSEL	621
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South Carolina Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5675



WCC File #: 0800660
Carrier File #: 1167461
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: Cindy Dozier SSN: _____ Employer's Name: American Red Cross
Address: _____ Address: 2751 Bull Street
City: Sumter State: SC Zip: 29150 City: Columbia State: SC Zip: 29201
Home Phone: (803) _____ Work Phone: () _____ Insurance Carrier: Old Republic Insurance Co.
Preparer's Name: Stephen Samuels Law Firm: Samuels Law Firm, LLC Preparer's Phone #: (803) 779-4000

REQUEST FOR COMMISSION REVIEW

Request for Commission Review by claimant employer (check one) Date of injury: 1/17/2008 (m/d/yyyy)

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 Attachment.

(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 Wesley J. Shull, Esquire
Name

Gilbert and Shull, 880 S. Pleasantburg Drive, Suite 3-G, Greenville, South Carolina 29607.
Address

on the 30 day of December, 2009 by first class mail personal service certified mail.

[Signature] Attorney at Law 12/30/09
Preparer's Signature Title 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.67-701B. Otherwise, file the original and four 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.

ATTACHMENT TO FORM 30

Cindy Dozier v. American Red Cross and Old Republic Insurance Company

WCC FILE: 0800660

Grounds of Appeal:

1. Whether the Single Commissioner erred as a matter of fact and law in failing to order past causally related medical treatment to be paid by the Carrier pursuant to § 42-15-60?
2. Whether the Single Commissioner erred as a matter of fact and law in allowing Defendants to designate a treating physician when good cause existed to designate Dr. Moore or one of the other treating physicians, such good cause being shown by Defendants wilful failure to provide treatment through the agreed upon authorized treating physician and the fact Defendants obtained *five* IME's?
3. Whether the Single Commissioner erred as a matter of law in failing to assess the mandatory 25% penalty for improper termination of temporary compensation?

STATE OF SOUTH CAROLINA)
)
COUNTY OF RICHLAND)

Cindy Ella Dozier,)
)
Claimant,)
)
-vs-)
)
American Red Cross,)
)
Employer,)
)
and)
)
Old Republic Insurance Company,)
)
Carrier,)
)
Defendants.)
_____)

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

WCC FILE NO. 0800660

**CLAIMANT/APPELLANT'S
BRIEF TO THE FULL COMMISSION**

The Claimant, by and through her undersigned attorney, hereby submits her Appellant's Brief to the Full Commission.

ISSUE ON APPEAL

Whether the Single Commissioner erred as a matter of fact and law in failing to order past causally related medical treatment to be paid by the Carrier pursuant to § 42-15-60?

STATEMENT OF THE CASE

This is an appeal from a Form 50 hearing in which the Single Commissioner awarded temporary total and ongoing medical treatment for injuries Claimant sustained to both her arms. At the hearing, Claimant requested her treatment be directed by Dr. Blake Moore as he was her treating physician. The parties had entered into a Consent Order designating Dr. McIntosh as the authorized treating physician, but Defendants sent her to Dr. McIntosh for an IME (one of five Defense IME's

in this case) rather than treatment in violation of the Consent Order.

After the hearing, the Defendants designated Dr. Zgleszewski as the authorized treating physician. As Dr. Zgleszewski is acceptable to Claimant, she no longer requests Dr. Moore be designated the treating physician. She does seek reimbursement for the treatment Dr. Moore and his referring physicians provided during the time Defendants failed to provide treatment.

Claimant Cindy Dozier was employed by the Red Cross as a phlebotomist working in mobile blood drives. She injured both arms in an admitted accident on January 17, 2008.

Defendants provided several months of treatment with Dr. Wright at Carolina Occupational Health Care and Dr. Nichols at Camden Bone & Joint. At that point, further treatment was denied. Instead, Defendants sent Dozier for *five separate IME's*.

The parties entered into a Consent Order in December 2008 designating an authorized treating physician. However, when Claimant attended that visit, she learned it was another IME.

No treatment was provided after April 2008 until after the hearing when Dr. Zgleszewski became the treating physician. During this time, Claimant treated extensively *for her causally related injuries* with several doctors, all directed by Dr. Blake Moore. She was forced to do this because Defendants provided no treatment.

ARGUMENT

Claimant is entitled to be reimbursed for causally related treatment she obtained on her own during the time Defendants refused to provide treatment.

The Commission has discretion to order the employer to pay for medical treatment. The statute specifically states, "If in an emergency, on account of the employer's failure to provide the medical care as specified in this section, a physician other than provided by the employer is called

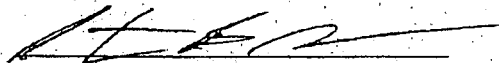
to treat the employee, the reasonable cost of the service must be paid by the employer, if ordered by the commission." S.C. Code Ann. § 42-15-60 (2007). Here, it is undisputed that Defendants failed to provide medical care *for over a year*, despite the existence of a Consent Order directing them to do so.

The appropriate remedy is to order Defendants to reimburse Claimant for the treatment she was forced to obtain on her own during this time.

CONCLUSION

For the foregoing reasons, the Appellate Panel should amend the Decision and Order of the Single Commissioner and order Defendants to reimburse Claimant for causally related treatment she obtained at her own expense due to Defendants' refusal to provide such treatment.

Respectfully Submitted,



Stephen B. Samuels
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P.O. Box 50349
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Columbia, South Carolina
March 5, 2010

South Carolina Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5675



WCC File #: 0800660
Carrier File #: 1167461
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: Cindy Dozier SSN: _____ Employer's Name: American Red Cross
Address: _____ Address: 2751 Bull Street
City: Sumter State: SC Zip: 29154 City: Columbia State: SC Zip: 29201
Home Phone: (803) Work Phone: () Insurance Carrier: Old Republic Insurance Co.
Preparer's Name: Stephen Samuels Law Firm: Samuels Law Firm, LLC Preparer's Phone #: (803) 779 - 4000

REQUEST FOR COMMISSION REVIEW

Request for Commission Review by claimant employer (check one) Date of injury: 1/17/2008 (m/d/yyyy)

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).

Please see Attachment to Form 30.

(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 Wesley J. Shull, Esquire
Name

Willson, Jones, Carter & Baxley, 872 S. Pleasantburg Drive, Greenville, South Carolina 29607.
Address

on the 31st day of May, 2012 by first class mail personal service certified mail.

[Signature] Attorney for Claimant 05/31/2012
Preparer's Signature Title 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.67-701B. Otherwise, file the original and four 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.

ATTACHMENT TO FORM 30

Cindy Dozier v. American Red Cross and Old Republic Insurance Company
WCC FILE: 0800660

Grounds of Appeal:

1. Whether the Single Commissioner erred as a matter of fact and law in failing to find Claimant was permanently and totally disabled under § 42-9-10.
2. Whether the Single Commissioner erred as a matter of fact and law in failing to find Claimant was entitled to lifetime medical treatment.
3. Whether the Single Commissioner erred as a matter of fact and law in failing to allocate the disability award pursuant to James.
4. Whether the Single Commissioner erred as a matter of fact and law in granting a credit for overpayment when defense counsel stipulated no credit was being sought.
5. Whether the Single Commissioner erred as a matter of fact and law in finding Claimant did not suffer from CRPS II when:
 - A. Claimant had prevailed on this issue at a previous hearing, such that the issue was res judicata as to Defendants.
 - B. Defendants had waived the right to contest the issue.
 - C. Defendants were estopped from contesting the issue.
 - D. Defendants had designated a treating physician to treat CRPS Type II and had authorized such treatment for two years prior to the hearing.
 - E. The expert medical evidence showed Claimant had developed CRPS Type II as a result of her injury.
 - F. Claimant changed her position on appeal in reliance on Defendants' acceptance of CRPS II and provision of medical treatment for that specific condition.
 - G. CRPS Type II has been an accepted part of this case for more than 150 days.
 - H. The Single Commissioner relied on the AMA Guide as a basis for his own diagnosis when the authorized treating physician testified that the AMA Guides were not valid, credible or authoritative nor designed to be used for diagnosing CRPS.
6. Whether the Single Commissioner erred as a matter of fact and law in finding Claimant could work based on James Myers' report when:
 - A. Myers' report contained numerous errors and inaccuracies in the job descriptions.
 - B. Myers' opinion had no basis in evidence, in that:

- i. Overlooked the work restrictions from Dr. Zgleszewski;
 - ii. Disregarded the work restrictions from Dr. Shealy;
 - iii. Assumed Claimant could work sedentary duty which requires the ability to lift 10 pounds when the evidence conclusively shows Claimant cannot lift 5 pounds nor can she use her hands more than occasionally; and
 - iv. The opinion assumes Claimant can perform the listed jobs which are all outside her qualifications and physical limitations.
 - C. Myers' is not a credible witness.
7. Whether the Single Commissioner erred as a matter of fact and law in awarding 20% disability to each arm when the award has no relation to the actual disability and loss of earnings capacity suffered by Claimant.
 8. Whether the Single Commissioner erred as a matter of fact and law in finding the Commission had previously ruled *against* Claimant on the extent of her arm injuries, specifically finding that the Commission had denied the claim for RSD/CRPS when the opposite is true. Furthermore, the conduct of the parties reveals that they had interpreted the Commission's previous order as a finding that Claimant had sustained RSD/CRPS as a result of her injury.
 9. Whether the Single Commissioner erred as a matter of fact and law in speculating that Dr. Shealy would not have given Claimant any work restrictions.
 10. Whether the Single Commissioner erred as a matter of fact and law in finding Claimant is not permanently and totally disabled due to the fact that work is available that would allow her to work under the 5 pound weight restriction when there is no evidence in the record from James Myers or anyone else that such jobs exist.
 11. Whether the Single Commissioner erred as a matter of fact and law in finding Claimant is not permanently and totally disabled based on the fact she had not sought employment when a work search is not required proof and when no such jobs exist within Claimant's restrictions.

KINGSTREE SURGICAL ASSOCIATES
BLAKE H. MOORE, MD FACS
144 COLDSTREAM DRIVE
COLUMBIA SC 29212

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EMAIL: BHMFACTS@hotmail.com

INDEPENDENT MEDICAL REVIEW:

PATIENT: CINDY E. DOZIER

DOB: 4/28/1970

ADDRESS: ALICE DRIVE, SUMTER, S.C. 29150

SS#

PREPARED FOR: JOSEPH MCELVEEN, ESQ.

ADDRESS: 17 E. CALHOUN STREET
SUMTER, S.C. 29151-2038

DATE: August 20th, 2008

Dear Mr. McElveen;

I had the pleasure of seeing your client Ms. Dozier on 8/15/08. As you are aware she claims that she was injured at work, while employed by the Red Cross. She describes her job duties as including lifting 80 pound kits for blood drives. She was diagnosed by Dr. Nichols with Camden Bone and Joint as having "tenosynovitis" in her wrist. Conservative care failed and she continued to have significant pain. She was seen by my office for a second opinion.

She was noted with marked hypersensitivity in her left hand. She described temperature sensitivity, and was noted with resting edema. Her exam revealed a positive Phalen's and a positive Tinnel's sign.

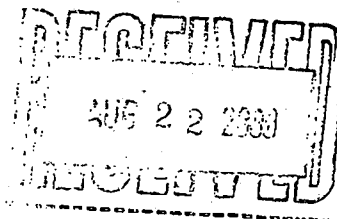
I strongly suspect that she has an underlying neuropathy that has gone undiagnosed. This will likely be either a simple median neuropathy (Carpal Tunnel Syndrome), or a more complex CRPS type entity.

I have ordered serology testing and an NCS/EMG to clarify her condition further. I have prescribed Ultram and Cymbalta to assist with her symptoms. I believe that she has a significant injury that appears to be work related to the standard of "reasonable medical certainty". She will require ongoing treatment and care.

RESPECTFULLY SUBMITTED



BLAKE H. MOORE, MD, FACS



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PATIENT: CINDY E. DOZIER
DOB: 4/28/1970
ADDRESS: ALICE DRIVE, SUMTER, S.C. 29150
SS# [REDACTED]
Phone: 803- [REDACTED]

PREPARED FOR: JOSEPH T. MCELVEEN, JR., ESQ.
ADDRESS: 17 EAST CALHOUN STREET
SUMTER, S.C. 29150

DATE: December 5th, 2008


Dear Mr. McElveen;

Pursuant to your request I have reviewed my records of your client Ms. Dozier in regards to her documented complaints related to her upper extremities. I offer the following as a means of explanation.

The current management plan consists of arranging a referral to Dr. Ezra Riber to evaluate her for diagnostic and possible therapeutic ganglion block. As I have previously outlined she has carpal tunnel syndrome. Her symptom complex seems to be in excess of what one would typically expect to see from an isolated median compression neuropathy. I have discussed carpal tunnel release with her orthopaedic consultant, but at this time the recommendation is to proceed with an evaluation of concurrent Complex Regional Pain Syndrome via ganglion blockade.

As her ability to engage in her employment activities is still impaired, she is unable to return to her previous work activities and should remain under a temporary disability status. It is hopeful that ganglion blockade may result in significant symptom abatement. She will be re-evaluated in 8 weeks, at which time a decision will be made as to her ability to return to work. I hope this answers your questions and concerns as to Ms. Dozier's status.

If there are any questions, please feel free to contact my office accordingly.

Very truly yours,

Blake H. Moore, MD FACS

KINGSTREE SURGICAL ASSOCIATES

BLAKE H. MOORE, MD FACS

144 COLDSTREAM DRIVE

COLUMBIA SC 29212

(803)-749-7497

FAX: (803)-781-8907

EMAIL: BHMFACTS@hotmail.com

PATIENT: CINDY E. DOZIER

DOB: 4/28/1970

ADDRESS: ALICE DRIVE, SUMTER, S.C. 29150

SS#

Phone: 803/

PREPARED FOR: JOSEPH T. MCELVEEN, JR., ESQ.

ADDRESS: 17 EAST CALHOUN STREET
SUMTER, S.C. 29150

DATE: January 22nd, 2009

Dear Mr. McElveen;

Pursuant to your request I have reviewed my records of your client Ms. Dozier in regards to her documented complaints related to her upper extremities. I offer the following as an interval update as per your request.


The current management plan consists of her seeing a pain specialist to further evaluate Complex Regional Pain Syndrome via ganglion blockade. As per prior she is noted with a mild case of median neuropathy (carpal tunnel syndrome). Her orthopaedic consultants have felt that non-operative management is most prudent at this time.

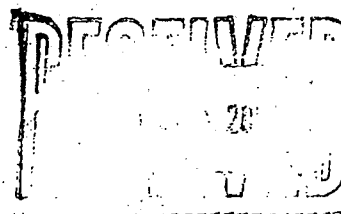
As her ability to engage in her employment activities is still impaired, she is unable to return to her previous work activities and should remain under a temporary disability status. It is hopeful that ganglion blockade may result in significant symptom abatement. She will be re-evaluated in 2 weeks, at which time a decision will be made as to her ability to return to work. It is hopeful that the ganglion block will be both diagnostic and therapeutic, and will allow her to return to a reasonable level of function.

I have had several lengthy discussions with Ms. Dozier regarding the differential diagnoses and the treatment plan. I have filled out forms with Matrix regarding her Freedom Finance Loan in accordance with this treatment plan.

If there are any questions, please feel free to contact my office accordingly.

Very truly yours,


Blake H. Moore, MD FACS



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COLUMBIA SC 29212

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PATIENT: CINDY E. DOZIER
DOB: 4/28/1970
ADDRESS: ALICE DRIVE, SUMTER, S.C. 29150
SS#:
Phone: 803-

PREPARED FOR: JOSEPH T. MCELVEEN, JR., ESQ.
ADDRESS: 17 EAST CALHOUN STREET
SUMTER, S.C. 29150

DATE: February 22nd, 2009

Dear Mr. McElveen;

Pursuant to your request I have reviewed my records of your client Ms. Dozier in regards to her documented complaints related to her upper extremities. I offer the following as an interval update as per your request.

Since my last update she has been seen in consultation by Dr. Lisa Mancuso with the First Choice Pain Clinic in Florence. A cervical MRI has been obtained revealing multilevel cervical disc disease. A Nuclear Medicine Bone Scan was obtained revealing bilateral wrist uptake. This is consistent with the diagnostic impression of a Complex Regional Pain Syndrome as previously suspected.

Dr. Mancuso has begun a planned series of diagnostic/therapeutic blocks. Cervical ESI has been provided. Ms. Dozier reports subjective improvement with this course of treatment.

As her ability to engage in her employment activities is still impaired, she is unable to return to her previous work activities and should remain under a temporary disability status. She is making progress and hopefully will soon be able to return to an increased schedule of activity.

If there are any additional questions, please feel free to contact my office accordingly.

Very truly yours,



Blake H. Moore, MD FACS

KINGSTREE SURGICAL ASSOCIATES
BLAKE H. MOORE, MD FACS
144 COLDSTREAM DRIVE
COLUMBIA SC 29212

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PATIENT: CINDY E. DOZIER
DOB: 4/28/1970
ADDRESS: ALICE DRIVE, SUMTER, S.C. 29150
SS#
Phone: 803

PREPARED FOR: SAMUELS LAW FIRM
ADDRESS: P.O. BOX 50349
COLUMBIA, S.C. 29250

DATE: July 30th, 2009

Dear Mr. Samuels;

Pursuant to the request of your client, I am providing the following case update. I saw Ms. Dozier again this day.

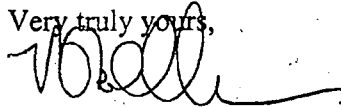
She has been seen by Carolina PT at the request of the Workers Comp. insurance carrier. Their findings revealed loss of strength, pain, and loss of ROM. They recommended ongoing treatment for "CTS and cervical DDD for pain management". It is clear that she remains short of MMI.

She has been seen in consultation by Dr. Lisa Mancuso and George Bitting with the First Choice Pain Clinic in Florence. A cervical MRI has been obtained revealing multilevel cervical disc disease. A Nuclear Medicine Bone Scan was obtained revealing bilateral wrist uptake. This is consistent with the diagnostic impression of a Complex Regional Pain Syndrome as previously suspected.

Dr. Rhea has seen her and concurred that her pain is inconsistent with a simple median neuropathy or simple cervical disc disease. Her findings suggest a CRPS entity. I have made a referral to Dr. Ogburu a Columbia pain specialist to consider a diagnostic and therapeutic ganglion block to further define the issue of CRPS.

If there are any additional questions, please feel free to contact my office accordingly.

Very truly yours,



Blake H. Moore, MD FACS



Lisa Mancuso MD, D-ABPM
Board Certified - Pain Management
Fellowship Trained

700 Medical Park Drive
Hartsville, SC 29550
Phone: 843-350-0100
Fax: 843-383-3745

September 16, 2009

Mr. Stephen B. Samuels
Attorney at Law
Samuels Law Firm, LLC
1527 Blanding Street
P.O. Box 50349
Columbia, SC 29250

Dear Mr. Samuels:

This letter is to inform you that I have deferred all medical care for Cindy Dozier to the current treating physicians effective March 4, 2009 when I left the employ of First Choice Healthcare. I regret that I have been unable to continue to see Ms. Dozier, and I wish her all the best in her chronic pain care.

Please remit the nominal fee of \$35.00 for preparation of this letter.

With Warmest Regards,

Lisa Mancuso MD, D-ABAPM

CORVEL

Throughout Ms. Dozier's previous work history and experience, the following General Development Skills were identified.

<u>APTITUDES</u>	<u>PERCENTILE</u>	<u>TYPICAL PERFORMANCE LEVEL</u>
G - Intelligence	33% to 66%	Average
V - Verbal	10% to 33%	Below Average
N - Numerical	10% to 33%	Below Average
S - Spatial perception	10% to 33%	Below Average
P - Form perception	10% to 33%	Below Average
Q - Clerical perception	66% to 89%	Average
K - Motor coordination	10% to 33%	Below Average
F - Finger dexterity	34% to 65%	Average
M - Manual dexterity	34% to 65%	Average
E - Eye/hand/foot coord	10% to 33%	Below Average
C - Color discrimination	34% to 65%	Average

The following Physical Demands were identified to be within Ms. Dozier's previous work experience:

STRENGTH:

Medium - Exert force 20-50lbs. occasionally, 10-25lbs frequently, or up to 10 lbs constantly, frequently, or over 20 lbs., constantly.

PHYSICAL DEMANDS:

Occasional	ST - Stooping
Occasional	CR - Crouching
Frequent	RE - Reaching
Frequent	HA - Handling
Frequent	FI - Fingering
Frequent	FE - Feeling
Frequent	TA - Talking
Frequent	HE - Hearing
Frequent	NE - Near Acuity (Under 20 inches)
Occasional	FA - Far Acuity (Over 20 feet)
Frequent	AC - Accommodation (Focal length change)
Frequent	CV - Color Vision

The VDARE identified the following environmental conditions within Ms. Dozier's previous employment:

Loud NO - Noise Intensity Level

SPECIFIC VOCATIONAL PREPARATION: Over 12 months up to and including one year (SVP=5). This demonstrates a semi skilled worker.

Transferable Employment Occupations:

66

CORVEL

Based upon Ms. Dozier's past work experience and transferable skills, the following positions have been identified as possible alternative employment opportunities.

	Occupation	DOT/SVP	Exertion Level
1.	Sorter	734.687-082/2	Sedentary
2.	Customer Service Representative	239.227-010/5	Sedentary
3.	Industrial Order Clerk	221.367-022/4	Sedentary
4.	Greeter	241.367-014/5	Sedentary
5.	Collection Clerk	241.357-010/5	Sedentary
6.	EKG Tech	078.362-018/4	Sedentary

Sources Utilized to Obtain Transferable Skills Analysis:

Vocational Diagnosis and Assessment of residual Employability (VDARE), Dictionary of Occupational Titles (DOT), O'NET and the Classification of Jobs (COJ)

Comment Section:

Ms. Dozier was cooperative throughout the Initial Vocational Evaluation and indicated on several occasions her desire to return to gainful employment, if she were physically able to do so. Ms. Dozier is a semi-skilled individual with a variety of work experiences.

It is this CRC's opinion that Ms. Dozier is a viable candidate for Vocational Rehabilitation Services and will benefit from her continued participation with those services. Based upon the recommendations of the Dr. Shealy and previous life experiences, Ms. Dozier should be able to return to work in a Sedentary to Light Physical Demand Level (PDL) position identified in the Transferrable Skills Analysis. Dr. Shealy reported placing a 5 lb restriction at the request of Ms. Dozier and upon further clarification in his deposition on 08/26/11 reported he normally releases with no restrictions, but Ms. Dozier requested a 5lb restriction. This would suggest Ms. Dozier is functioning at a higher physical demand level due to self limiting.

Ms. Dozier lives in an urban area of the Midlands of SC, is within a 50 mile radius of the city of Columbia, SC, with a supported worker base of 265,374. Current unemployment is 8.1% compared to a state average of 11.9%. This information was obtained from the South Carolina Statistical abstract and US Department of Labor and is based on 2011 data.

Work conditioning should be explored to facilitate a successful return to work due to Ms. Dozier being out of the work place for over one year, if deemed appropriate by the treating physician. Ms. Dozier was also informed of services being offered by the SC Department of Vocational Rehabilitation Services and local library, if her desire to return to work changes in the future.

Submitted by: James R Myers MA, QRP, CCM, CRC
Certified Rehabilitation Counselor

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200 Center Point Circle
Suite 290
Columbia SC 29210

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843/650-4941 Fax

607

HEALTH HISTORY QUESTIONNAIRE

First Name: Cindy Middle: _____ Last: Dorien
 SSN: _____ Date of Birth: 04/28/70 Gender: Male Female
 Phone: (H) _____ (W) (803) _____ (803) _____
 Race: D Emergency Contact Person: Lionel Dorien Number: (803) 316-6533

Chief Complaint and Present Illness

Chief Complaint: _____

If symptoms include Pain, check the boxes that best describe: Aching Boring Burning
 Cramping Crushing Constricting Deep Dull Gnawing Heavy Knife Like Lancinating
 Piercing Pounding Pressure Like Sharp Shooting Stabbing Tearing Tender Throbbing
 Tight Other _____

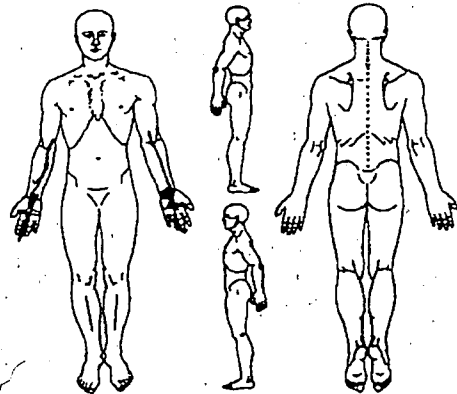
Date or Time Since Symptoms Began: 17th Jan 08

Location of Symptoms: _____
 Please mark all areas of symptoms on the diagram

Onset manner of symptoms: Gradual Sudden Injury

Frequency of Symptoms: _____
 Rare Occasional Intermittent Frequent Constant

Severity of Pain: Minimal Mild Moderate Severe



Rate your pain on a scale of 1-10 with 10 being the worst:

How long do your symptoms usually last: _____

How did symptoms start: Right wrist & left hand was hurting first but let up a little when I let hand and wrist start hurting swelling up and pain running up hands and arms.

How have symptoms progressed: Improved Unchanged Getting Worse

What brings on symptoms: it just hurt What makes symptoms worse: using hand and arms lifting heavy things

What relieves symptoms: not using them too much

Medications

Please list all medications that you are currently taking, both prescription and over the counter

Medication Name	Dosage	Frequency	Who Prescribed Medication
<u>naproxen</u>	<u>1 tw. cc 4 days</u>		<u>James nichols</u>
<u>Darvocet</u>	<u>1-2 tabs</u>		<u>James nichols</u>
<u>Darvon</u>	<u>1-9 hours</u>		<u>Blake moses</u>

55005

Past Medical History

Please provide a list and history of all past medical conditions: Ex; Asthma, Diabetes, High blood pressure etc

Provide a complete list of all illnesses, injuries, surgeries, and hospitalization. (Use back of page if necessary)

List Illnesses, Surgeries, and Hospitalizations	Date	Treatment
Eye Stereotaxing	06-05-08	
Head when I was young 6 or 7 years old		

Check any childhood diseases that you have had:

- Chicken Pox
 Measles
 Mumps
 Polio
 Rheumatic Fever
 Rubella
 Scarlet Fever
 None

Have you ever had a Blood Transfusion: Yes No

Have you ever been exposed to a Sexually Transmitted Disease: Yes No If yes, list disease: _____

Allergies

List all allergies including medications and the reaction. If none, write none.

List Allergies	Reaction you had
Codine	makes me sick on stomach
Dilaudid	breaks out in hives and ran fever

Family History

	Status	Age	Illnesses	Cause of Death
Father	<input type="checkbox"/> Living <input checked="" type="checkbox"/> Deceased <input type="checkbox"/> Unknown			Old age
Mother	<input checked="" type="checkbox"/> Living <input type="checkbox"/> Deceased <input type="checkbox"/> Unknown	73	high blood sugar Diabetes	

	Number	List any illnesses
Siblings	12	None
Children	2	single in childhood Asthma

Social History

Marital Status: Single Engaged Married Separated Divorced Spouse Deceased

Occupation: _____ Highest Level of Education: 12th

Tobacco Use: Never Current Discontinued - Type: _____ Quantity: _____ Years: _____

Alcohol Use: Never Beer(s) ___/Week Liquor ___/Week Wine ___/Week Recovering Alcoholic

Caffeine: Coffee ___ Tea ___ Soda ___

13

55005

Exercise: Not Exercising Exercising ___ Times per week - Type of exercise: _____

Illicit Drug Usage: Never Past History Current. Please list drugs used _____
 Drug/Alcohol Abuse Treatment Yes No. If yes, In-Patient Out-Patient Both

Review of Systems

Please check all symptoms or illnesses that you have currently.

<p style="text-align: center;">General</p> <input type="checkbox"/> Decreased Activity <input type="checkbox"/> Changes in Appetite <input type="checkbox"/> Chills <input type="checkbox"/> Decreased Energy <input type="checkbox"/> Fainting <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Sweating <input type="checkbox"/> Weight Change <input type="checkbox"/> None of above	<p style="text-align: center;">Eyes</p> <input type="checkbox"/> Discharge <input type="checkbox"/> Dry <input type="checkbox"/> Itching <input type="checkbox"/> Drooping <input type="checkbox"/> Redness <input type="checkbox"/> Swelling <input type="checkbox"/> Visual Difficulties <input type="checkbox"/> Vision Loss <input checked="" type="checkbox"/> None of above	<p style="text-align: center;">Ears/Nose/Mouth/Throat</p> <input type="checkbox"/> Congestion <input type="checkbox"/> Discharge <input type="checkbox"/> Earache <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hearing Sensitivity <input type="checkbox"/> Pain <input type="checkbox"/> Popping <input type="checkbox"/> Ringing <input type="checkbox"/> Vertigo <input checked="" type="checkbox"/> None of Above	<p style="text-align: center;">Nose</p> <input type="checkbox"/> Altered Smell <input type="checkbox"/> Bleeding <input type="checkbox"/> Congestion <input type="checkbox"/> Discharge <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Sinus Pain <input type="checkbox"/> Sinus Pressure <input type="checkbox"/> Snoring <input checked="" type="checkbox"/> None of above
<p style="text-align: center;">Mouth</p> <input type="checkbox"/> Altered Sense of Taste <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Burning Tongue <input type="checkbox"/> Lesion <input type="checkbox"/> Mass <input type="checkbox"/> Sore <input type="checkbox"/> Pain <input type="checkbox"/> Gum Problems <input checked="" type="checkbox"/> None of above	<p style="text-align: center;">Throat</p> <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sore Throat <input type="checkbox"/> Lesion <input type="checkbox"/> Mass <input type="checkbox"/> Cough <input type="checkbox"/> Apnea <input type="checkbox"/> Snoring <input type="checkbox"/> Dryness <input type="checkbox"/> Reflux <input checked="" type="checkbox"/> None of above	<p style="text-align: center;">Lungs/Respiratory</p> <input type="checkbox"/> Cough <input type="checkbox"/> Coughing Blood <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Sputum <input type="checkbox"/> Wheezes <input checked="" type="checkbox"/> None of above	<p style="text-align: center;">Heart/Cardiac</p> <input type="checkbox"/> Chest Discomfort <input type="checkbox"/> Chest Pain <input type="checkbox"/> Chest Pressure <input type="checkbox"/> Cold Hands/Feet <input type="checkbox"/> Blue Extremities <input type="checkbox"/> Difficulty Breathing with Exercise <input type="checkbox"/> Extremity Swelling <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Palpitations <input type="checkbox"/> Increase Heart Rate <input checked="" type="checkbox"/> None of above
<p style="text-align: center;">Digestive/Gastrointestint</p> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Bloating <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Food Intolerance <input type="checkbox"/> Gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Indigestion <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Loss of Weight <input type="checkbox"/> Nausea <input type="checkbox"/> Regurgitation <input type="checkbox"/> Abnormal Stool <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Vomiting <input checked="" type="checkbox"/> None of above	<p style="text-align: center;">Genitourinary</p> <input type="checkbox"/> Bloody Urine <input type="checkbox"/> Frequency <input type="checkbox"/> Bed-Wetting <input type="checkbox"/> Incontinence <input type="checkbox"/> Odor <input type="checkbox"/> Pain with Urination <input type="checkbox"/> Passing Stones <input type="checkbox"/> Abnormal Stream <input type="checkbox"/> Abnormal Urine Appearance <input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> Genital Lesion <input type="checkbox"/> Libido Changes <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Sexual Dysfunction <input checked="" type="checkbox"/> None of above	<p style="text-align: center;">Female Only</p> <p>Vaginal</p> <input type="checkbox"/> Burning <input type="checkbox"/> Discharge <input type="checkbox"/> Dryness <input type="checkbox"/> Irritation <input type="checkbox"/> Itching <input type="checkbox"/> Lesions <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Premenstrual Sympt <input type="checkbox"/> Menstrual Symptom <input type="checkbox"/> Irregular Bleeding <input type="checkbox"/> Cramps <input type="checkbox"/> Pain <input type="checkbox"/> Menopausal <input checked="" type="checkbox"/> None of above Date of last Menstrual Period: _____	<p style="text-align: center;">Musculoskeletal</p> <p>Joint</p> <input type="checkbox"/> Inflammation <input type="checkbox"/> Redness <input checked="" type="checkbox"/> Pain in hand - arms <input type="checkbox"/> Limited Motion <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Tenderness <input checked="" type="checkbox"/> Weakness heels - arms <p>Muscle</p> <input type="checkbox"/> Atrophy <input type="checkbox"/> Cramps <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Weakness <input checked="" type="checkbox"/> None of above

Review of Systems Continued

Please check all symptoms or illnesses that you have **currently**.

<p style="text-align: center;">Neurological</p> <input type="checkbox"/> Blackouts <input type="checkbox"/> Balance Problems <input type="checkbox"/> Concentration <input type="checkbox"/> Confused/Disoriented <input type="checkbox"/> Coordination Loss <input type="checkbox"/> Drowsiness <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Gait Abnormality <input checked="" type="checkbox"/> Headache <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Loss of Sensation <input type="checkbox"/> Loss of Memory <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizures <input type="checkbox"/> Speech Changes <input type="checkbox"/> Tremors <input type="checkbox"/> None of above	<p style="text-align: center;">Skin</p> <input type="checkbox"/> Color Changes <input type="checkbox"/> Texture Changes <input type="checkbox"/> Itching <input type="checkbox"/> Blisters <input type="checkbox"/> Sores <input type="checkbox"/> Mole Changes <input type="checkbox"/> Rashes <input type="checkbox"/> Hives <input type="checkbox"/> Hair Changes <input type="checkbox"/> Nail Changes <input checked="" type="checkbox"/> None of above	<p style="text-align: center;">Blood/Lymphatics</p> <input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> Prolonged Bleeding <input type="checkbox"/> Abnormal Bruising <input type="checkbox"/> Painful Lymph Nodes <input type="checkbox"/> Tender Lymph Nodes <input type="checkbox"/> Swollen Lymph Nodes <input checked="" type="checkbox"/> None of above	<p style="text-align: center;">Psychiatric</p> <input type="checkbox"/> Abuse Victim <input type="checkbox"/> Personality Change <input type="checkbox"/> Compulsiveness <input type="checkbox"/> Depression <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Irritability <input type="checkbox"/> Hostility <input type="checkbox"/> Hyperactive <input type="checkbox"/> Nervousness <input type="checkbox"/> Memory Problems <ul style="list-style-type: none"> <input type="checkbox"/> Short Term Loss <input type="checkbox"/> Long Term Loss <input type="checkbox"/> Mood Swings <input type="checkbox"/> Anxiety <input type="checkbox"/> Sleep Problems <input type="checkbox"/> Suicidal Thoughts <input checked="" type="checkbox"/> None of above
	<p style="text-align: center;">Endocrine</p> <input type="checkbox"/> Hair Loss <input type="checkbox"/> Voice Changes <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Excessive Hunger <input type="checkbox"/> Excessive Urination <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> None of above		

By signing below I certify that that above information is true to the best of my knowledge and I consent to the provider to evaluate and recommend treatment for the condition or conditions present above.

Cindy Dezier
Signature

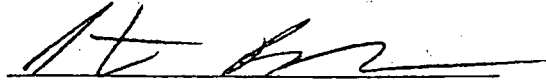
01-26-09
Date

How did you find out about our office? Referred by Doctor Murre

CERTIFICATE OF COUNSEL

The undersigned hereby certifies that this Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

Respectfully Submitted,



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