ATTACHMENT A

CONTENTS OF COMMISSION'S FILE AS OF 12/07/2012

ATT. A1

Rec'd
cl 1/6

Alexander Guice

P.O. Box 8651
Tampa, FL 33674
aguice@hotmail.com
(813) 335-4046 T
(813) 898-2908 F

CHECK DATE
CHECK # 11/18/12
MO
ID # 10137272
COPY FILE 208873
COPY
TO BE IN
ATTY E
PREV. COPY
END #
BEG. # 35 - 20 = 15

November 18, 2012

VIA CERTIFIED MAIL

South Carolina Workers' Compensation Commission
Attn: Claims Department
P.O. Box 1715
Columbia, South Carolina 29202

RE: WCC No.: 0506205 – Request For Copy of File

Dear Ms. Burckhalter or To Whom It May Concern:

Respectfully, I, Alexander Guice, the Claimant, SSN# ~~Request a copy of File WCC~~ No.: 0506205, or the like, with regards to my injury which occurred on May 5, 2005. I am the injured employee with regards to the aforementioned claim and request.

Pursuant to the Freedom of Information Act, § 30-4-30 (b), I have enclosed a twenty-dollar ($20.00) money order with regards to the research, retrieval of the file, postage and up to twenty pages of copies. I also acknowledge that additional pages are $.50 each and will be invoiced if required.

Please mail the requested file copy WCC No.: 0506205, or the like, to the address listed above.

If you have any questions or require additional information, please do not hesitate to contact me.

Sincerely,

Alexander Guice
Claimant
ag

Enclosure(s): $20.00 Money Order

cc: FILE

RECEIVED
NOV 27 2012
Division of Claims
Office of Administrator
S.C. Workers' Comp. Comm.

CERTIFICATE OF SERVICE

This certifies that I, Alexander Guice, the Claimant, did mail, with sufficient postage, through the U.S. Postal Service, a Request for Copy of file WCC No.: 0506205 dated 11/18/2012; a twenty-dollar ($20.00) money order and certificate of service, via Certified Mail, on the party listed below.

I

Alexander Guice
Claimant
P.O. Box 8651
Tampa, Florida 33674
(813) 335-4046 T
(813) 898-2908 F
alguice@hotmail.com

Mailed this 18th day of November, 2012
Hillsborough County
Tampa, Florida

COPIES MAILED TO:

South Carolina Workers' Compensation Commission
Attn: Claims Department
P.O. Box 1715
Columbia, SC 29202
Confirmation No: 70122210000174446935

ATT. A2

TURNER PADGET
TURNER PADGET GRAHAM & LANEY P.A.

CHARLESTON
COLUMBIA
FLORENCE
GREENVILLE

Walter H. Barefoot
Email: WBarefoot@TurnerPadget.com
Writer's Direct Dial: 843-656-4414

April 11, 2006

Mr. Greg Line, Claims Director
S. C. WORKERS' COMPENSATION COMMISSION
Post Office Box 1715
Columbia, SC 29202

RE:

Claimant:	Alexander Guice
Employer:	US Food Service, Inc.
Carrier:	MAC Risk Management, Inc.
Claim No.:	104/0000015899/01
WCC File No.:	0506205
Our File No.:	3796.00213

Dear Mr. Line:

We previously filed a Form 19 in the above-referenced matter. Please find enclosed the original and one copy of a Revised Form 19 setting forth the attorney's fees paid by the Employer. Please file this Revised Form 19 with the Commission and return to us a filed copy in the enclosed stamped self-addressed envelope.

With kind personal regards, we are

Very truly yours,

TURNER, PADGET, GRAHAM & LANEY, P.A.

Walter H. Barefoot

Walter H. Barefoot
WHB/tph
Enclosure
cc: Mr. Larry Grant

South Carolina Workers' Compensation Commission
P.O. Box 1715 ? 1612 Marion Street
Columbia, South Carolina 29202-1715
(803)737-5700

WCC File # 0506205
Carrier File # 104/0000015898/01
Carrier Code # 00461
Employer FEIN

Alexander Guice — Claimant's Name — SSN

2998 Gaston Dr — Address — Lexington — City — SC — State — 29569 — Zip

843-756-6479 — Home Phone # — 803-951-4200 — Work Phone #

Us Foodservice — Employer's Name

120 LONGS POND ROAD P.O. BOX 8
120 LONGS POND ROAD P.O. BOX 889 — Address — Lexington — City — SC — State — 29072 — Zip

Misc

Insurance Carrier

Larry Grant — Preparer's Name — 781-298-4909 — Phone #

Compensation Paid:	Number of Weeks	From	TO	Amount
1. Number of weeks T.T.	12	5/6/05 11/7/05	8/19/05 12/17/05	7110.72
2. Number of weeks T.P.	18	8/20/05 10/03/05	9/18/05 11/6/05	4534.56
3. Number of weeks P.P.				
4. Disfigurement				
5. Agreement and Final Release	Settlement to clincher			20,000.00
	Total Compensation Paid			31,645.28
6. Total Medical Benefits* Paid				9387.57
7. Funeral Benefits				0

☐ Case Denied

Date of Injury: 05/05/2005 (month day year)

By signing this receipt, I acknowledge that I have received the compensation shown above.

By: _____ Claimant

By: Walter H. Barber Jr for Larry Grant — Employer's Representative

Date: December 01, 2005

Print or type the name of the person, other than the claimant, receiving benefits and sign below.

By: _____

Report of additional Fees and Recoupment

A. Carrier Reimbursement by Third Party

B. Attorney's Fee Paid by Employer $657.00

C. Attorney's Fee Paid by Claimant (Non contingent fees, only)

RECEIVED
JAN 12 2006
Division of Claims
Claims Administrator
SC Workers' Comp. Com.

File this form with the Claims Department according to R.67-414 and R.67-1204. A person, other than the claimant, receiving benefits should sign on the line provided. *Do not include as medical costs fees paid for expert testimony, fees for determining carrier's liability, costs of autopsy, birth and death certificates and impartial examination. Form 19 must be filed within sixteen days of final payment of compensation. Form

Revised

South Carolina Workers' Compensation Commission
P.O. Box 1715 ? 1612 Marion Street
Columbia, South Carolina 29202-1715
(803)737-5700

1106

WCC File # 0506205
Carrier File # 104/0000015898/01
Carrier Code # 00481
Employer FEIN

Alexander Guica
Claimant's Name SSN

2898 Gaston Dr | Lexington | SC | 29073
Address | City | State | Zip

843-756-6479
Home Phone #

803-951-4200
Work Phone #

Larry Grant
Preparer's Name

Us Foodservice
Employer's Name

120 LONGS POND ROAD P.O. BOX 8
120 LONGS POND ROAD P.O. BOX 869 | Lexington | SC | 29072
Address | City | State | Zip

Mac
Insurance Carrier

781-298-4909
Phone #

Compensation Paid:	Number of Weeks	From	TO	Amount
1. Number of weeks T.T.	12	5/8/05 11/7/05	6/18/05 12/17/05	7110.72
2. Number of weeks T.P.	18	6/20/05 10/03/05	9/18/05 11/6/05	4534.56
3. Number of weeks P.P.				
4. Disfigurement				
5. Agreement and Final Release Settlement to clincher				20,000.00
Total Compensation Paid				31,645.28
6. Total Medical Benefits* Paid				9387.57
7. Funeral Benefits				0

☐ Case Denied

Date of Injury: 05/05/2005
month day year

By signing this receipt, I acknowledge that I have received the compensation shown above.

By: _____ Claimant

By: Walter H. Graber by Larry Grant Larry Grant Jr. Employer's Representative

Date: December 01, 2005

Print or type the name of the person, other than the claimant, receiving benefits and sign below.

By: _____

Report of additional Fees and Recoupment

A. Carrier Reimbursement by Third Party _____

B. Attorney's Fee Paid by Employer $657.00

C. Attorney's Fee Paid by Claimant (Non contingent fees, only) _____

RECEIVED
JAN 12 2006
Division of Claims Administration
SC Workers' Comp. Comm.

File this form with the Claims Department according to R.67-414 and R67-1204. A person, other than the claimant, receiving benefits should sign on the line provided. *Do not include as medical costs fees paid for expert testimony, fees for determining carrier's liability, costs of autopsy, birth and death certificates and impartial examination. Form 19 must be filed within sixteen days of final payment of compensation. Form

REVISED

19 must be filed when a claim is denied.

WCC FORM # 19 REV. DATE 3/96

19

STATUS REPORT AND COMPENSATION RECEIPT

ATT. A3

TURNER PADGET
TURNER PADGET GRAHAM & LANEY P.A.

CHARLESTON
COLUMBIA
FLORENCE
GREENVILLE

Walter H. Barefoot
Email: WBarefoot@TurnerPadget.com
Writer's Direct Dial: 843-656-4414

January 11, 2006

Mr. Greg Line
S. C. WORKERS' COMPENSATION COMMISSION
Post Office Box 1715
Columbia, SC 29202

RE:	Claimant:	Alexander Guice
	Employer:	US Food Service, Inc.
	Carrier:	MAC Risk Management, Inc.
	Claim No.:	104/0000015899/01
	WCC File No.:	0506205
	Our File No.:	3796.00213

Dear Mr. Line:

Please find enclosed the original and two copies of a **Form 19** in the above-referenced matter. Please file this Form 19 with the Commission and return to us a filed copy in the enclosed stamped self-addressed envelope.

With kind personal regards, we are

Very truly yours,

TURNER, PADGET, GRAHAM & LANEY, P.A.

Walter H. Barefoot

Walter H. Barefoot
WHB/kxm

Enclosures
cc: Mr. Larry Grant
Robert G. Bacon, Esquire

South Carolina Workers' Compensation Commission
P.O. Box 1715 ? 1612 Marion Street
Columbia, South Carolina 29202-1715
(803)737-5700

WCC File # 0506205
Carrier File # 104/0000015899/01
Carrier Code # 00461
Employer FEIN

Alexander Guice			SSN	Us Foodservice			
Claimant's Name				Employer's Name			
2998 Gaston Dr	Loris	SC	29569	120 LONGS POND ROAD P.O. BOX 8			
				120 LONGS POND ROAD P.O. BOX 869	Lexington	SC	29072
Address	City	State	Zip	Address	City	State	Zip
843-756-6479	803-951-4200			Mac			
Home Phone #	Work Phone #			Insurance Carrier			
	Larry Grant				781-298-4809		
	Preparer's Name				Phone #		

Compensation Paid:	Number of Weeks	From	TO	Amount
1. Number of weeks T.T.	12	5/6/05	8/19/05	7110.72
		11/7/05	12/17/05	
2. Number of weeks T.P.	18	8/20/05	9/18/05	4534.56
		10/03/05	11/6/05	
3. Number of weeks P.P.				
4. Disfigurement				
5. Agreement and Final Release	Settlement to clincher			20,000.00
Total Compensation Paid				31,645.28
6. Total Medical Benefits* Paid				9387.57
7. Funeral Benefits				0

☐ Case Denied

Date of Injury: 05/05/2005
month day year

By signing this receipt, I acknowledge that I have received the compensation shown above.

By: _____ By: Larry Grant Walter H. Bamford for Larry Grant Date: December 01, 2005
Claimant Employer's Representative

Print or type the name of the person, other than the claimant, receiving benefits and sign below.

By: _____

Report of additional Fees and Recoupment

A. Carrier Reimbursement by Third Party _____

B. Attorney's Fee Paid by Employer _____

C. Attorney's Fee Paid by Claimant _____
(Non contingent fees, only)

File this form with the Claims Department according to R.67-414 and R.67-1204. A person, other than the claimant, receiving benefits should sign on the line provided. *Do not include as medical costs fees paid for expert testimony, fees for determining carrier's liability, costs of autopsy, birth and death certificates and impartial examination. Form 19 must be filed within sixteen days of final payment of compensation. Form

ATT. A4

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 0506205

ALEXANDER GUICE,

Employee,

Claimant,

vs.

US FOOD SERVICE, INC.

Employer,

AND

MAC RISK MANAGEMENT, INC.,

Carrier,

Defendants.

SETTLEMENT AGREEMENT AND RELEASE

APPROVED

JAN 5 2006

S. C. Workers' Comp. Comm.

WHEREAS, the undersigned, Alexander Guice, hereinafter referred to as Claimant, alleges to have sustained an injury to his low back, right knee and neck, by accident arising out of and in the course of his employment with US Food Service, Inc., hereinafter referred to as Employer, on or about May 5, 2005 when he allegedly was involved in a motor vehicle accident; and

WHEREAS, MAC Risk Management, Inc., hereinafter referred to as Carrier, is the Insurance Carrier for the Employer; and

WHEREAS, the average weekly wage is $1,154.00; and the compensation rate is $592.56; and

WHEREAS, all parties are operating under and are subject to the provisions of the South Carolina Workers' Compensation Act; and

WHEREAS, the Claimant contends that that he has sustained a permanent impairment in excess of the rating(s) of the physician(s); and the Employer and Carrier deny the same; and

WHEREAS, the Claimant has been treated and/or evaluated by Dr. Alan Tamadon, who found the Claimant at maximum medical improvement on October 27, 2005 and who rated the Claimant's permanent impairment at five (5%) percent to the whole person. The Claimant has also been treated and/or evaluated by Dr. Wayne B. Bauerle, Doctor's Care of Conway, Genex and Long Bay Diagnostic Imaging; and

WHEREAS, there is a bona fide dispute between the Claimant and the Employer and Carrier as set forth above; and

WHEREAS, on account of the doubts that exist as to what benefits, if any, the Claimant would be adjudged to be entitled to recover under the Workers' Compensation Act, the Claimant and the Employer and Carrier, with the approval of the South Carolina Workers' Compensation Commission, have deemed it advisable, proper and in the best interests of all parties to compromise and settle all possible liabilities and controversies between them, now and in the future, the basis of such settlement being as follows:

WHEREAS, in consideration of the sum of Twenty Thousand and 00/100 Dollars ($20,000.00), the undersigned, Alexander Guice, does hereby release and forever discharge US Food Service, Inc. and MAC Risk Management, Inc. from any and all claims, demands, actions or causes of action under the South Carolina Worker's Compensation Act, on account of any and all injuries, disability, disfigurement, specific loss, death, operations, medical, hospital or like expense, continuances, recurrences, aggravations, changes of condition, ailments, illnesses, and diseases or other damages, consequences or results, past, present or future in any way connected with, or arising from the alleged injury sustained by the Claimant on or about May 5, 2005, and does hereby acknowledge that US Food Service, Inc. and MAC Risk Management, Inc. have fully, finally and completely paid and discharged each and every of their obligations, liabilities and responsibilities under the South Carolina Workers' Compensation Act and that the sum set forth above is being paid to, and received by, the undersigned, Alexander Guice, in full and final satisfaction of all claims whatsoever as a result of the alleged accident described above and that US Food Service, Inc. and/or

MAC Risk Management, Inc. shall not henceforth be liable for the payment of any amount whatsoever; and

WHEREAS, without in any way affecting the overall terms of this settlement insofar as the Defendants are concerned, and with the Claimant and the Claimant's attorney acknowledging that the Defendants make no representations as to the effect such allocation may have on the Claimant's receipt of other benefits, the Claimant and his attorney hereby request this Commission to approve the allocation of the proposed settlement sum of $20,000.00; and

Prior to the trial of this case being held before the South Carolina Workers' Compensation Commission, the parties commenced settlement negotiations and, in view of the real dispute which exists between the parties, the parties agreed upon a full, final and complete settlement and termination of all claims by the Claimant against the Defendants, for any and all claimed injuries or accidents heretofore sustained in connection with the Claimant's employment by the named employer, subject to the approval of the South Carolina Worker's Compensation Commission, the terms of the settlement agreement between the parties being that the Defendants will pay to the Claimant in lump sum, with the Defendants expressly waiving all rights to commutation thereof, the sum of $20,000.00 in full and final satisfaction for any and all compensation benefits or other payments under the Worker's Compensation Act to be allocated as follows:

$13,333.34 in compromise settlement of disputed future disability benefits at the rate of $6.489 per week commencing on December 15, 2005, for a period of 39.51 years representing the Claimant's life expectancy pursuant to Section 19-1-150 of the South Carolina Code of Law (1976), and pursuant to Section 42-9-10 and 42-9-20 of the 1976 Code of Laws as interpreted by the South Carolina Supreme Court decision of Utica Mohak Mills v. Orr, 277 S.C. 226, 87 SE 2d 593; Sciarotta v. Bowen, 837 F 2d 135; Lemire v. Secretary of Health and Human Services, 682 F. Supp. 102 (D.C.N.H. 1988) and Hatch v. Heckler, 626 F. Supp. 1367 (N.D. California 1986); and $6,666.66 as attorney's fees pursuant to a written agreement between the Claimant and his attorney; and

WHEREAS, the Employer and Carrier have paid or have agreed to pay authorized medical expenses through December 1, 2005 incurred as a result of the alleged accident described above, in such amounts as may be approved by the South Carolina Workers' Compensation Commission; and

WHEREAS, this Settlement Agreement and Release is full, final and complete regardless of whether the Claimant is able to keep any employment whatsoever, or is able to earn any wages at any time in the future; and

WHEREAS, full and complete medical reports are on file with the South Carolina Workers' Compensation Commission and these are duly considered by it in approving this Settlement Agreement and Release.

WHEREAS, the Claimant represents that he has been fully advised of his rights under the South Carolina Workers' Compensation Act and that he is of the opinion that the proposed settlement is reasonable and fair, and requests that the South Carolina Workers' Compensation Commission approve this settlement as set forth in this Settlement Agreement and Release. The parties acknowledge that the Commission relies upon the representation of counsel for the claimant that the claimant has been fully apprised of his rights under the laws of the South Carolina Workers' Compensation Act and that he believes the settlement is reasonable and fair and thus requests that the South Carolina Workers Compensation Commission approve this settlement as set forth herein.

NOW THEREFORE, upon approval of this settlement by the South Carolina Workers' Compensation Commission, the Claimant hereby relinquishes and releases each and every claim related to this accident, which he now has, or may hereafter have, so that he shall not henceforth have any other or future claim or demand related to this accident, as a result of the alleged accident described above, nor shall anyone on his behalf or claiming by, through or under him or as dependent, have any claim or demand on account of this accident; as a result of the alleged accident described above; and

The undersigned further acknowledges that the consideration herein expressly recited is the sole and only consideration for the execution hereof, and that no promise, agreement or suggestions of any other or additional consideration has been made to, or received by, me.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at Myrtle Beach, this 22 day of December 2005.

Alexander Guice

IN THE PRESENCE OF:

ATTORNEY'S CERTIFICATE

I, Robert G. Bacon, Esquire, a practicing attorney of Myrtle Beach, South Carolina, do hereby certify that I represent Alexander Guice and as his attorney and with his approval, I negotiated and secured the foregoing Agreement for the payment of the amount recited therein, on the conditions and terms and for the reasons therein stated, and that as attorney for Alexander Guice it is my opinion that such disposition is for the best interest of Alexander Guice, under all circumstances and that the consideration as recited in Agreement is full and adequate under the circumstances, and that as his attorney, I approve the Agreement, and I further certify that, before Alexander Guice signed and executed the above Agreement, the same was read over and explained to him and understood by him, and was executed freely and voluntarily on his part, and that the consideration therein recited is the sole and only consideration for the execution thereof.

Dated at Myrtle Beach, South Carolina, this 22 day of December, 2005.

Robert G. Bacon, Esquire
Attorney for Claimant

ORDER AND AWARD

Upon examination and consideration of the foregoing Agreement and Release, the Attorney's Certificate of Robert G. Bacon, Esquire, and the Workers' Compensation Commission File No. 0506205, and it appearing that the settlement set forth in the Agreement and Release is proper and complies with the requirements of the South Carolina Workers' Compensation Act;

Further, upon representation of the claimant and his counsel that his rights have been fully explained to him and that he understands them, that the settlement is reasonable and fair, and that it is the claimant's desire that the settlement as set forth herein be approved;

IT IS ORDERED AND AWARDED that the Settlement Agreement and Release be, and the same hereby is, approved and made the Order and Award of the South Carolina Workers' Compensation Commission, and that upon the payment of the amount recited, the Employer, US Food Service, Inc., and the Carrier, MAC Risk Management, Inc., be, and are forever discharged from each and every liability or responsibility under the South Carolina Workers' Compensation Act on account of the Claimant's injuries on or about May 5, 2005, whether for compensation, disfigurement or for medical or related services or for any account whatsoever and each and every consequence or result thereof, past, present or future, whether for continuation, aggravation, recurrence or otherwise as a result of this accident.

The sum set forth in the Settlement Agreement and Release shall be paid to the Claimant in a lump sum without commutation; whereupon, the Employer and Carrier are authorized to close their files in this matter and the Commission's files shall be, and they are hereby finally closed.

All orders, awards, and opinion heretofore issued by the South Carolina Workers' Compensation Commission in this case are hereby set aside, abrogated, and nullified.

Dated at Columbia, South Carolina on _____.

SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION

BY: _____
1/5/06

I CONSENT:

Walter H. Barefoot

Walter H. Barefoot
Attorney for Employer and Carrier

ATT. A5

SC Workers' Compensation Commission
1612 Marion Street
Post Office Box 1715
Columbia, South Carolina 29202-1715

WCC File #: 05062205
Carrier File #:
Carrier Code #:
Employer FEIN #:

Claimant's Name: Alexander Guice SSN:
Address: 2916 Gaston Drive
City: Loris State: SC Zip: 29569
Home Phone: ( ) Work Phone: ( )
Preparer's Name: Robert G Bacon Law Firm: Harry Lawlock + Associates

Employer's Name: U.S. Food Service
Address: 11687 Hwy 501-East
City: Conway State: SC Zip: 29526
Insurance Carrier: MAC Risk Management
Preparer's Phone #: (843) 448-9471

Date Attorney Was Hired: May 17, 2005
Compensation Rate: 592.56

Date of Injury: 5-5-05
Does this conclude the case? ☑ Yes ☐ No

PLEASE CHECK AND COMPLETE ONLY ONE: (A, B or C)

☑ **A.** R.67-1205C does not apply to the facts of this case. A 33.3 % fee of the award or settlement (excluding medical costs) and the costs of this action, as shown by the attached Settlement of Costs, are requested for approval.

☐ **B.** The subsection of R. 67-1205C applicable to this claim is (C)(____). A fee of $_____ is requested for approval based on the following:

Date of first impairment rating or offer of settlement:
Impairment Rating given and/or **Settlement amount** offered prior to date attorney hired:
Impairment Rating given and/or **Settlement amount** offered after date attorney hired:
Authorized Health Care Provider's Name:

☐ **C.** Admitted Death Claim - $2,500.

I agree to pay my attorney the fee and costs stated. I understand the fee and costs are paid out of my compensation and I understand how much money I will receive after I pay my attorney.

Alexander Guice
Client

12/22/05
Date

I certify that this form and the attached Statement of Costs are accurate.

Robert Bacon
Attorney for Claimant

12-22-05
Date

Summary

Total Amount of Compensation		$ 20,000.00
Attorney's Fee	$ 6,666.00	
Costs	$	
Total Fees and Costs		-$ 6,666.66
Client Will Receive		$ 13,333.34

RESERVED FOR COMMISSION'S USE:

☑ Approved ☐ Rejected ☐ Set for Hearing

Commissioner

1/5/06
Date

A Statement of Costs must be attached before costs may be approved. File this form in duplicate with the Claims Department. Enclose a self-addressed, stamped envelope. For further information, refer to R.67-1203, R.67-1204, R.67-1205, and R.67-1206.

WCC Form # 61
Revised 01/05

61

ATTORNEY FEE PETITION

C-1-9
MB

ATT. A6

TURNER PADGET
TURNER PADGET GRAHAM & LANEY P.A.

CHARLESTON
COLUMBIA
FLORENCE
GREENVILLE

7209

Kara Motegi
Email: KMotegi@TurnerPadget.com
Writer's Direct Dial: 843-656-4461

December 30, 2005

S. C. WORKERS' COMPENSATION COMMISSION
Attn: Ms. Mary Bost
Post Office Box 1715
Columbia, SC 29202

RE:

Claimant:	Alexander Guice
Employer:	US Food Service, Inc.
Carrier:	MAC Risk Management, Inc.
Claim No.:	104/0000015899/01
WCC File No.:	0506205
Our File No.:	3796.00213

Dear Ms. Bost:

Per your request, enclosed please find the signed Clincher Agreement and Form 19s for filing in the above matter. Please submit the Clincher to the appropriate Commissioner for their review and approval. After it is approved, please return a copy to the Claimant's attorney listed below and us.

With kind personal regards, we are

Very truly yours,

TURNER, PADGET, GRAHAM & LANEY, P.A.

Kara Motegi

Kara Motegi
Paralegal to Walter H. Barefoot

Enclosure
(1) Settlement Agreement
(2) Form 19
(3) Self-addressed, stamped envelopes

cc: Robert G. Bacon, Esquire
Mr. Larry Grant

RECEIVED
JAN 04 2006
Division of Claims
Claims Administrator
S.C. Workers' Comp. Comm.

ATT. A7

TURNER PADGET
TURNER PADGET GRAHAM & LANEY P.A.

CHARLESTON
COLUMBIA
FLORENCE
GREENVILLE

Walter H. Barefoot
Email: WBarefoot@TurnerPadget.com
Writer's Direct Dial: 843-656-4414

December 28, 2005

Date 12-29-05
Check # 2592
Serial # 198981
MB

Mr. Greg Line, Claims Director
S. C. WORKERS' COMPENSATION COMMISSION
Post Office Box 1715
Columbia, SC 29202

RE: Claimant: Alexander Guice
Employer: US Food Service, Inc.
Carrier: MAC Risk Management, Inc.
Claim No.: 104/0000015899/01
WCC File No.: 0506205
Our File No.: 3796.00213

Dear Mr. Line:

We have enclosed the original and two copies of a Clincher Agreement, a Form 19, and a Form 61 for filing in the above matter. Please submit the Clincher to the appropriate Commissioner for their review and approval. After it is approved, please return a copy to the Claimant's attorney listed below and us. Our check for the $25.00 filing fee is enclosed.

With kind personal regards, we are

Very truly yours,

TURNER, PADGET, GRAHAM & LANEY, P.A.

Walter H. Barefoot

5440

WHB/kxm
Enclosures (1) Settlement Agreement
(2) Form 19
(3) Self-addressed, stamped envelopes
(4) $25.00 check

cc: Robert G. Bacon, Esquire
Mr. Larry Grant

RECEIVED
DEC 29 2005
Division of Claims
Claims Administrator
S. Workers' Comp. Comm.

Turner, Padget, Graham & Laney, P.A.

Check Request Form

Click here for Instructions on using this form

Requested by: kxm For Walt Barefoot *(No Initials)*

Case name: Guice v. US Food Service, Inc.

File no(s): 03796.00213 *(up to three different ones)*

Date ordered: 12/27/2005 *(format: mm/dd/yyyy)*

Date needed: 12/28/2005 *(format: mm/dd/yyyy)*

Make payable to: SCWCC

Address: P.O. Box 1715
Columbia, SC 29202

For: Filing Fee -- 410

Amount: $25.00

Special Instructions:

☐ Trust Funds (check if applicable)

Marketing Budget:

- ○ Attorney Business Development
- ○ Attorney Professional Development
- ○ Recruitment Committee Budget
- ○ Retreat Committee Budget
- ○ Practice Group Budget
- ○ Other

IMPORTANT: Please attach receipts or invoices if applicable and submit to the Accounting Department

Print Page Clear Form

Accounting Department Use Only:

Check No. 2892 Date Written DEC 2 8 2005

Approval clg G/L Account#

ATT. A8

Harry Pavilack & Associates, P.A.
Attorneys at Law
PO Box 2740
Myrtle Beach, SC 29578-2740
Office: 843-448-9471 · Fax: 843-626-0003

Harry Pavilack, SC FL

Robert S. Halght, Jr., PA, SC, NC
James M. Robbins, SC
Debra S. Harpe, NC, SC
Jennifer L. Lineback, GA

Cynthia M. Lover, S
Jeffrey A. Keenan, S
Robert G. Bacon, S
John Ahn, S

December 22, 2005

Walter H. Barefoot
Turner, Padget, Graham & Laney, P.A.
BB&T Building, 4th Floor
1831 West Evans Street
Florence, South Carolina 29501

RE:

Claimant:	Alexander Guice
Employer:	US Food Service, Inc.
Carrier:	MAC Risk Management, Inc.
WCC File No.:	0506205
Your File #:	3796.00213

Dear Mr. Barefoot:

Enclosed please find the executed Form 19's and Settlement Agreement and Release's. Also, please find enclosed a Form 61. Please file this form with Worker's Compensation Commission along with the documents noted above.

Thank you for your assistance in this matter. Should you have any questions or concerns in this matter, please call my office.

Sincerely,
PAVILACK & ASSOCIATES, P.A.

RGB/lac

Robert G. Bacon, Esq.

Enclosures
RGB/lac

ATT. A9

SC Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715

File #: 0506205
Carrier File #: 104/0000015899/01
Carrier Code #: 00461
Employer FEIN #:

Claimant's Name: Alexander Guice SSN:
Address: 2996 Gaston Dr
City: Loris State: SC Zip: 29569
Home Phone: 843-756-6479 Work Phone: 803-951-4200
Preparer's Name: Larry Grant

Employer's Name: Us Foodservice
Address: 120 LONGS POND ROAD P.O. BOX 8
City: Lexington State: Zip:
Carrier: Mac
Preparer's Phone #: 781-298-4909

Date of injury: 05/05/2005 Date of Notice to Employer of Injury: 05/05/2005

I. Payment of Temporary Compensation

Check one: ☐ Initial period ☐ Additional period ☐ Corrected compensation rate

(choose A, B, or C)

☐ A. Temporary Total at the compensation rate of $ _____ per week. For this period of disability, disability began on _____ and the date of first payment was _____.

☐ B. Temporary Partial at the compensation rate of $ _____ per week. Note: When the Temporary Partial compensation rate will vary, report the first payment here. Supplement this report throughout the period of Temporary Partial compensation by filing a **Form 15S** with the **Form 18,** which shall be filed six months after the date of injury and each six months thereafter until the file is closed.
For this period of disability, disability began on _____ and the date of first payment was _____

Calculation of Temporary Partial rate:

Average weekly wage before injury		$
Current weekly wage	-	$
Difference in wages before injury and now		
x .6667	x	.6667
Temporary Partial Compensation Rate		$

☐ C. Salary in lieu of Temporary ☐ Total / ☐ Partial compensation in the amount of $ _____ per week.
(Choose one)
For this period of disability, disability began on _____ and the date of first payment of salary in lieu of temporary compensation was _____.

THIS SECTION MAY BE USED ONLY WITHIN 150 DAYS AFTER NOTICE TO EMPLOYER OF INJURY.
ATTACH DOCUMENTATION AS TO THE REASON OF THE TERMINATION.

II. Termination of Temporary Compensation

Temporary compensation payments were stopped on 9/18/05 for the following reason:

☐ Claimant has returned to work at least 15 days and no temporary partial compensation is due.
☐ Claimant agrees he/she is able to return to work and has signed a **Form 17**.
☐ Based on a good faith investigation, the claim is denied. Reason for denial: _____
XX Claimant has been released to return to work without restrictions and employment has been offered.
☐ Claimant has been released to return to work at limited duty and employer has provided limited duty work consistent with the terms upon which the Employee has been released.
☐ Claimant has refused medical treatment, examination, or evaluation. Note: Benefits must be resumed if claimant accepts the treatment, examination, or evaluation. Additional report must be filed if compensation is resumed.

I certify that this form has been served on the claimant per R.67-211.

LARRY GRANT 12/1/05
Signature of Claims Administrator Date

PROCESSED
DEC 06 2005
SC WORKERS' COMP COMM

III. Notice to Injured Worker or Legal Representative when Temporary Compensation Has Been Stopped:

The employer's representative may stop temporary compensation within 150 days of the date of notice of injury for the above reasons. However, if you believe that the temporary compensation should not have been stopped, you may request a hearing by signing below and returning this form to SCWCC Judicial Department at the address at the top of this form. A hearing will be held within 60 days of receipt of your request to determine if temporary compensation has been properly terminated.

MY SIGNATURE BELOW INDICATES THAT I DO NOT AGREE WITH THE TERMINATION OF TEMPORARY COMPENSATION.
I REQUEST A HEARING TO DETERMINE WHETHER I AM ENTITLED TO FURTHER TEMPORARY COMPENSATION PAYMENTS.

Check one: **Form 15(II)** ☐ Has ☐ Has not been received.

Signature of Claimant or legal representative Date

Employer's representative must complete and file **Form 15** with Claims Department within ten days after compensation begins or is terminated. Employer's representative must serve the **Form 15** on the claimant when compensation begins per R.67-211. Employer's representative must prepare and serve **Form 20** within thirty days of beginning compensation per R.67-1603. Employer's representative must serve per R.67-211 two copies of the **Form 15** on claimant immediately on termination of compensation with documentation attached as to the reason for the termination. Injured worker may contest termination of compensation by completing section III of the **Form 15** and filing it with Judicial Department.

ATT. A10

SC Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715

File #: 0506205
Carrier File #: 104/0000015899/01
Carrier Code #: 00461
Employer FEIN #:

Claimant's Name: Alexander Guice SSN:
Address: 2996 Gaston Dr
City: Loris State: SC Zip: 29569
Home Phone: 843-756-6479 Work Phone: 803-951-4200
Preparer's Name: Larry Grant

Employer's Name: Us Foodservice
Address: 120 LONGS POND ROAD P.O. BOX 8
City: Lexington State: Zip:
Carrier: Mac
Preparer's Phone #: 781-298-4909

Date of injury: 05/05/2005 Date of Notice to Employer of Injury: 05/05/2005

I. Payment of Temporary Compensation
(choose A, B, or C) Check one: ☐ Initial period x☐ Additional period ☐ Corrected compensation rate

x☐ A. Temporary Total at the compensation rate of $ 592.56 per week. For this period of disability, disability began on 11/7/05 and the date of first payment was 11/15/05.

☐ B. Temporary Partial at the compensation rate of $ _____ per week. Note: When the Temporary Partial compensation rate will vary, report the first payment here. Supplement this report throughout the period of Temporary Partial compensation by filing a **Form 15S** with the **Form 18**, which shall be filed six months after the date of injury and each six months thereafter until the file is closed.
For this period of disability, disability began on 11/7/05, and the date of first payment was _____.

Calculation of Temporary Partial rate:

Average weekly wage before injury		$ 1161.00
- Current weekly wage		- $
Difference in wages before injury and now		
x .6667		x .6667
Temporary Partial Compensation Rate		$

☐ C. Salary in lieu of Temporary ☐ Total / ☐ Partial compensation in the amount of $ _____ per week.
(Choose one)
For this period of disability, disability began on _____ and the date of first payment of salary in lieu of temporary compensation was _____.

THIS SECTION MAY BE USED ONLY WITHIN 150 DAYS AFTER NOTICE TO EMPLOYER OF INJURY.
ATTACH DOCUMENTATION AS TO THE REASON OF THE TERMINATION.

II. Termination of Temporary Compensation
Temporary compensation payments were stopped on _____ for the following reason:

☐ Claimant has returned to work at least 15 days and no temporary partial compensation is due.
☐ Claimant agrees he/she is able to return to work and has signed a **Form 17**.
☐ Based on a good faith investigation, the claim is denied. Reason for denial: _____
☐ Claimant has been released to return to work without restrictions and employment has been offered.
☐ Claimant has been released to return to work at limited duty and employer has provided limited duty work consistent with the terms upon which the Employee has been released.
☐ Claimant has refused medical treatment, examination, or evaluation. Note: Benefits must be resumed if claimant accepts the treatment, examination, or evaluation. Additional report must be filed if compensation is resumed.

I certify that this form has been served on the claimant per R.67-211.

PROCESSED
JUN 06 2005
SC WORKERS COMP. COMM.

Signature of Claims Administrator Date

III. Notice to Injured Worker or Legal Representative when Temporary Compensation Has Been Stopped:
The employer's representative may stop temporary compensation within 150 days of the date of notice of injury for the above reasons. However, if you believe that the temporary compensation should not have been stopped, you may request a hearing by signing below and sending this form to SCWCC Judicial Department at the address at the top of this form. A hearing will be held within 60 days of receipt of your request to determine if temporary compensation has been properly terminated.

MY SIGNATURE BELOW INDICATES THAT I DO NOT AGREE WITH THE TERMINATION OF TEMPORARY COMPENSATION. I REQUEST A HEARING TO DETERMINE WHETHER I AM ENTITLED TO FURTHER TEMPORARY COMPENSATION PAYMENTS.

Check one: **Form 15(II)** ☐ Has ☐ Has not been received.

Signature of Claimant or legal representative Date

Employer's representative must complete and file **Form 15** with Claims Department within 40 days after compensation begins or is terminated. Employer's representative must serve the **Form 15** on the claimant when compensation begins per R.67-211. Employer's representative must prepare and serve **Form 20** within thirty days of beginning compensation per R.67-1603. Employer's representative must serve per R.67-211 two copies of the **Form 15** on claimant immediately on termination of compensation with documentation attached as to the reason for the termination. Injured worker may contest termination of compensation by completing section III of the **Form 15** and filing it with Judicial Department.

ATT. A11

SC Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715

File #: 0506205
Carrier File #: 104/0000015899/01
Carrier Code #: 00461
Employer FEIN #:

Claimant's Name: Alexander Guice SSN:
Address: 2996 Gaston Dr
City: Loris State: SC Zip: 29569
Home Phone: 843-756-6479 Work Phone: 803-951-4200
Preparer's Name: Larry Grant

Employer's Name: Us Foodservice
Address: 120 LONGS POND ROAD P.O. BOX 8
City: Lexington State: Zip:
Carrier: Mac
Preparer's Phone #: 781-298-4909

Date of injury: 05/05/2005 Date of Notice to Employer of Injury: 05/05/2005

I. Payment of Temporary Compensation

(choose A, B, or C) Check one: ☐ Initial period X☐ Additional period ☐ Corrected compensation rate

☐ A. Temporary Total at the compensation rate of $ _____ per week. For this period of disability, disability began on _____ and the date of first payment was _____.

X☐ B. Temporary Partial at the compensation rate of $ 255.48 per week. Note: When the Temporary Partial compensation rate will vary, report the first payment here. Supplement this report throughout the period of Temporary Partial compensation by filing a **Form 15S** with the **Form 18,** which shall be filed six months after the date of injury and each six months thereafter until the file is closed.
For this period of disability, disability began on 10/3/05, and the date of first payment was 10/17/05.

Calculation of Temporary Partial rate:

Average weekly wage before injury	$	1154.00
- Current weekly wage	- $	770.79
Difference in wages before injury and now		383.21
x .6667	x	.6667
Temporary Partial Compensation Rate	$	255.48

☐ C. Salary in lieu of Temporary ☐ Total / ☐ Partial compensation in the amount of $ _____ per week. (Choose one)
For this period of disability, disability began on _____ and the date of first payment of salary in lieu of temporary compensation was _____.

THIS SECTION MAY BE USED ONLY WITHIN 150 DAYS AFTER NOTICE TO EMPLOYER OF INJURY. ATTACH DOCUMENTATION AS TO THE REASON OF THE TERMINATION.

II. Termination of Temporary Compensation

Temporary compensation payments were stopped on _____ for the following reason:

☐ Claimant has returned to work at least 15 days and no temporary partial compensation is due.
☐ Claimant agrees he/she is able to return to work and has signed a **Form 17**.
☐ Based on a good faith investigation, the claim is denied. Reason for denial: _____
☐ Claimant has been released to return to work without restrictions and employment has been offered.
☐ Claimant has been released to return to work at limited duty and employer has provided limited duty work consistent with the terms upon which the Employee has been released.
☐ Claimant has refused medical treatment, examination, or evaluation. Note: Benefits must be resumed if claimant agrees to the treatment, examination, or evaluation. Additional report must be filed if compensation is resumed.

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S.C. WORKERS' COMP. COMM.

I certify that this form has been served on the claimant per R.67-211.

Signature of Claims Administrator Date

III. Notice to Injured Worker or Legal Representative when Temporary Compensation Has Been Stopped:

The employer's representative may stop temporary compensation within 150 days of the date of notice of injury for the above reasons. However, if you believe that the temporary compensation should not have been stopped, you may request a hearing by signing below and returning this form to SCWCC Judicial Department at the address at the top of this form. A hearing will be held within 60 days of receipt of your request to determine if temporary compensation has been properly terminated.

MY SIGNATURE BELOW INDICATES THAT I DO NOT AGREE WITH THE TERMINATION OF TEMPORARY COMPENSATION. I REQUEST A HEARING TO DETERMINE WHETHER I AM ENTITLED TO FURTHER TEMPORARY COMPENSATION PAYMENTS.

Check one: **Form 15(II)** ☐ Has ☐ Has not been received

Signature of Claimant or legal representative Date

Employer's representative must complete and file **Form 15** with Claims Department within ten days after compensation begins or is terminated. Employer's representative must serve the **Form 15** on the claimant when compensation begins per R.67-211. Employer's representative must prepare and serve **Form 20** within thirty days of beginning compensation per R.67-1603. Employer's representative must serve per R.67-211 two copies of the **Form 15** on claimant immediately on termination of compensation with documentation attached as to the reason for the termination. Injured worker may contest termination of compensation by completing section III of the **Form 15** and filing it with Judicial Department.

ATT. A12

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803)737-5700

WCC File # 606205
Carrier File # 04/0000015899/01
Carrier Code # 00461
Employer FEIN

Alexander Gulce				Us Foodservice			
Claimant's Name	SSN			Employer's Name			
2996 Gaston Dr	Loris	SC	29569	120 LONGS POND ROAD P.O. BOX 8 120 LONGS POND ROAD P.O. BOX 869	Lexington	SC	29072
Address	City	State	Zip	Address	City	State	Zip
843-756-6479	803-951-4200			MAC RISK MGT PO BOX 200001 WOODSTOCK, GA 30189			
Home Phone #	Work Phone #			Insurance Carrier			

Larry Grant — Preparer's Name
781-298-4909 — Phone #

Supplemental Report of Varying Temporary Partial Payments

Date of Injury: 05/05/2005 (month day year)

From 6/27/05 through 7/3/05, claimant was paid $ 242.49 per week as temporary partial compensation. The weekly wage before the injury was $ 1154.00 The weekly wage for this period was $ 790.28

From 7/4/05 through 7/10/05, claimant was paid $ 103.33 per week as temporary partial compensation. The weekly wage before the injury was $ 1154.00 The weekly wage for this period was $ 999.00

From 7/11/05 through 7/17/05, claimant was paid $ 457.08 per week as temporary partial compensation. The weekly wage before the injury was $ 1154.00 The weekly wage for this period was $ 468.40

From 7/18/05 through 7/24/05, claimant was paid $ 257.34 per week as temporary partial compensation. The weekly wage before the injury was $ 1154.00 The weekly wage for this period was $ 768.00

From 7/25/05 through 7/31/05, claimant was paid $ 257.34 per week as temporary partial compensation. The weekly wage before the injury was $ 1154.00 The weekly wage for this period was $ 768.00

From 8/1/05 through 8/7/05, claimant was paid $ 257.34 per week as temporary partial compensation. The weekly wage before the injury was $ 1154.00 The weekly wage for this period was $ 768.00

From 8/8/05 through 8/14/05, claimant was paid $ [illegible] per week as temporary partial compensation. The weekly wage before the injury was $ 1154.00 The weekly wage for this period was $ 768.00

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SC WORKERS' COMP COMM

From 8/15/05 through 8/21/05, claimant was paid $ [illegible] per week as temporary partial compensation. The weekly wage before the injury was $ 1154.00 The weekly wage for this period was $ 766.69

From 8/22 through 8/28, claimant was paid $ 230.46 per week as temporary partial compensation. The weekly wage before the injury was $ 1154.00 The weekly wage for this period was $ 508.32

In an ongoing period of temporary partial, when the compensation rate varies from week to week, the employers representative shall report the first payment on a Form 15 according to R.67-503. Supplemental payments shall be reported on a Form 15S, to be filed with the document stopping that period of temporary partial compensation or with the Form 18, which shall be filed six months after the date of injury and each six months thereafter until the file is closed. See R.67-503.

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803)737-5700

WCC File # 606205
Carrier File # 04/0000015899/01
Carrier Code # 00461
Employer FEIN

Alexander Gulce
Claimant's Name
SSN

2996 Gaston Dr
Address
Lons City SC State 29569 Zip

843-756-6479
Home Phone #
803-951-4200
Work Phone #

Us Foodservice
Employer's Name
120 LONGS POND ROAD P.O. BOX 8
120 LONGS POND ROAD P.O. BOX 869
Address
Lexington City SC State 29072 Zip

MAC RISK MGT/ACE PO BOX 200001 WOODSTOCK, GA 30189
Insurance Carrier

Larry Grant
Preparer's Name
781-298-4909
Phone #

Supplemental Report of Varying Temporary Partial Payments

Date of Injury: 05/05/2005
month day year

From 8/29/05 through 9/4/05, claimant was paid $ 257.34 per week as temporary partial compensation. The weekly wage before the injury was $ 1154.00 The weekly wage for this period was $ 768.00

From 9/5/05 through 9/11/05, claimant was paid $ 152.52 per week as temporary partial compensation. The weekly wage before the injury was $ 1154.00 The weekly wage for this period was $ 925.23

From 9/12/05 through 9/18, claimant was paid $ 257.34 per week as temporary partial compensation. The weekly wage before the injury was $ 1154.00 The weekly wage for this period was $ 768.00

From _____ through _____, claimant was paid $ _____ per week as temporary partial compensation. The weekly wage before the injury was $ _____ The weekly wage for this period was $ _____

From _____ through _____, claimant was paid $ _____ per week as temporary partial compensation. The weekly wage before the injury was $ _____ The weekly wage for this period was $ _____

From _____ through _____, claimant was paid $ _____ per week as temporary partial compensation. The weekly wage before the injury was $ _____ The weekly wage for this period was $ _____

From _____ through _____, claimant was paid $ _____ per week as temporary partial compensation. The weekly wage before the injury was $ _____ The weekly wage for this period was $ _____

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S.C. WORKERS' COMP. COMM.

From _____ through _____, claimant was paid $ _____ per week as temporary partial compensation. The weekly wage before the injury was $ _____ The weekly wage for this period was $ _____

From _____ through _____, claimant was paid $ _____ per week as temporary partial compensation. The weekly wage before the injury was $ _____ The weekly wage for this period was $ _____

In an ongoing period of temporary partial, when the compensation rate varies from week to week, the employers representative shall report the first payment on a Form 15 according to R.67-503. Supplemental payments shall be reported on a Form 15S, to be filed with the document stopping that period of temporary partial compensation or with the Form 18, which shall be filed six months after the date of injury and each six months thereafter until the file is closed. See R.67-503.

South Carolina Workers' Compens[illegible]n Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803)737-5700

WCC File # 606205
Carrier File # 04/0000015899/01
Carrier Code # 00461
Employer FEIN

Claimant's Name: Alexander Gulca	SSN:
Address: 2996 Gaston Dr, City: Loris, State: SC, Zip: 29569	
Home Phone #: 843-756-6479	Work Phone #: 803-951-4200
Employer's Name: Us Foodservice	
Address: 120 LONGS POND ROAD P.O. BOX 8 / 120 LONGS POND ROAD P.O. BOX 869, City: Lexington, State: SC, Zip: 29072	
Insurance Carrier: Mac	
Preparer's Name: Larry Grant	Phone #: 781-298-4909

Supplemental Report of Varying Temporary Partial Payments

Date of Injury: 05/05/2005 (month day year)

From 10/10/05 through 10/16, claimant was paid $ 250.41 per week as temporary partial compensation. The weekly wage before the injury was $ 1154.00 The weekly wage for this period was $ 778.40

From 10/17 through 10/23, claimant was paid $ 250.41 per week as temporary partial compensation. The weekly wage before the injury was $ 1154.00 The weekly wage for this period was $ 778.40

From 10/24 through 10/30, claimant was paid $ 250.41 per week as temporary partial compensation. The weekly wage before the injury was $ 1154.00 The weekly wage for this period was $ 778.40

From 10/31 through 11/6, claimant was paid $ 282.38 per week as temporary partial compensation. The weekly wage before the injury was $ 1154.00 The weekly wage for this period was $ 730.44

From ______ through ______, claimant was paid $ ______ per week as temporary partial compensation. The weekly wage before the injury was $ ______ The weekly wage for this period was $ ______

From ______ through ______, claimant was paid $ ______ per week as temporary partial compensation. The weekly wage before the injury was $ ______ The weekly wage for this period was $ ______

From ______ through ______, claimant was paid $ ______ per week as temporary partial compensation. The weekly wage before the injury was $ ______ The weekly wage for this period was $ ______

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S.C. WORKERS' COMP. COMM.

From ______ through ______, claimant was paid $ ______ per week as temporary partial compensation. The weekly wage before the injury was $ ______ The weekly wage for this period was $ ______

From ______ through ______, claimant was paid $ ______ per week as temporary partial compensation. The weekly wage before the injury was $ ______ The weekly wage for this period was $ ______

In an ongoing period of temporary partial, when the compensation rate varies from week to week, the employers representative shall report the first payment on a Form 15 according to R.67-503. Supplemental payments shall be reported on a Form 15S, to be filed with the document stopping that period of temporary partial compensation or with the Form 18, which shall be filed six months after the date of injury and each six months thereafter until the file is closed. See R.67-503.

ATT. A13

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803)737-5700

WCC #: 0506205
Carrier File #: 104/0000015899/01
Carrier Code #: 00461
Employer FEIN:

Alexander Guice			SSN	Us Foodservice			
Claimant's Name				Employer's Name			
2996 Gaston Dr	Loris	SC	29569	120 LONGS POND ROAD P.O. BOX 8 120 LONGS POND ROAD P.O. BOX 869	Lexington	SC	29072
Address	City	State	Zip	Address	City	State	Zip
843-756-6479	803-951-4200			Mac			
Home Phone #	Work Phone #			Insurance Carrier			

Larry Grant — Preparer's Name
781-298-4909 — Phone #

1. Date of injury: 05/05/2005 (month day year)

2. Total Weeks of Compensation Paid: 10460.16

3. Type of Compensation Paid (TP or TT)/Periods of Payment:

Type:	TTD	From:	5/6/05	To:	6/19/05
Type:	TPD	From:	6/20/05	To:	11/6/05
Type:	TTD	From:	11/7/05	To:	12/4/05

4. Date of First Payment: 5/13/05 (month day year)

5. Total Amount Paid (a) Compensation: 10460.16

(b) Medical (Include Nursing, Hospital Drugs, Etc.): 9387.57

6. Informal Conference is Requested: ☐ yes ☒ no (check one)

7. Use these lines to send a memo to the Commission:

Larry Grant
Employer's Representative

781-298-4909
Phone #

December 01, 2005
Date

Type or print all information. File this form 6 months after the alleged injury date and each 6 months until the Commission's File is closed. Form 18 must be filed whether or not compensation is ongoing. Check "yes" after number 6 to request an informal conference. Refer to R.67-413, R.67-507, and R.67-804 for further information.

ATT. A14

SC Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715

WCC File #: 0506205
Carrier File #: 104/0000015899/01
Carrier Code #: 00461
Employer FEIN #:

Claimant's Name: Alexander Guice SSN: Employer's Name: Us Foodservice

Address: 2996 Gaston Dr Address: 120 LONGS POND ROAD P.O. BOX 8

City: Loris State: SC Zip: 29569 City: Lexington State: Zip:

Home Phone: 843-756-6479 Work Phone: 803-951-4200 Carrier: Mac

Preparer's Name: Larry Grant Preparer's Phone #: 781-298-4909

Date of Injury: 05/05/2005 Date of Notice to Employer of Injury: 05/05/2005

I. Payment of Temporary Compensation
(choose A, B, or C)

Check one: ☐ Initial period ☐ Additional period ☐ Corrected compensation rate

☐ A. Temporary Total at the compensation rate of $ _____ per week. For this period of disability, disability began on _____ and the date of first payment was _____

☐ B. Temporary Partial at the compensation rate of $ _____ per week. Note: When the Temporary Partial compensation rate will vary, report the first payment here. Supplement this report throughout the period of Temporary Partial compensation by filing a **Form 15S** with the **Form 18**, which shall be filed six months after the date of injury and each six months thereafter until the file is closed.
For this period of disability, disability began on _____, and the date of first payment was _____.

Calculation of Temporary Partial rate:

Average weekly wage before injury	$	1161.00
- Current weekly wage	- $	
Difference in wages before injury and now		
x .6667	x	.6667
Temporary Partial Compensation Rate	$	

☐ C. Salary in lieu of Temporary ☐ Total / ☐ Partial compensation in the amount of $ _____ per week.
(Choose one)
For this period of disability, disability began on _____ and the date of first payment of salary in lieu of temporary compensation was _____.

THIS SECTION MAY BE USED ONLY WITHIN 150 DAYS AFTER NOTICE TO EMPLOYER OF INJURY.
ATTACH DOCUMENTATION AS TO THE REASON OF THE TERMINATION.

II. Termination of Temporary Compensation
Temporary compensation payments were stopped on 9/18/05 for the following reason:

☐ Claimant has returned to work at least 15 days and no temporary partial compensation is due.
☐ Claimant agrees he/she is able to return to work and has signed a **Form 17**.
☐ Based on a good faith investigation, the claim is denied. Reason for denial: _____
XX Claimant has been released to return to work without restrictions and employment has been offered.
☐ Claimant has been released to return to work at limited duty and employer has provided limited duty work consistent with the terms upon which the Employee has been released.
☐ Claimant has refused medical treatment, examination, or evaluation. Note: Benefits must be resumed if claimant accepts the treatment, examination, or evaluation. Additional report must be filed if compensation is resumed.

I certify that this form has been served on the claimant per R.67-211.

PROCESSED
OCT 12 2005

LARRY GRANT
Signature of Claims Administrator

OCT 5, 2005
Date

III. Notice to Injured Worker or Legal Representative when Temporary Compensation Stopped:
The employer's representative may stop temporary compensation within 150 days of the date of notice of injury for the above reasons. However, if you believe that the temporary compensation should not have been stopped, you may request a hearing by signing below and returning this form to SCWCC Judicial Department at the address at the top of this form. A hearing will be held within 60 days of receipt of your request to determine if temporary compensation has been properly terminated.

MY SIGNATURE BELOW INDICATES THAT I DO NOT AGREE WITH THE TERMINATION OF TEMPORARY COMPENSATION. I REQUEST A HEARING TO DETERMINE WHETHER I AM ENTITLED TO FURTHER TEMPORARY COMPENSATION PAYMENTS.

Check one: **Form 15(II)** ☐ Has ☐ Has not been received

Signature of Claimant or legal representative Date

Employer's representative must complete and file **Form 15** with Claims Department within ten days after compensation begins or is terminated. Employer's representative must serve the **Form 15** on the claimant when compensation begins per R.67-211. Employer's representative must prepare and serve **Form 20** within thirty days of beginning compensation per R.67-1603. Employer's representative must serve per R.67-211 two copies of the **Form 15** on claimant immediately on termination of compensation with documentation attached as to the reason for the termination. Injured worker may contest termination of compensation by completing section III of the **Form 15** and filing it with Judicial Department.

ATT. A15

SC Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715

File #: 0506205
Carrier File #: 104/0000015899/01
Carrier Code #: 00461
Employer FEIN #:

Claimant's Name: Alexander Guice SSN:
Address: 2996 Gaston Dr
City: Loris State: SC Zip: 29569
Home Phone: 843-756-6479 Work Phone: 803-951-4200
Preparer's Name: Larry Grant

Employer's Name: Us Foodservice
Address: 120 LONGS POND ROAD P.O. BOX 8
City: Lexington State: Zip:
Carrier: Mac
Preparer's Phone #: 781-298-4909

Date of injury: 05/05/2005 Date of Notice to Employer of Injury: 05/05/2005

I. Payment of Temporary Compensation

(choose A, B, or C) Check one: X☐ Initial period ☐ Additional period ☐ Corrected compensation rate

☐ A. Temporary Total at the compensation rate of $ _____ per week. For this period of disability, disability began on _____ and the date of first payment was _____.

X☐ B. Temporary Partial at the compensation rate of $ 257.34 per week. Note: When the Temporary Partial compensation rate will vary, report the first payment here. Supplement this report throughout the period of Temporary Partial compensation by filing a **Form 15S** with the **Form 18,** which shall be filed six months after the date of injury and each six months thereafter until the file is closed.

For this period of disability, disability began on 6/20/05, and the date of first payment was 7/7/05

Calculation of Temporary Partial rate:

Average weekly wage before injury	$	1154.00
Current weekly wage	- $	768.80
Difference in wages before injury and now		386.00
x 6667	x	.6667
Temporary Partial Compensation Rate	$	257.34

☐ C. Salary in lieu of Temporary ☐ Total / ☐ Partial compensation in the amount of $ _____ per week. (Choose one)

For this period of disability, disability began on _____ and the date of first payment of salary in lieu of temporary compensation was _____.

THIS SECTION MAY BE USED ONLY WITHIN 150 DAYS AFTER NOTICE TO EMPLOYER OF INJURY. ATTACH DOCUMENTATION AS TO THE REASON OF THE TERMINATION.

PROCESSED JUL 19 2005 SCWORKERS' COMP. COMM.

II. Termination of Temporary Compensation

Temporary compensation payments were stopped on _____ for the following reason:

- ☐ Claimant has returned to work at least 15 days and no temporary partial compensation is due.
- ☐ Claimant agrees he/she is able to return to work and has signed a Form 17.
- ☐ Based on a good faith investigation, the claim is denied. Reason for denial: _____
- ☐ Claimant has been released to return to work without restrictions and employment has been offered.
- ☐ Claimant has been released to return to work at limited duty and employer has provided limited duty work consistent with the terms upon which the Employee has been released.
- ☐ Claimant has refused medical treatment, examination, or evaluation. Note: Benefits must be resumed if claimant accepts the treatment, examination, or evaluation. Additional report must be filed if compensation is resumed.

I certify that this form has been served on the claimant per R.67-211.

Signature of Claims Administrator Date

III. Notice to Injured Worker or Legal Representative when Temporary Compensation Has Been Stopped:

The employer's representative may stop temporary compensation within 150 days of the date of notice of injury for the above reasons. However, if you believe that the temporary compensation should not have been stopped, you may request a hearing by signing below and returning this form to SCWCC Judicial Department at the address at the top of this form. A hearing will be held within 60 days of receipt of your request to determine if temporary compensation has been properly terminated.

MY SIGNATURE BELOW INDICATES THAT I DO NOT AGREE WITH THE TERMINATION OF TEMPORARY COMPENSATION. I REQUEST A HEARING TO DETERMINE WHETHER I AM ENTITLED TO FURTHER TEMPORARY COMPENSATION PAYMENTS.

Check one: Form 15(II) ☐ Has ☐ Has not been received

Signature of Claimant or legal representative Date

Employer's representative must complete and file Form 15 with Claims Department within ten days after compensation begins or is terminated. Employer's representative must serve the Form 15 on the claimant when compensation begins per R.67-211. Employer's representative must prepare and serve Form 20 within thirty days of beginning compensation per R.67-1603. Employer's representative must serve per R.67-211 two copies of the Form 15 on claimant immediately on termination of compensation with documentation attached as to the reason for the termination. Injured worker may contest termination of compensation by completing section III of the Form 15 and filing it with Judicial Department.

ATT. A16

SC Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715

WCC File #: 0506205
Carrier File #: 104/0000015899/01
Carrier Code #: 00461
Employer FEIN #:

Claimant's Name: Alexander Guice SSN:
Address: 2996 Gaston Dr
City: Loris State: SC Zip: 29569
Home Phone: 843-756-6479 Work Phone: 803-951-4200
Preparer's Name: Larry Grant

Employer's Name: Us Foodservice
Address: 120 LONGS POND ROAD P.O. BOX 8
City: Lexington State: Zip:
Carrier: Mac
Preparer's Phone #: 781-298-4909

Date of injury: 05/05/2005 Date of Notice to Employer of Injury: 05/05/2005

I. Payment of Temporary Compensation rate
Check one: xx☐ Initial period ☐ Additional period ☐ Corrected compensation
(choose A, B, or C)

x☐ A. Temporary Total at the compensation rate of $ 592.56 per week. For this period of disability, disability began on 5/6/05 and the date of first payment was 5/13/05

☐ B. Temporary Partial at the compensation rate of $ _____ per week. Note: When the Temporary Partial compensation rate will vary, report the first payment here. Supplement this report throughout the period of Temporary Partial compensation by filing a **Form 15S** with the **Form 18**, which shall be filed six months after the date of injury and each six months thereafter until the file is closed.
For this period of disability, disability began on _____ and the date of first payment was _____

Calculation of Temporary Partial rate:

Average weekly wage before injury	$	1161.00
- Current weekly wage	- $	
Difference in wages before injury and now		
x .6667	x	.6667
Temporary Partial Compensation Rate	$	

☐ C. Salary in lieu of Temporary ☐ Total / ☐ Partial compensation in the amount of $ _____ per week.
(Choose one)
For this period of disability, disability began on _____ and the date of first payment of salary in lieu of temporary compensation was _____

THIS SECTION MAY BE USED ONLY WITHIN 150 DAYS AFTER NOTICE TO EMPLOYER OF INJURY.
ATTACH DOCUMENTATION AS TO THE REASON OF THE TERMINATION.

II. Termination of Temporary Compensation
Temporary compensation terminated on _____ for the following reason:

PROCESSED
JUN 01 2005
SC WORKERS' COMP COMM

☐ Claimant has returned to work at least 15 days and no temporary partial compensation is due.
☐ Claimant agrees he/she is able to return to work and has signed a **Form 17**.
☐ Based on a good faith investigation, the claim is denied. Reason for denial _____
☐ Claimant has been released to return to work without restrictions and employment has been offered.
☐ Claimant has been released to return to work at limited duty and employment has been offered consistent with the terms upon which the Employee has been released.
☐ Claimant has refused medical treatment, examination, or evaluation. Note: Benefits must be resumed if claimant accepts the treatment, examination, or evaluation. Additional report must be filed if compensation is resumed.

I certify that this form has been served on the claimant per R.67-211.

Signature of Claims Administrator Date

III. Notice to Injured Worker or Legal Representative when Temporary Compensation Has Been Stopped:
The employer's representative may stop temporary compensation within 150 days of the date of notice of injury for the above reasons. However, if you believe that the temporary compensation should not have been stopped, you may request a hearing by signing below and returning this form to SCWCC Judicial Department at the address at the top of this form. A hearing will be held within 60 days of receipt of your request to determine if temporary compensation has been properly terminated.

MY SIGNATURE BELOW INDICATES THAT I DO NOT AGREE WITH THE TERMINATION OF TEMPORARY COMPENSATION. I REQUEST A HEARING TO DETERMINE WHETHER I AM ENTITLED TO FURTHER TEMPORARY COMPENSATION PAYMENTS.

Check one Form 15(II) ☐ Has ☐ Has not been received

Signature of Claimant or legal representative Date

Employer's representative must complete and file Form 15 with Claims Department within ten days after compensation begins or is terminated. Employer's representative must serve the **Form 15** on the claimant when compensation begins per R.67-211.5. Employer's representative must prepare and serve **Form 20** within thirty days of beginning compensation per R.67-1003. Employer's representative must send copies of the Form 15 on claimant immediately on termination of compensation with documentation attached as to the reason for the termination. Injured worker may contest termination of compensation by completing section III of the Form 15 and filing it with Judicial Department.

ATT. A17

0000

Harry Pavilack & Associates, P.A.
Attorneys at Law
PO Box 2740
Myrtle Beach, SC 29578-2740
Office: 843-448-9471 · Fax: 843-626-0003

Harry Pavilack, SC FL

Robert S. Haight, Jr., PA, SC, NC
James M. Robbins, SC
Debra S. Harpe, NC, SC
Jennifer L. Lineback, GA

Cynthia M. Lover, SC
Jeffrey A. Keenan, SC
Robert G. Bacon, SC
John Ahn, SC

May 23, 2005

South Carolina Worker's Compensation Commission
Judicial Department
Post Office Box 1715
Columbia, SC 29202-1715

#05062005

RE: WCC FILE NO.:

Employee:	Alexander Guice
Employee's Address:	2996 Gaston Drive Loris, SC 29569
Employee's Telephone No.:	(843) 756-6479
Employee's SSN:	
Date of Injury:	05/05/05
Type of Injury/Part of Body:	back, knee and neck
Description of Accident:	Motor vehicle accident while operating company vehicle.
Location of Accident:	Charleston, SC
Employer:	U.S. Food Service
Employer's Address:	1687 Highway 501-East Conway, SC 29526
Employer's Telephone No.:	(843) 347 -4691
Carrier:	MAC Risk Management, Inc. Attn: Larry Grant, Adjuster PO Box 55840 Boston, MA 02205-5840

Sir/Madam:

The injured employee has retained this firm for representation in a claim for injuries covered by the Workers' Compensation Act, and to establish a claim prior to the expiration of the Statutes of Limitations.

I am requesting the following documents if a claim has been established:

❑	First Report of Injury.	Form 12-A
❑	Physicians's Report(s).	Form 14
❑	Agreement as to Compensation.	Form 15
❑	Settlement Agreement for Compensation.	Form 16
❑	Application to Stop Payment of Compensation.	Form 21
❑	Any other Information Contained in File.	

Sincerely yours,

PAVILACK & ASSOCIATES, P.A.

Robert G. Bacon, Esq.

6175AA

RGB/lac

cc: Larry Grant

ATT. A18

ACORD™ WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)
Us Foodservice
120 LONGS POND ROAD P.O. BOX 8
120 LONGS POND ROAD P.O. BOX 869
Lexington SC 29072

CARRIER/ADMINSTRATOR CLAIM NUMBER: 104/0000015899/01
REPORT PURPOSE CODE:
JURISDICTION: SC
JURISDICTION CLAIM NUMBER:
INSURED REPORT NUMBER:
EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT): 461
LOCATION #:
SIC CODE:
EMPLOYER FEIN:
PHONE #: 803-951-4200

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO): Mac Risk Mgt po box 55840 Boston,MA 02205
POLICY PERIOD: 12/01/2004 TO 11/30/2005
CHECK IF APPROPRIATE: [ ] SELF INSURANCE
CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO):
CARRIER FEIN:
POLICY/SELF-INSURED NUMBER: WC2005
ADMINISTRATOR FEIN:
AGENT NAME & CODE NUMBER:

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE): Guice, Alexander
DATE OF BIRTH:
SOCIAL SECURITY NUMBER:
DATE HIRED: 10/01/2001
STATE OF HIRE: SC
ADDRESS (INCL ZIP): 2996 Gaston Dr
Loris SC 29569
SEX: [X] MALE [ ] FEMALE [ ] UNKNOWN
MARITAL STATUS: [ ] UNMARRIED [ ] SINGLE/DIVORCED [ ] MARRIED [ ] SEPARATED [ ] UNKNOWN
OCCUPATION/JOB TITLE: Driver
EMPLOYMENT STATUS: Full Time
PHONE: 843-756-6479
 # OF DEPENDENTS: 03
NCCI CLASS CODE:
RATE: 1161.00 PER [X] DAY [ ] WEEK [ ] MONTH [ ] OTHER (Hour)
 # DAYS WORKED/WEEK: 0.00
FULL PAY FOR DAY OF INJURY? [ ] YES [ ] NO
DID SALARY CONTINUE? [ ] YES [ ] NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK: 06:00 [X] AM [ ] PM
DATE OF INJURY/ILLNESS: 05/05/2005
TIME OF OCCURRENCE: 06:45 [X] AM [ ] PM
LAST WORK DATE: 05/05/2005
DATE EMPLOYER NOTIFIED: 05/05/2005
DATE DISABILITY BEGAN: 5/6/05
CONTACT NAME PHONE NUMBER: Becky Padgett 803-951-4318
TYPE OF INJURY/ILLNESS: Contusion
PART OF BODY AFFECTED: Multiple Head Inj
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? [ ] YES [X] NO
TYPE OF INJURY/ILLNESS CODE: 10
PART OF BODY AFFECTED CODE: 10
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED: Interatate
North Charleston SC 29405
ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED: Driving To 1st Stop
WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:
There was a broken down veh without any warning lights and our driver struck the rear bumper
CAUSE OF INJURY CODE: 81
DATE RETURNED TO WORK: / /
IF FATAL GIVE DATE OF DEATH: / /
WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? [ ] YES [ ] NO
WERE THEY USED? [ ] YES [ ] NO
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS):
HOSPITAL (NAME & ADDRESS): Conway Hosp Pr
Conway SC 29526
INITIAL TREATMENT:
[ ] NO MEDICAL TREATMENT
[ ] MINOR BY EMPLOYER
[ ] MINOR CLINIC/HOSP
[X] EMERGENCY CARE
[ ] HOSPITALIZED > 24 HRS
[ ] FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED
WITNESSES (NAME & PHONE #):
DATE ADMINISTRATOR NOTIFIED: 05/05/2005
DATE PREPARED: 05/13/2005
PREPARER'S NAME & TITLE: Larry Grant Wc Adjuster
PHONE NUMBER: 781-298-4909

ACORD 4 (2/95) SEE BACK FOR IMPORTANT STATE INFORMATION/SIGNATURE

WCC FORM 12-A REV DATE 3/95

ATT. A19

SOUTH CAROLINA — WORKERS' COMPENSATION EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS
CONTAINS ALL ITEMS REQUIRED BY OSHA FORM 101 (Enter all dates in MM/DD/YY format)

EMPLOYER: US FOODSERVICE
120 LONGS POND ROAD P O BOX 8
120 LONGS POND ROAD P O BOX 8
LEXINGTON SC 29072-
SIC CODE:

CARRIER CLAIM #: 104000001589901
JURISDICTION CLAIM #: 0506205
UNEMPLOY/FED. TAX I.D. NO.:

INSURANCE CARRIER: ACE
45 DAN ROAD
CANTON MA 02021-2852
CC#: 952371728 00461
POLICY/SELF-INSURED#:
POLICY PERIOD: TO
SELF INSURED: N

EMPLOYEE NAME (Last, First, Middle): GUICE ALEXANDER
SOCIAL SECURITY NUMBER:
PHONE NO. (A/C No): (843)756-6479

ADDRESS: 2996 GASTON DR
LORIS SC 29569-
DATE OF BIRTH:
MARITAL STATUS: M
MALE/FEMALE: M
DEPENDENT CHILDREN: 00

DATE OF HIRE: 10/01/01
OCCUPATION: DRIVER

WAGE INFORMATION
RATE: $1,161.00 WEEKLY
FULL PAY FOR DAY OF INJURY? N
DATE RETURN(ED) TO WORK:
DID SALARY CONTINUE? N

OCCURRENCE
PLACE OF ACCIDENT OR OCCURRENCE: 29405- CHARLESTON
DATE OF INJ: 05/05/05
TIME OF INJ: 06 AM
EMPLOYER'S PREMISES?: N
LAST WORKDATE: 05/05/05
DATE EMPL'R NOTIF'D: 05/05/05

DESCRIBE NATURE OR INJURY OR ILLNESS IN DETAIL

CAUSE: STRUCK BY
NATURE: SPRAINS/BRUISES/CONTUSIONS
LOCATION: HEAD/FACE

DESCRIBE EMPLOYEE'S ACTIVITIES WHEN INJURY OCCURED WITH DETAILS OF HOW EVENT OCCURRED

THERE WAS A BROKEN DOWN VEH WITHOUT ANY WARNING

IF FATAL, GIVE DATE OF DEATH:

ELECTRONIC FILING. Original date sent: 05/21/05 Date processed: 05/24/05

Trading Partner: MAC RISK MANAGEMENT
P O BOX 9227
BOSTON MA 02209-9935

ATT. A20

RE: WCC 0506205

From: **Alexander Guice** (alguice@hotmail.com)
Sent: Fri 12/07/12 3:20 PM
To: Gary Cannon (gcannon@wcc.sc.gov)

Dear Director Cannon:

Thank you for your prompt and courteous response.

Alexander Guice
P.O. Box 8651
Tampa, FL 33674
(813) 335-4046 Phone
(813) 898-2908 Fax

From: gcannon@wcc.sc.gov
To: alguice@hotmail.com
CC: kballentine@wcc.sc.gov
Date: Fri, 7 Dec 2012 14:47:56 -0500
Subject: WCC 0506205

Dear Mr. Guice;

Attached the documents your requested. Two Form 27's and a document containing copies of the documents in your case file. Please advise if you would like us to mail you copies via the US postal Service.

Please contact our office if we may be of further assistance.

Gary M. Cannon

Executive Director

1333 Main Street, Suite 500

P.O. Box 1715

Columbia, SC 29201-1715

803.737.5744

gcannon@wcc.sc.gov

www.wcc.sc.gov

ATT. A21

Line, Greg

From: Cannon, Gary
Sent: Thursday, December 06, 2012 3:48 PM
To: Line, Greg
Subject: FW: Ombudsman - Request for Assistance - Follow Up- WCC File No.: 0506205

Greg
This is FYI. Pertains to the file I discussed with you earlier this afternoon.
Thanks.

Gary M. Cannon
Executive Director

From: Alexander Guice [mailto:alguice@hotmail.com]
Sent: Thursday, December 06, 2012 1:20 PM
To: Cannon, Gary
Subject: Ombudsman - Request for Assistance - Follow Up- WCC File No.: 0506205

Dear Mr. Cannon:

This is a follow up message to document the contents our conversation earlier today.

I requested to speak with the Ombudsman for South Carolina Workers' Compensation Commission (SCWCC), and you identified yourself as the Ombudsman for SCWCC. I informed you of the proper request I submitted for a copy of my Claims file from SCWCC. I informed you that I contacted Joan Burckhalter who confirmed receipt of my request along with the enclosed and required $20.00 money order, as well as Ms. Burckhalter stating that due to only one (1) individual working at the South Carolina Department of Archives that Ms. Burckhalter was unable to provide a specific time as to when I could expect to receive a copy of WCC Claim File No.: 0506205.

I informed you that I submitted a proper written request, via facsimile, to SCWCC, attention the Judicial Department, requesting two (2) signed blanked WCC form 27's. I informed you that I received confirmation, via email, from Eugenia Hollmon, that the request was received by their office, however the individual authorized to sign the blank WCC form 27 would be out of the office until at or around 12/10/2012. I informed you that I thought the information provided by Ms. Hollmon was disturbing on the basis that someone within the SCWCC Judicial Department should always be available to sign blank WCC form 27's for Pro Se Claimants and this action reflected an unfair delay in the Claims process by SCWCC.

You stated that you would look into both issues, and contact me today and provide confirmed dates with regards to when I could expect to receive a copy of Claims File and when I could expect to receive the signed blank form 27's.

If possible, in an effort to reduce the delay associated with receiving the requested documents through regular mail, please feel free to have personnel scan the requested document(s) and send the documents attachment(s) to this email address.

I truly appreciated your fast and courteous response with regards to your call earlier today, and look forward to hearing from you regarding the stated issues above. Please feel free to respond via email.

Again, thank you for your assistance.

Sincerely,

Alexander Guice
Pro Se Claimant

P.O. Box 8651
Tampa, FL 33674
(813) 335-4046 Phone
(813) 898-2908 Fax

ATT. B

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 0506205

ALEXANDER GUICE,

Employee,

Claimant,

vs.

US FOOD SERVICE, INC.

Employer,

AND

MAC RISK MANAGEMENT, INC.,

Carrier,

Defendants.

SETTLEMENT AGREEMENT AND RELEASE

WHEREAS, the undersigned, Alexander Guice, hereinafter referred to as Claimant, alleges to have sustained an injury to his low back, right knee and neck, by accident arising out of and in the course of his employment with US Food Service, Inc., hereinafter referred to as Employer, on or about May 5, 2005 when he allegedly was involved in a motor vehicle accident; and

WHEREAS, MAC Risk Management, Inc., hereinafter referred to as Carrier, is the Insurance Carrier for the Employer; and

WHEREAS, the average weekly wage is $1,154.00; and the compensation rate is $592.56; and

WHEREAS, all parties are operating under and are subject to the provisions of the South Carolina Workers' Compensation Act; and

WHEREAS, the Claimant contends that that he has sustained a permanent impairment in excess of the rating(s) of the physician(s); and the Employer and Carrier deny the same; and

WHEREAS, the Claimant has been treated and/or evaluated by Dr. Alan Tamadon, who found the Claimant at maximum medical improvement on October 27, 2005 and who rated the Claimant's permanent impairment at five (5%) percent to the whole person. The Claimant has also been treated and/or evaluated by Dr. Wayne B. Bauerle, Doctor's Care of Conway, Genex and Long Bay Diagnostic Imaging; and

WHEREAS, there is a bona fide dispute between the Claimant and the Employer and Carrier as set forth above; and

WHEREAS, on account of the doubts that exist as to what benefits, if any, the Claimant would be adjudged to be entitled to recover under the Workers' Compensation Act, the Claimant and the Employer and Carrier, with the approval of the South Carolina Workers' Compensation Commission, have deemed it advisable, proper and in the best interests of all parties to compromise and settle all possible liabilities and controversies between them, now and in the future, the basis of such settlement being as follows:

WHEREAS, in consideration of the sum of Twenty Thousand and 00/100 Dollars ($20,000.00), the undersigned, Alexander Guice, does hereby release and forever discharge US Food Service, Inc. and MAC Risk Management, Inc. from any and all claims, demands, actions or causes of action under the South Carolina Worker's Compensation Act, on account of any and all injuries, disability, disfigurement, specific loss, death, operations, medical, hospital or like expense, continuances, recurrences, aggravations, changes of condition, ailments, illnesses, and diseases or other damages, consequences or results, past, present or future in any way connected with, or arising from the alleged injury sustained by the Claimant on or about May 5, 2005, and does hereby acknowledge that US Food Service, Inc. and MAC Risk Management, Inc. have fully, finally and completely paid and discharged each and every of their obligations, liabilities and responsibilities under the South Carolina Workers' Compensation Act and that the sum set forth above is being paid to, and received by, the undersigned, Alexander Guice, in full and final satisfaction of all claims whatsoever as a result of the alleged accident described above and that US Food Service, Inc. and/or

MAC Risk Management, Inc. shall not henceforth be liable for the payment of any amount whatsoever; and

WHEREAS, without in any way affecting the overall terms of this settlement insofar as the Defendants are concerned, and with the Claimant and the Claimant's attorney acknowledging that the Defendants make no representations as to the effect such allocation may have on the Claimant's receipt of other benefits, the Claimant and his attorney hereby request this Commission to approve the allocation of the proposed settlement sum of $20,000.00; and

Prior to the trial of this case being held before the South Carolina Workers' Compensation Commission, the parties commenced settlement negotiations and, in view of the real dispute which exists between the parties, the parties agreed upon a full, final and complete settlement and termination of all claims by the Claimant against the Defendants, for any and all claimed injuries or accidents heretofore sustained in connection with the Claimant's employment by the named employer, subject to the approval of the South Carolina Worker's Compensation Commission, the terms of the settlement agreement between the parties being that the Defendants will pay to the Claimant in lump sum, with the Defendants expressly waiving all rights to commutation thereof, the sum of $20,000.00 in full and final satisfaction for any and all compensation benefits or other payments under the Worker's Compensation Act to be allocated as follows:

$13,333.34 in compromise settlement of disputed future disability benefits at the rate of $6.489 per week commencing on December 15, 2005, for a period of 39.51 years representing the Claimant's life expectancy pursuant to Section 19-1-150 of the South Carolina Code of Law (1976), and pursuant to Section 42-9-10 and 42-9-20 of the 1976 Code of Laws as interpreted by the South Carolina Supreme Court decision of Utica Mohak Mills v. Orr, 277 S.C. 226, 87 SE 2d 593; Sciarotta v. Bowen, 837 F 2d 135; Lemire v. Secretary of Health and Human Services, 682 F. Supp. 102 (D.C.N.H. 1988) and Hatch v. Heckler, 626 F. Supp. 1367 (N.D. California 1986); and $6,666.66 as attorney's fees pursuant to a written agreement between the Claimant and his attorney; and

WHEREAS, the Employer and Carrier have paid or have agreed to pay authorized medical expenses through December 1, 2005 incurred as a result of the alleged accident described above, in such amounts as may be approved by the South Carolina Workers' Compensation Commission; and

WHEREAS, this Settlement Agreement and Release is full, final and complete regardless of whether the Claimant is able to keep any employment whatsoever, or is able to earn any wages at any time in the future; and

WHEREAS, full and complete medical reports are on file with the South Carolina Workers' Compensation Commission and these are duly considered by it in approving this Settlement Agreement and Release.

WHEREAS, the Claimant represents that he has been fully advised of his rights under the South Carolina Workers' Compensation Act and that he is of the opinion that the proposed settlement is reasonable and fair, and requests that the South Carolina Workers' Compensation Commission approve this settlement as set forth in this Settlement Agreement and Release. The parties acknowledge that the Commission relies upon the representation of counsel for the claimant that the claimant has been fully apprised of his rights under the laws of the South Carolina Workers' Compensation Act and that he believes the settlement is reasonable and fair and thus requests that the South Carolina Workers Compensation Commission approve this settlement as set forth herein.

NOW THEREFORE, upon approval of this settlement by the South Carolina Workers' Compensation Commission, the Claimant hereby relinquishes and releases each and every claim related to this accident, which he now has, or may hereafter have, so that he shall not henceforth have any other or future claim or demand related to this accident, as a result of the alleged accident described above, nor shall anyone on his behalf or claiming by, through or under him or as dependent, have any claim or demand on account of this accident, as a result of the alleged accident described above; and

The undersigned further acknowledges that the consideration herein expressly recited is the sole and only consideration for the execution hereof, and that no promise, agreement or suggestions of any other or additional consideration has been made to, or received by, me.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at Myrtle Beach, this 22 day of December 2005.

Alexander Guice

IN THE PRESENCE OF:

ATT. C

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WCC FILE NO. 0506205

Alexander Guice, Claimant, vs. US Food Service, Inc., Employer, MAC Risk Management, Inc. Carrier, Defendants	ORDER

Claimant settled his claim (WCC# 0506205) through a Full and Final Settlement Agreement which was approved by the South Carolina Workers' Compensation Commission on January 5, 2006. A Form 19 was submitted by Defendants as well.

In January 2013, Claimant filed a Form 50 relating to the claim (WCC# 0506205) which he previously settled.

As this case was settled on a Full and Final basis on or about January 6, 2006, Claimant's hearing request is hereby denied, and the hearing set for March 28, 2013 in Summerville, South Carolina is cancelled. Further, any and all motions filed pertaining to WCC# 0506205 are hereby dismissed as well.

AND IT IS SO ORDERED.

Columbia, SC

Susan S. Barden, Commissioner

February 22, 2013

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 mail addressed to any unrepresented party.

By Kristi Love on February 22, 2013

ATT. D

APPELLATE PANEL

DECISION AND ORDER

OF THE

S. C. WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO. 0506205

ALEXANDER GUICE — EMPLOYEE, CLAIMANT/APPELLANT,

vs.

U.S. FOOD SERVICE, INC., — EMPLOYER,

AND

GALLAGHER BASSETT SERVICES, INC., — CARRIER, DEFENDANTS/RESPONDENTS.

Appellate Panel Review held in Columbia, South Carolina, on May 21, 2013, per notices timely and properly served upon all parties of interest.

Appellate Panel Decision and Order filed 7-17, 2013

APPEARANCES: This matter was decided without oral arguments pursuant to Reg. 67-701

Claimant/Appellant pro se

Defendants/Respondents represented by Erin L. Hantske, Esquire, Charleston, South Carolina

STATEMENT OF THE CASE

The Appellant alleges sustaining injury to his low back, right knee, and neck by accident arising out of and in the course and scope of his employment with Respondents on or about May 5, 2005, when he was allegedly involved in a motor vehicle accident. At the time of his alleged accident, Appellant had an average weekly wage of $1,154.00, and a corresponding compensation rate of $592.56 (maximum compensation rate for injuries sustained in 2005). Appellant was treated by Dr. Allen Tamadon, who opined that Appellant reached maximum medical improvement on October 27, 2005, and assigned a 5% medical impairment rating to the whole person.

Subsequent to Appellant's release at maximum medical improvement, the parties entered into a Settlement Agreement and Release resolving Appellant's South Carolina Workers' Compensation File No. 0506205 on a full and final clincher basis for a lump sum payment of $20,000.00. This Settlement Agreement was approved by the South Carolina Workers' Compensation Commission on January 5, 2006. Thereafter, the file was closed with the South Carolina Workers' Compensation Commission pursuant to a filed Form 19.

Appellant then filed a Form 50/Hearing Request dated December 7, 2012 and an Amended Form 50/Hearing Request on January 5, 2013, under the same Workers' Compensation Commission file number, 0506205, alleging a date of accident of May 5, 2005, and injury to the back, neck and right knee. Appellant requested additional medical examination and treatment for the alleged injuries, temporary total disability benefits from November 2, 2006 through the present and permanent partial disability benefits. Respondents timely filed a Form 51 denying any entitlement to additional medical care or treatment, temporary total disability benefits, or permanent disability benefits based upon the parties' previous Settlement Agreement to clincher

the claim approved by the South Carolina Workers' Compensation Commission on January 5, 2006. A hearing was scheduled for March 28, 2013 in Summerville, South Carolina before Commission Susan S. Barden. Prior to the scheduled hearing, Appellant submitted two motions: one requesting a telephonic hearing, and the other requesting a change of jurisdiction. On February 22, 2013, Commissioner Barden issued the following Order:

> **Claimant settled his claim (WCC No. 0506205) through a Full and Final Settlement Agreement which was approved by the South Carolina Workers' Compensation Commission on January 5, 2006. A Form 19 was submitted by Defendants as well.**
>
> **In January 2013, Claimant filed a Form 50 relating to the claim (WCC No. 0506205) which he previously settled.**
>
> **As this case was settled on a Full and Final basis on or about January 6, 2006, Claimant's hearing request is hereby denied, and the hearing set for March 28, 2013 in Summerville, South Carolina is cancelled. Further, any and all motions filed pertaining to WCC No. 0506205 are hereby dismissed as well.**
>
> **AND IT IS SO ORDERED.**

Within the statutory period, the pro se Claimant filed an Application for Review in the case setting forth his reasons, copies of which were furnished to all interested parties. Appellant requested this matter be heard without oral arguments. All proferred testimony has been taken. Such, together with all documentary evidence, has been delivered to the individual members of the Appellate Panel and has since been under study and consideration. By appeal, Claimant submitted the following:

1. "Did Commissioner Susan S. Barden have proper Jurisdictional authority to make any judgments regarding WCC No. 0506205?"
2. "Was Commissioner Barden's Order invalid due to no regulatory or statutory grounds stated to support canceling the hearing?"
3. "Did the Order signed by Commissioner Barden on 02/22/13 violate Rule 5(b)(3) SCRCP?"

4. "Did the Order signed by Commissioner Barden on 02/22/13, with respect to cancelling the hearing, violate Rule 7(b)(1) SCRCP?"

5. "Did Commissioner Barden's Order dated 02/22/13 violate the Appellant's Right to a Hearing?"

6. "Was the Appellant subjected to a conspiracy involving Commissioner Barden, Virginia L. Crocker, Judicial Director, and Erin L. Hantske, Esquire, the Representative for the Respondent?"

7. "Is Commissioner Barden's conduct subject to be reported to the South Carolina Ethics Commission IAW Rule 501(3)(D)(I) SCACR with respect to the Order dated 02/22/13?"

In an Appellant Review, the Appellate Panel shall, pursuant to S.C. Code Ann. Section 42-17-50 (1995), review the Award, weigh the evidence as presented, and, if good grounds be shown therefore, make its own Findings of Fact and reach its own Conclusions of Law consistent with or inconsistent with those of the Single Commissioner.

After careful review in the instance case, the Commission, by unanimous vote, has determined that the Single Commissioner's Order was correct in its entirety. Accordingly, the Appellate Panel has issued a **FULL AFFIRMATION** of the Single Commissioner's Order.

FINDINGS OF FACT

Based upon the documentary evidence submitted by the respective parties pursuant to the Administrative Procedures Act and the Commission file relative to this claim, we, the Appellate Panel, issue the following Order:

1. Claimant settled his claim (WCC No. 0506205) through a Full and Final Settlement Agreement which was approved by the South Carolina Workers' Compensation Commission on January 5, 2006. A Form 19 was submitted by Defendants as well.

2. In January 2013, Claimant filed a Form 50 relating to the claim (WCC No. 0506205) which he previously settled.

3. As this case was settled on a Full and Final basis on or about January 6, 2006, Claimant's hearing request is hereby denied, and the hearing set for March 28, 2013 in Summerville, South Carolina was appropriately cancelled. Further, any and all motions filed pertaining to WCC No. 0506205 are hereby dismissed as well.

CONCLUSIONS OF LAW

Under the South Carolina Workers' Compensation Act and other applicable law, it is the determination and conclusion of the Appellate Panel that:

1. Pursuant to S.C. Reg. 67-801, Claimant settled his claim (WCC No. 0506205) through a Full and Final Settlement Agreement which was approved by the South Carolina Workers' Compensation Commission on January 5, 2006.
2. Pursuant to S.C. Code Reg. 67-801(E), the Employer and the Insurance Carrier are relieved from any further responsibility for payment of compensation or medical expenses, and by signing the Full and Final Settlement Agreement which was approved by the South Carolina Workers' Compensation Commission, the Claimant does not have the right to ask for additional payments in the future. As such, the hearing request and motions of the Claimant were appropriately denied.

ORDER

IT IS THEREFORE ORDERED that the Order of the Single Commissioner is hereby **FULLY AFFIRMED** and the above Findings of Fact and Conclusions of Law are the decision of the Workers' Compensation Commission.

AND IT IS SO ORDERED.

Commissioner Andrea C. Roche

Commissioner Melody James

Commissioner Avery Wilkerson, Chair

CERTIFICATE OF SERVICE

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

This 17 day of July, 2013.

By Valerie S. Deller

Administrative Assistant to the Commissioner

Alexander Guice (Reg & Cert)

Erin L. Hartstein

ATT. E

CAUTION: NOT TO BE USED FOR IDENTIFICATION PURPOSES

THIS IS AN IMPORTANT RECORD. SAFEGUARD IT.

ANY ALTERATIONS IN SHADED AREAS RENDER FORM VOID

CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY

1. NAME (Last, First, Middle)	2. DEPARTMENT, COMPONENT AND BRANCH	3. SOCIAL SECURITY NO.
GUICE, ALEXANDER	ARMY/RA	

4.a GRADE, RATE OR RANK	4.b PAY GRADE	5. DATE OF BIRTH (YYYYMMDD)	6. RESERVE OBLIG. TERM. DATE
SGT	E5		Year 0000 Month 00 Day 00

7.a PLACE OF ENTRY INTO ACTIVE DUTY	7.b HOME OF RECORD AT TIME OF ENTRY (City and state, or complete address if known)
TAMPA, FL	3001 W. 46TH ST TAMPA, FL 33605

8.a LAST DUTY ASSIGNMENT AND MAJOR COMMAND	8.b STATION WHERE SEPARATED
187RIN BN 1 HHC (AACLT) FC	FT CAMPBELL, KY 42223-5000

9. COMMAND TO WHICH TRANSFERRED	10. SGLI COVERAGE
NA	☐ None Amount: $200,000.00

11. PRIMARY SPECIALTY (List number, title and years and months in specialty. List additional specialty numbers and titles involving periods of one or more years.)	12. RECORD OF SERVICE	Year(s)	Month(s)	Day(s)
92G2O FOOD SERVICE SPECIALIST--6 YRS-6 MOS //NOTHING FOLLOWS	a. Date entered AD This Period	1990	11	06
	b. Separation Date This Period	1997	10	08
	c. Net Active Service This Period	0006	11	03
	d. Total Prior Active Service	0000	00	00
	e. Total Prior Inactive Service	0000	00	00
	f. Foreign Service	0003	06	25
	g. Sea Service	0000	00	00
	h. Effective Date of Pay Grade	1996	03	01

13. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED (All periods of service)

ARMY ACHIEVEMENT MEDAL (4TH AWARD)//ARMY LAPEL BUTTON//ARMY COMMENDATION MEDAL//ARMY GOOD CONDUCT MEDAL (2ND AWARD)//NATIONAL DEFENSE SERVICE MEDAL//NONCOMMISSIONED OFFICER'S PROFESSIONAL DEVELOPMENT RIBBON//ARMY SERVICE RIBBON//OVERSEAS SERVICE RIBBON//UNITED NATIONS MEDAL//MARKSMAN BADGE M-16 RIFLE//NOTHING FOLLOWS

14. MILITARY EDUCATION (Course title, number of weeks and month and year completed)

FOOD SERVICE SPECIALIST COURSE, 9 WEEKS, APR 1991//NOTHING FOLLOWS

15.a MEMBER CONTRIBUTED TO POST-VIETNAM ERA VETERAN'S EDUCATIONAL ASSISTANCE PROGRAM	Yes	No	15.b HIGH SCHOOL GRADUATE OR EQUIVALENT	Yes	No	16. DAYS ACCRUED LEAVE PAID
		X		X		21.5

17. MEMBER WAS PROVIDED A COMPLETE DENTAL EXAM AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION ☐ Yes ☒ No

18. REMARKS

DATA HEREIN SUBJECT TO COMPUTER MATCHING WITHIN DOD OR WITH OTHER AGENCIES FOR VERIFICATION PURPOSES AND DETERMINING ELIGIBILITY OR COMPLIANCE FOR FEDERAL BENEFITS//IMMEDIATE REENLISTMENTS THIS PERIOD-- 19901106-19930309, 19930310-19960930//SUBJECT TO ACTIVE DUTY RECALL, MUSTER DUTY AND/OR ANNUAL SCREENING//BLOCK 6, PERIOD OF DELAYED ENTRY PROGRAM: 19900717-19901105//DISABILITY SEVERANCE PAY-- $21222.60//MEMBER HAS COMPLETED FIRST FULL TERM OF SERVICE//NOTHING FOLLOWS

19.a MAILING ADDRESS AFTER SEPARATION (Include Zip Code)	19.b NEAREST RELATIVE (Name and address - include Zip Code)
2996 GASTON DR LORIS, SC 29569	PAMELA GEE 2996 GASTON DR LORIS, SC 29569

20. MEMBER REQUESTS COPY 6 BE SENT TO SC DIR OF VET AFFAIRS	☒ Yes	☐ No

21. SIGNATURE OF MEMBER BEING SEPARATED	22. OFFICIAL AUTHORIZED TO SIGN (Type name, grade, title, and signature)
	BILLIE P. WEDDINGTON / GS9, CHIEF, TP

SPECIAL ADDITIONAL INFORMATION (For use by authorized agencies only)

23. TYPE OF SEPARATION	24. CHARACTER OF SERVICE (Include upgrades)	
DISCHARGE	HONORABLE	
25. SEPARATION AUTHORITY	26. SEPARATION CODE	27. REENTRY CODE
AR 635-40 PARA 4-24B(3)	JFL	3

28. NARRATIVE REASON FOR SEPARATION

DISABILITY, SEVERANCE PAY

29. DATES OF TIME LOST DURING THIS PERIOD	30. MEMBER REQUESTS COPY 4
NONE	Initials

ATT. F

STATE OF FLORIDA

OFFICE of VITAL STATISTICS

CERTIFIED COPY

CERTIFICATION OF BIRTH

STATE FILE NUMBER: 109-1971-014389

CHILD'S NAME: ALEXANDER GUICE

DATE OF BIRTH:

SEX: MALE

COUNTY OF BIRTH: HILLSBOROUGH

DATE FILED: MARCH 5, 1971

MOTHER'S MAIDEN NAME: THELMA DELORES COPELAND

FATHER'S NAME: ALBERT GUICE

DATE ISSUED: JULY 8, 2009

, State Registrar

REQ: 2009592047

THE ABOVE SIGNATURE CERTIFIES THAT THIS IS A TRUE AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE.

WARNING: THIS DOCUMENT IS PRINTED OR PHOTOCOPIED ON SECURITY PAPER WITH A WATERMARK OF THE GREAT SEAL OF THE STATE OF FLORIDA ON THE FRONT, AND THE BACK CONTAINS SPECIAL LINES WITH TEXT AND SEALS IN THERMOCHROMIC INK.

FLORIDA DEPARTMENT OF HEALTH

DH FORM 1946 (08-04)

25779553

CERTIFICATION OF VITAL RECORD

ATT. G

RE: Status of Appeal - WCC No.: 0506205

From: **Hollmon, Eugenia** (EHollmon@wcc.sc.gov) This sender is in your contact list.
Sent: Thu 11/15/12 10:55 AM
To: Alexander Guice (alguice@hotmail.com)

We have scanned all of the documents that you sent to you file, but your appeal is not proper. You can only file an appeal if you have had an official order signed by a Commissioner. According to our records this case has never had a hearing of any kind. It is currently closed, but if you are seeking benefits you need to file for a hearing. You may do that by downloading a Form 50 off of our website. The Form 50 requires a $25 filing fee and if you are unable to pay that you can also download a Form 32.

Since you are represented by Atty. Bacon he must file these documents for you or you will need to send a letter requesting to have him released along with the required forms.

Genia Hollmon

From: Alexander Guice [mailto:alguice@hotmail.com]
Sent: Wednesday, November 14, 2012 10:36 PM
To: Hollmon, Eugenia
Subject: Status of Appeal - WCC No.: 0506205

Dear Ms. Hollmon.

I am respectfully requesting to know whether or not I am required to submit any further paperwork with regards to the Appeal received by your office on November 6, 2012. On the Certificate of Service submitted with the Appeal received by your office, US Foods Inc., the Respondent, received a certified copy of the Appeal on November 5, 2012.

If there is any further documentation required at this time by the Appellant, please do not hesitate to contact me. Thank you. Please respond.

Alexander Guice
Pro Se Appellant

ATT. H

REHABILITATION MEDICINE SERVICES, P.C.
4237 River Hills Drive, Suite 130
Little River, S.C. 29566
(910) 362-1112
Fax (910) 362-1115

PATIENT: Alex Guice DOB:
CHART #: T02447

OUTPATIENT FOLLOW-UP
October 27, 2005

CC: Neck and low back pain, stable.

HPI: Mr. Guice presents here in follow-up of his work-related injuries. He states that, as work restrictions have been once again incorporated, his pain is under acceptable control. He occasionally has bouts of pain for which he resorts to prescription medications provided. He reports to be comfortable today.

REVIEW OF SYSTEMS:
Patient denies any bowel or bladder changes, saddle dysesthesias, or new onset weakness.

CURRENT MEDICATIONS:
Ibuprofen, hydrocodone, Flexeril.

SOCIAL HISTORY:
Patient was placed on a 25 lb work restriction and no truck driving previously.

PAST MEDICAL HISTORY:
Reviewed.

PHYSICAL EXAM:
General: Patient is well developed, well nourished, in no acute distress.

Gait: Gait is physiologic with physiologic arm swing and velocity.

Neurologic: Cranial nerves II through XII are grossly intact. Memory, insight, and judgment are within normal limits. Patient is alert and oriented x 4.

Neck: On inspection, no asymmetry is noted. Range of motion is within functional limits with pain on the extremes of motion. Myofascial pain is noted in the cervical and trapezius region. Provocative maneuvers are negative.

Upper limbs: Range of motion is full. Sensation is intact to light touch. Strength is graded as overall good. Neurovascular exam is otherwise intact.

Back: On palpation, once again, myofascial pain is noted. Lumbosacral range of motion is within functional limits with pain reported on the extremes of motion. No frank muscle spasm is noted on today's visit.

Continued ...

PHYSICAL EXAM (Continued):

Lower limbs: Seated straight leg raise test is negative. Strength is graded as overall good. Patient is able to walk on heels and toes. Deep squats are associated with right knee pain. Range of motion of the right knee is within normal limits with full extension and flexion greater than 120 degrees. No varus or valgus laxity or ankylosis is noted. Neurovascular exam is otherwise intact.

ASSESSMENT:

(1) Neck pain.
(2) Low back pain.
(3) Right knee pain.
(4) Other medical problems per chart, stable.

PLAN/DISCUSSION:

Approximately 45 minutes was spent with patient face to face out of which greater than 50% was for counseling. Functional Capacity Evaluation done was reviewed. Patient was made aware of the good effort placed and the results to be valid. Indeed, the results have yielded performing physical work at light level as defined by US Department of Labor. For this reason, he will be placed on permanent restrictions of no lifting greater than 25 lbs occasionally and no lifting greater than 10 lbs if to be done constantly or frequently. Medications were reviewed. Patient has adequate refills for the present time, however, may continue with these medications as needed in the future and is able to contact this office for refills on an as needed basis. With patient's permission, case manager was asked to enter the room for rehab nurse conference.

REHAB NURSE CONFERENCE:

Cathy Dayton, RN, patient's case manager, was made aware of the permanent restrictions. She was further made aware that patient is at maximal medical improvement. Subject of rating was raised. MRI results of the right knee were reviewed. It is noted that right knee MRI was essentially within normal limits with the exception of quadriceps which showed evidence of mild tendinitis. Electrodiagnostic studies were reviewed which showed no evidence of radiculopathy or otherwise nerve impingement and, indeed, an improvement from last comparison study done. In view of such findings, recommend a five percent (5%) impairment rating of the whole person for neck, low back, and right knee pain as a result of this injury. All other questions were answered. His follow-up is left open.

Alan Tamadon, M.D.

/dh

cc: Dr. Bauerle

Rehabilitation Medicine Services, P.C.

Musculoskeletal Injury, Electrodiagnostics
Workers Compensation and Coordination of Care

1709-B South 16th Street
Wilmington, N.C. 28401
Phone:(910) 362-1112
Fax: (910) 362-1115

215-A Station Street
Jacksonville, N.C. 28546
Phone: (910) 577- 4300
Fax: (910) 577-6630

Notice of Work Status

Employee: Alex Grice DOB: _____

Diagnosis: Neck & LSP Next Appt: 3pcs

Date: _____ Time: _____

☐ Return to work without restriction on _____
☐ Off balance of this shift only
☐ Temporary total disability until: _____
☒ Modified work description. Please describe: (permanent) X

No lifting > 25 pounds occasionally
No lifting > 10 Pounds frequently or Constantly

☐ Physical / Occupational Therapy: ☐ YES ☒ NO Next Appointment: _____

Frequency: _____ days per week, for _____ weeks.

☐ Patient referred to specialist for: _____

Physician: _____ Specialty: _____

Phone #: _____ Appt Date: _____

☐ Patient referred for: _____

☒ Patient Released

Physician Signature: _____ Date: 10/27/05
Alan Tamadon, MD

Revised 09/04

ATT. I

GENEX

Solving the Cost/Care Equation

October 28, 2005

Alexander Guice
2996 Gaston Drive
Loris, SC 29569

RE:

Claimant:	Alexander Guice
Claim #:	104/0000/5899/01-US
GENEX Case #:	CNG38B
Employer:	U S Food Service
DOI:	05-May-2005

Dear Mr. Guice:

This letter is in follow-up to the appointment with Dr. Tamadon. He has recommended that you have long term working restrictions, to prevent further injury to yourself. You should always use proper body mechanics and ask for assistance when needed, at home or at work. He has recommended that you avoid lifting greater than 25 pounds on an occasional basis.

Unfortunately, US Foods can not accommodate long term work restrictions, and your light duty job availability will end on November 6th. You need to discuss available option with your employer, as soon as possible.

Dr. Tamadon has agreed to provide you with the Flexeril and Hydrocodone on a long term basis. You will need to call his office when prescriptions are needed and arrange to pick them up.

I have provided Mr. Larry Grant at MAC Risk Management with an update, and anticipate that I will be closing your file, when I receive Dr. Tamadon's documentation.

In the interim, if I can be of assistance in any fashion, please do not hesitate to contact me. I can be reached at 910-579-4720.

Sincerely,

Cathy Dayton

Cathy Dayton, RN, CCM
Medical Case Manager

ATT. J

00779-00779

MAC Risk Management, Inc.
Mailing Address: P.O. Box 55840, Boston, MA. 02205-5840

US

GUICE, ALEXANDER
2996 GASTON DR
LORIS, SC 29569

Check No.	0000554698
Check Date	05/13/2005
Check Amount	$1,185.12
Reference No.	104/0000015899

CLAIM #	LOSS DATE	CLAIMANT	LOCATION	REMARKS	AMOUNT
0000015899	05/05/05	GUICE, ALEXANDER	5D	FROM 05/06/05 TO 05/20/05	1,185.12

00003-00003

MAC Risk Management, Inc.
Mailing Address: P.O. Box 55840, Boston, MA 02205-5840

RD

GUICE, ALEXANDER
2996 GASTON DR
LORIS, SC 29569

Check No. 0000561979
Check Date 05/25/2005
Check Amount $1,185.12
Reference No. 104/0000015899

CLAIM #	LOSS DATE	CLAIMANT	LOCATION	REMARKS	AMOUNT
0000015899	05/05/05	GUICE, ALEXANDER	SD	FROM 05/21/05 TO 06/04/05	1,185.12

00006-00006

MAC *Risk Management, Inc.*
Mailing Address: P.O. Box 55840 Boston, MA 02205-5840

RD

GUICE, ALEXANDER
2996 GASTON DR
LORIS, SC 29569

Check No.	0000573914
Check Date	06/16/2005
Check Amount	$1,185.12
Reference No.	104/0000015899

CLAIM #	LOSS DATE	CLAIMANT	LOCATION	REMARKS	AMOUNT
0000015899	05/05/05	GUICE, ALEXANDER	5D	FROM 06/05/05 TO 06/18/05	1,185.12

00334-00334

MAC Risk Management, Inc.
Mailing Address: P.O. Box 55840, Boston, MA. 02205-5840

US

GUICE, ALEXANDER
2996 GASTON DR
LORIS, SC 29569

Check No.	0000585033
Check Date	07/07/2005
Check Amount	$499.83
Reference No.	104/0000015899

CLAIM #	LOSS DATE	CLAIMANT	LOCATION	REMARKS	AMOUNT
0000015899	05/05/05	GUICE, ALEXANDER	SD	FROM 06/20/05 TO 07/03/05	499.83

00005-00005

MAC Risk Management, Inc.
Mailing Address: P.O. Box 200001 Woodstock, GA 30189-0400

RD

GUICE, ALEXANDER
2996 GASTON DR
LORIS, SC 29569

Check No.	0000596111
Check Date	07/22/2005
Check Amount	$560.41
Reference No.	104/0000015899

CLAIM #	LOSS DATE	CLAIMANT	LOCATION	REMARKS	AMOUNT
0000015899	05/05/05	GUICE, ALEXANDER	5D	FROM 07/04/05 TO 07/17/05	560.41

00004-00004

MAC *Risk Management, Inc.*
Mailing Address: P.O. Box 200001 Woodstock, GA 30189-0400

RD

GUICE, ALEXANDER
2996 GASTON DR
LORIS, SC 29569

Check No.	0000609738
Check Date	08/12/2005
Check Amount	$772.02
Reference No.	104/0000015899

CLAIM #	LOSS DATE	CLAIMANT	LOCATION	REMARKS	AMOUNT
0000015899	05/05/05	GUICE, ALEXANDER	5D	FROM 07/18/05 TO 08/07/05	772.02

00719-00719

MAC Risk Management, Inc.
Mailing Address: P.O. Box 300001 Woodstock, GA 30189-0400

US

GUICE, ALEXANDER
2996 GASTON DR
LORIS, SC 29569

Check No.	0000616712
Check Date	08/26/2005
Check Amount	$257.34
Reference No.	104/0000015899

CLAIM #	LOSS DATE	CLAIMANT	LOCATION	REMARKS	AMOUNT
0000015899	05/05/05	GUICE, ALEXANDER	5D	FROM 08/08/05 TO 08/15/05	257.34

MAC Risk Management, Inc.
Mailing Address: P.O. Box 200001 Woodstock, GA 30189-0400

00008-00008

RD

GUICE, ALEXANDER
2996 GASTON DR
LORIS, SC 29569

Check No.	0000621443
Check Date	09/09/2005
Check Amount	$746.01
Reference No.	104/0000015899

CLAIM #	LOSS DATE	CLAIMANT	LOCATION	REMARKS	AMOUNT
0000015899	05/05/05	GUICE, ALEXANDER	5D	FROM 08/15/05 TO 09/04/05	746.01

00006-00006

MAC Risk Management, Inc.
Mailing Address: P.O. Box 200001 Woodstock, GA 30189-0400

RD

GUICE, ALEXANDER
2996 GASTON DR
LORIS, SC 29569

Check No.	0000626941
Check Date	09/21/2005
Check Amount	$152.52
Reference No.	104/0000015899

CLAIM #	LOSS DATE	CLAIMANT	LOCATION	REMARKS	AMOUNT
0000015899	05/05/05	GUICE, ALEXANDER	5D	FROM 09/05/05 TO 09/11/05	152.52

00447-00447

PMAC Risk Management, Inc.
Mailing Address: P.O. Box 200001 Woodstock, GA 30189-0001

US

GUICE, ALEXANDER
2996 GASTON DR
LORIS, SC 29569

Check No.	0000636377
Check Date	10/05/2005
Check Amount	$257.34
Reference No.	104/0000015899

CLAIM #	LOSS DATE	CLAIMANT	LOCATION	REMARKS	AMOUNT
0000015899	05/05/05	GUICE, ALEXANDER	SD	FROM 09/12/05 TO 09/18/05	257.34

00275-00275

MAC Risk Management, Inc.
Mailing Address: P.O. Box 200001 Woodstock, GA 30159-0400

US

GUICE, ALEXANDER
2996 GASTON DR
LORIS, SC 29569

Check No.	0000643274
Check Date	10/17/2005
Check Amount	$255.48
Reference No.	104/0000015899

CLAIM #	LOSS DATE	CLAIMANT	LOCATION	REMARKS	AMOUNT
0000015899	05/05/05	GUICE, ALEXANDER	5D	FROM 10/03/05 TO 10/09/05	255.48

00008-00008

PMC *Risk Management, Inc.*
Mailing Address: P.O. Box 200001 Woodstock, GA 30189-0400

RD

GUICE, ALEXANDER
2996 GASTON DR
LORIS, SC 29569

Check No.	0000650686
Check Date	10/27/2005
Check Amount	$250.41
Reference No.	104/0000015899

CLAIM #	LOSS DATE	CLAIMANT	LOCATION	REMARKS	AMOUNT
0000015899	05/05/05	GUICE, ALEXANDER	SD	FROM 10/10/05 TO 10/16/05	250.41

00287-00287

MAC Risk Management, Inc.
Mailing Address: P.O. Box 200001 Woodstock, GA 30189-0400

US

GUICE, ALEXANDER
2996 GASTON DR
LORIS, SC 29569

Check No.	0000653082
Check Date	11/01/2005
Check Amount	$250.41
Reference No.	104/0000015899

CLAIM #	LOSS DATE	CLAIMANT	LOCATION	REMARKS	AMOUNT
0000015899	05/05/05	GUICE, ALEXANDER	5D	FROM 10/17/05 TO 10/23/05	250.41

00341-00341

MAG *Risk Management, Inc.*
Mailing Address: P.O. Box 200001 Woodstock GA 30189-0400

US

GUICE, ALEXANDER
2996 GASTON DR
LORIS, SC 29569

Check No.	0000663408
Check Date	11/14/2005
Check Amount	$532.79
Reference No.	104/0000015899

CLAIM #	LOSS DATE	CLAIMANT	LOCATION	REMARKS	AMOUNT
0000015899	05/05/05	GUICE, ALEXANDER	5D	FROM 10/25/05 TO 11/02/05	532.79

P&C Risk Management, Inc.
Mailing address: P.O. Box 200987 Woodstock, GA 30159-0400

00884-00884

US

GUICE, ALEXANDER
2996 GASTON DR
LORIS, SC 29569

Check No: 0000680044
Check Date 12/02/2005
Check Amount $578.74
Reference No: 104/0000015899

CLAIM #	LOSS DATE	CLAIMANT	LOCATION	REMARKS	AMOUNT
0000015899	05/05/05	GUICE, ALEXANDER	5D	FROM 07/07/05 TO 10/27/05	578.74

00002-00002

MAC Risk Management, Inc.
Mailing Address: P O Box 200001 Woodstock, GA 30189-0100

RD

GUICE, ALEXANDER
2996 GASTON DR
LORIS, SC 29569

Check No.	0000678272
Check Date	12/01/2005
Check Amount	$2,370.24
Reference No.	104/0000015899

CLAIM #	LOSS DATE	CLAIMANT	LOCATION	REMARKS	AMOUNT
0000015899	05/05/05	GUICE, ALEXANDER	5D	FROM 11/07/05 TO 12/04/05	2,370.24

PAC Risk Management, Inc.
Mailing Address: P.O. Box 200001 Woodstock, GA 30189-0400

00883-00883

US

GUICE, ALEXANDER
2996 GASTON DR
LORIS, SC 29569

Check No.	0000680043
Check Date	12/02/2005
Check Amount	$1,185.12
Reference No.	104/0000015899

CLAIM #	LOSS DATE	CLAIMANT	LOCATION	REMARKS	AMOUNT
0000015899	05/05/05	GUICE, ALEXANDER	5D	FROM 12/05/05 TO 12/17/05	1,185.12

ATT. K

ROUTE TO:
1) Human Resources
2) Payroll (if applicable)

EMPLOYEE STATUS NOTICE (rev 03/2005)

(Hires/Changes/Transfers)

Effective Date	Employee ID (6 digits)	Name (First)	(Middle Initial)	(Last)
11/2/05	121674	Alexander		Guice

Section 1

Action(s)	Reason(s)	STD % if applicable
Termination	I09 - NO Position Avail Permanent lifting restrictions	n/a

Section 2

Comments/Special Processing

Termination of Employment- Released from Doctor with permanent lifting restrictions not comparable with job duties

Section 3

Job Information - Present (A)		Job Information - Proposed (B)	
Business Unit (5 digits) USF- Conway, S.C site	Job Code (5 chars)	Business Unit (5 digits)	Job Code (5 chars)
Position # (8 digits)	Grade	Position # (8 digits)	Grade
Job Title Delivery Driver		Job Title	
Department # (10 digits) and name Same		Department # (10 digits) and name	
Location (4 digits) and name Transportation		Location (4 digits) and name	
Conway, S C			

Section 4

General Employment Information - Complete if new hire, rehire, or changing

Reg/Temp:	Empl Class:	Union Code:	Employee Type:
☐ Regular ☐ Temporary	☐ Standard (blank) ☐ Commission ☐ Stepdown ☐ Incentive	☐ Non-Union ☐ Union Union Code:	☐ Salaried ☐ Hourly ☐ Exception Hourly (only commissioned
Full time / Part time: ☐ Full time — Std Work Hours ☐ Part time — Std Work Hours			
Current Pay Group	Current Tax Location (4 digits):	Proposed Pay Group:	Proposed Tax Location (4 digits)

Section 5

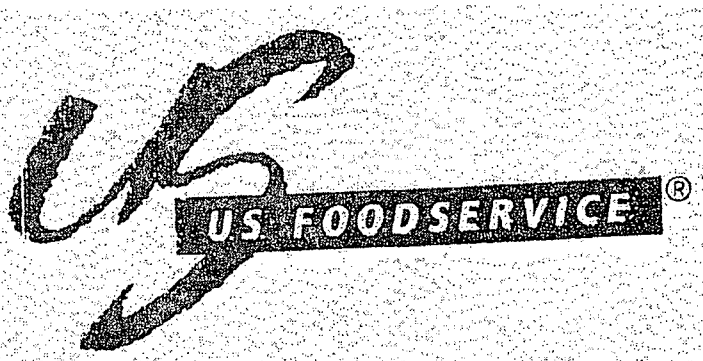
Compensation - Current (A)		Compensation - Proposed (B)		
Comp Rate Code ☐ NAANNL(annual) ☐ NAHRLY(hourly)		Comp Rate Code ☐ NAANNL(annual) ☐ NAHRLY(hourly)		
Comp Rate (annual amount or hourly rate)	Target Bonus %	Comp Rate (annual amount or hourly rate)	% Chg	Target Bonus
Additional Pay - Present (A)		**Additional Pay - Proposed (B)**		
Car Allowance	☐ Yes ☐ No Amount/pay period: $	Car Allowance	☐ Yes ☐ No Amount/pay period $	
Other (describe)	☐ Yes ☐ No Amount/pay period: $	Other (describe)	☐ Yes ☐ No Amount/pay period $	

Section 6

APPROVALS (some changes may require only some of the signatures indicated)

	Date		Date
Immediate Supervisor Mike Sanders	11/2/05	Division HR K Pollard	11-2-05
R A Bennett Division President	11/2/05	Zone or Region President (for exceptions or regional staff changes)	
		Region HR VP (for exceptions or regional staff changes)	
		Processed by HR Angela D. Middleton	11-4-05
Approvals for DIVISION TRANSFERS - Sending Division			
Division HR (sending division)	Date	Processed by Payroll	Date

ATT. L



March 9, 2006

To Whom It May Concern

Alexander Guice was employed by US Foodservice from October 1, 2001 to November 2, 2005. During that time Mr. Guice reported to work as scheduled and always responded to any company direction in a professional manner.

As mandated by law as a CDL driver he fell under DOT guideline for drug and alcohol testing. Mr. Guice left the company in 2005 because he could not longer perform the duties of a delivery driver.

If you have questions please call me.

K. K. Pollard

K. K. Pollard
VP Human Resources

P.O. Box 869 (29071)
120 Longs Pond Road
Lexington, SC 29072
803.951.4200

ATT. M

Your payment would be about

a month

at full retirement age

Alexander Guice

January 20, 2017

Your Social Security Statement

Your *Social Security Statement* tells you about **how much you or your family would receive** in disability, survivor, or retirement benefits. It also includes our record of your lifetime earnings. Check out your earnings history, and **let us know right away if you find an error**. This is important because we base your benefits on our record of your lifetime earnings.

Social Security benefits are **not intended to be your only source of income when you retire**. On average, Social Security will replace about 40 percent of your annual pre-retirement earnings. You will need other savings, investments, pensions, or retirement accounts to make sure you have enough money to live comfortably when you retire.

Carolyn W. Colvin
Acting Commissioner

Follow the Social Security Administration at these social media sites.

Your Earnings Record

Years You Worked	Your Taxed Social Security Earnings	Your Taxed Medicare Earnings
1987		
1988		
1989		
1990		
1991		
1992		
1993		
1994		
1995		
1996		
1997		
1998		
1999		
2000		
2001	44,386	44,386
2002	49,055	49,055
2003	53,137	53,137
2004	55,959	55,959
2005	38,173	38,173
2006	0	0
2007	0	0
2008	0	0
2009	0	0
2010	0	0
2011	0	0
2012	0	0
2013	0	0
2014	0	0
2015	0	0
2016	Not yet recorded	Not yet recorded

You and your family may be eligible for valuable benefits:

When you die, your family may be eligible to receive survivors benefits.

Social Security may help you if you become disabled—even at a young age.

A young person who has worked and paid Social Security taxes in as few as two years can be eligible for disability benefits.

Social Security credits you earn move with you from job to job throughout your career.

Total Social Security and Medicare taxes paid over your working career through the last year reported on the chart above:

Estimated taxes paid for Social Security:
You paid:
Your employers paid:

Estimated taxes paid for Medicare:
You paid:
Your employers paid:

Note: Currently, you and your employer each pay a 6.2 percent Social Security tax on up to $127,200 of your earnings and a 1.45 percent Medicare tax on all your earnings. If you are self-employed, you pay the combined employee and employer amount, which is a 12.4 percent Social Security tax on up to $127,200 of your net earnings and a 2.9 percent Medicare tax on your entire net earnings. If you have earned income of more than $200,000 ($250,000 for married couples filing jointly), you must pay 0.9 percent more in Medicare taxes.

Help Us Keep Your Earnings Record Accurate

You, your employer and Social Security share responsibility for the accuracy of your earnings record. Since you began working, we recorded your reported earnings under your name and Social Security number. We have updated your record each time your employer (or you, if you're self-employed) reported your earnings.

Remember, it's your earnings, not the amount of taxes you paid or the number of credits you've earned, that determine your benefit amount. When we figure that amount, we base it on your average earnings over your lifetime. If our records are wrong, you may not receive all the benefits to which you're entitled.

Review this chart carefully using your own records to make sure our information is correct and that we've recorded each year you worked. You're the only person who can look at the earnings chart and know whether it is complete and correct.

Some or all of your earnings from **last year** may not be shown on your *Statement*. It could be that we still were processing last year's earnings reports when your *Statement* was prepared. **Note:** If you worked for more than one employer during any year, or if you had both earnings and self-employment income, we combined your earnings for the year.

There's a limit on the amount of earnings on which you pay Social Security taxes each year. The limit increases yearly. Earnings above the limit will not appear on your earnings chart as Social Security earnings. (For Medicare taxes, the maximum earnings amount began rising in 1991. Since 1994, **all** of your earnings are taxed for Medicare.)

Call us right away at **1-800-772-1213** (7 a.m.-7 p.m. your local time, TTY **1-800-325-0778**) if any earnings for years **before last year** are shown incorrectly. Please have your W-2 or tax return for those years available. (If you live outside the U.S., follow the directions at the bottom of page 4.)

Your Estimated Benefits

***Retirement** You have earned enough credits to qualify for benefits. At your current earnings rate, if you continue working until...

your full retirement age (67 years), your payment would be about..... $ a month

age 70, your payment would be about..... $ a month

age 62, your payment would be about..... $ a month

***Disability** To get benefits if you become disabled right now, you need 24 credits of work, and 20 of these credits had to be earned in the last 10 years. Your record shows you do not have enough credits in the right time period.

***Family** If you get retirement or disability benefits, your spouse and children also may qualify for benefits.

***Survivors** You have earned enough credits for your family to receive survivors benefits. If you die this year, certain members of your family may qualify for the following benefits:

Your child..... $ a month

Your spouse who is caring for your child..... $ a month

Your spouse, if benefits start at full retirement age..... $ a month

Total family benefits cannot be more than..... $ a month

Your spouse or minor child may be eligible for a special one-time death benefit of $255.

Medicare You have enough credits to qualify for Medicare at age 65. Even if you do not retire at age 65, be sure to contact Social Security three months before your 65th birthday to enroll in Medicare.

*** Your estimated benefits are based on current law. Congress has made changes to the law in the past and can do so at any time. The law governing benefit amounts may change because, by 2034, the payroll taxes collected will be enough to pay only about 79 percent of scheduled benefits.**

We based your benefit estimates on these facts:

Your date of birth (please verify your name on page 1 and this date of birth)..... NONE

Your estimated taxable earnings per year after 2017.....

Your Social Security number (only the last four digits are shown to help prevent identity theft).....

How Your Benefits Are Estimated

To qualify for benefits, you earn "credits" through your work — up to four each year. This year, for example, you earn one credit for each $1,300 of wages or self-employment income. When you've earned $5,200, you've earned your four credits for the year. Most people need 40 credits, earned over their working lifetime, to receive retirement benefits. For disability and survivors benefits, young people need fewer credits to be eligible.

We checked your records to see whether you have earned enough credits to qualify for benefits. If you haven't earned enough yet to qualify for any type of benefit, we can't give you a benefit estimate now. If you continue to work, we'll give you an estimate when you do qualify.

What we assumed — If you have enough work credits, we estimated your benefit amounts using your average earnings over your working lifetime. For 2017 and later (up to retirement age), we assumed you'll continue to work and make about the same as you did in 2015 or 2016. We also included credits we assumed you earned last year and this year.

Generally, the older you are and the closer you are to retirement, the more accurate the retirement estimates will be because they are based on a longer work history with fewer uncertainties such as earnings fluctuations and future law changes. We encourage you to use our online Retirement Estimator to obtain immediate and personalized benefit estimates.

We can't provide your actual benefit amount until you apply for benefits. **And that amount may differ from the estimates above because:**

(1) Your earnings may increase or decrease in the future.

(2) After you start receiving benefits, they will be adjusted for cost-of-living increases.

(3) Your estimated benefits are based on current law. **The law governing benefit amounts may change.**

(4) Your benefit amount may be affected by **military service, railroad employment or pensions earned through work on which you did not pay Social Security tax.** Visit ***www.socialsecurity.gov*** to learn more.

Windfall Elimination Provision (WEP) — If you receive a pension from employment in which you did not pay Social Security taxes and you also qualify for your own Social Security retirement or disability benefit, your Social Security benefit may be reduced, but not eliminated, by WEP. The amount of the reduction, if any, depends on your earnings and number of years in jobs in which you paid Social Security taxes, and the year you are age 62 or become disabled. To estimate WEP's effect on your Social Security benefit, visit ***www.socialsecurity.gov/WEP-CHART***. In 2017, the maximum monthly reduction is $443. For more information, please see *Windfall Elimination Provision* (Publication No. 05-10045) at ***www.socialsecurity.gov/WEP***.

Government Pension Offset (GPO) — If you receive a pension based on federal, state or local government work in which you did not pay Social Security taxes and you qualify, now or in the future, for Social Security benefits as a current or former spouse, widow or widower, you are likely to be affected by GPO. If GPO applies, your Social Security benefit will be reduced by an amount equal to two-thirds of your government pension, and could be reduced to zero. Even if your benefit is reduced to zero, you will be eligible for Medicare at age 65 on your spouse's record. To learn more, please see *Government Pension Offset* (Publication No. 05-10007) at ***www.socialsecurity.gov/GPO***.

Some Facts About Social Security

About Social Security and Medicare...

Social Security pays retirement, disability, family and survivors benefits. Medicare, a separate program run by the Centers for Medicare & Medicaid Services, helps pay for inpatient hospital care, nursing care, doctors' fees, drugs, and other medical services and supplies to people age 65 and older, as well as to people who have been receiving Social Security disability benefits for two years or more. Your Social Security covered earnings qualify you for both programs. Medicare does not pay for long-term care, so you may want to consider options for private insurance. For more information about Medicare, visit ***www.medicare.gov*** or call **1-800-633-4227** (TTY **1-877-486-2048** if you are deaf or hard of hearing).

Retirement — If you were born before 1938, your full retirement age is 65. Because of a 1983 change in the law, the full retirement age will increase gradually to 67 for people born in 1960 and later.

Some people retire before their full retirement age. You can retire as early as 62 and take benefits at a reduced rate. If you work after your full retirement age, you can receive higher benefits because of additional earnings and credits for delayed retirement.

Disability — If you become disabled before full retirement age, you can receive disability benefits after six months if you have:

- enough credits from earnings (depending on your age, you must have earned six to 20 of your credits in the three to 10 years before you became disabled); and
- a physical or mental impairment that's expected to prevent you from doing "substantial" work for a year or more *or* result in death.

If you are filing for disability benefits, please let us know if you are on active military duty or are a recently discharged veteran, so that we can handle your claim more quickly.

Family — If you're eligible for disability or retirement benefits, your current or divorced spouse, minor children or adult children disabled before age 22 also may receive benefits. Each may qualify for up to about 50 percent of your benefit amount.

Survivors — When you die, certain members of your family may be eligible for benefits:

- your spouse age 60 or older (50 or older if disabled, or any age if caring for your children younger than age 16); and
- your children if unmarried and younger than age 18, still in school and younger than 19 years old, or adult children disabled before age 22.

If you are divorced, your ex-spouse could be eligible for a widow's or widower's benefit on your record when you die.

Extra Help with Medicare — If you know someone who is on Medicare and has limited income and resources, extra help is available for prescription drug costs. The extra help can help pay the monthly premiums, annual deductibles and prescription co-payments. To learn more or to apply, visit ***www.socialsecurity.gov*** or call **1-800-772-1213** (TTY **1-800-325-0778**).

Receive benefits and still work...

You can work and still get retirement or survivors benefits. If you're younger than your full retirement age, there are limits on how much you can earn without affecting your benefit amount. When you apply for benefits, we'll tell you what the limits are and whether work would affect your monthly benefits. When you reach full retirement age, the earnings limits no longer apply.

Before you decide to retire...

Carefully consider the advantages and disadvantages of early retirement. If you choose to receive benefits before you reach full retirement age, your monthly benefits will be reduced.

To help you decide the best time to retire, we offer a free publication, *When To Start Receiving Retirement Benefits* (Publication No. 05-10147), that identifies the many factors you should consider before applying. Most people can receive an estimate of their benefit based on their actual Social Security earnings record by using our online Retirement Estimator. You also can calculate future retirement benefits by using the Social Security Benefit Calculators at ***www.socialsecurity.gov***.

Other helpful free publications include:

- *Retirement Benefits* (No. 05-10035)
- *Understanding The Benefits* (No. 05-10024)
- *Your Retirement Benefit: How It Is Figured* (No. 05-10070)
- *Windfall Elimination Provision* (No. 05-10045)
- *Government Pension Offset* (No. 05-10007)
- *Identity Theft And Your Social Security Number* (No. 05-10064)

We also have other leaflets and fact sheets with information about specific topics such as military service, self-employment or foreign employment. You can request Social Security publications at our website, ***www.socialsecurity.gov***, or by calling us at **1-800-772-1213**. Our website has a list of frequently asked questions that may answer questions you have. We have easy-to-use online applications for benefits that can save you a telephone call or a trip to a field office.

You also may qualify for government benefits outside of Social Security. For more information on these benefits, visit ***www.benefits.gov***.

If you need more information — Contact any Social Security office, or call us toll-free at **1-800-772-1213**. (If you are deaf or hard of hearing, you may call our TTY number, **1-800-325-0778**.) If you have questions about your personal information, you must provide your complete Social Security Number. If you are in the United States, you also may write to the Social Security Administration, Office of Earnings Operations, P.O. Box 33026, Baltimore, MD 21290-3026. If you are outside the United States, please write to the Office of International Operations, P.O. Box 17769, Baltimore, MD 21235-7769, USA.

ATT. N

Department Of Veterans Affairs
5000 Wissahickon Avenue
P.O. Box 8079
Philadelphia, PA 19101

February 03, 2017

ALEXANDER GUICE
PO BOX 13281
TAMPA FL 33681

In Reply Refer To: TNH/310/NCC
CSS
Guice A

Dear Alexander Guice,

This letter is to confirm that the Veteran has been rated at 40% for a non-serviced connected lower back strain. The Department of Veteran Affairs does not allocate monetary benefits for non-serviced connected disability conditions.

Do You Have Questions or Need Assistance?

If you have any questions, you may contact us by telephone, e-mail, or letter.

If you	Here is what to do.
Telephone	For Compensation, call us at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 711. For Pension, call us at 1-877-294-6380.
Use the Internet	Send electronic inquiries through the Internet at https://iris.va.gov.
Write	Put your full name and VA file number on the letter. Please send all correspondence to the address below: Department of Veterans Affairs Evidence Intake Center PO Box 4444 Janesville, WI 53547-4444 Toll Free FAX: 1-844-531-7818 Local FAX: 248-524-4260

With sincere regard for the Veteran's service,

RO Director
VA Regional Office

To email us visit https://iris.va.gov

ATT. O

MEDICAL EVALUATION BOARD

CHIEF COMPLAINT: Bronchial asthma with allergic component

WHY REFERRED: This is a 26 year-old black male who is being seen for MEI assessment due to bronchial asthma with an allergic component. Due to the refractory nature of his condition and his requirement for medications or a daily basis he has not been able to run without experiencing shortness of breath. He is now referred to the disability system.

DATE OF PHYSICAL EXAMINATION: 25 JUN 97

ALL OTHER CONDITIONS:
1) Perennial allergic rhinitis
2) Nasal polyposis

MILITARY HISTORY: See attached 201 file.

HISTORY OF PRESENT ILLNESS: Symptoms of wheezing and shortness of breath were noted three years ago. The patient has been noted to have significant episodes of dyspnea with multiple emergency room visits requiring corticosteroid treatment. Despite treatment with pre-exercise Proventil and multiple inhaled preparations he has continued to exhibit chest symptoms and have difficulty with fast pace and long distance running. In addition he has had multiple exacerbations following upper respiratory infections. These multiple treatments did not result in any improvement of his clinical symptoms or his physical performance. The symptoms were also noted to be exacerbated with seasonal changes, cold weather and upon exposure to pollen inhalants. He has not required hospitalization however he has had multiple Emergency Room admissions.

MEDICATIONS:
1) Proventil 2 puffs prior to exercise and qid
2) Azmacort 4 puffs twice a day
3) Beconase nasal spray 2 sprays per nostril twice a day

PAST MEDICAL HISTORY: The soldier has smoked intermittently. The patient has no prior service history of asthma, symptoms of asthma, bronchitis, pneumonia, bronchiolitis, or prolonged cough lasting more than ten days.

Allergies: Penicillin

FAMILY HISTORY: Negative for allergic disease.

LIMONE C. COLLINS, COL, MC

☐ HISTORY & PHYSICAL EXAMINATION (SF 508, SF 509, & SF 510)	☐ OPERATION REPORT (SF 516)	NAME: GUICE, ALEXANDER SGT	
☐ CONSULTATION SHEET (SF 513)	☐ NARRATIVE SUMMARY (SF 502)	REGISTER NO.	WARD / SSN
☐ CHRON RECORD OF MEDICAL CARE (SF 600)	☐ AUTOPSY PROTOCOL (SF 503)	UNIT: 0187 IN BN 01 HHC	
☐ PROGRESS NOTE (SF 509)	☐	DATE DICT: 25 JUN 97	DATE TYPED: P:26 JUN 97/kw F:29 JUL 97/kw

BACH, FT CAMPBELL, KY 42223-5349

REVIEW OF SYSTEMS: Noncontributory

PHYSICAL EXAMINATION: In general this is a well developed, well nourished 26 year-old black male who appears in no acute distress. Height is 70 inches. Weight is 198 lbs. Blood pressure is 149/66. Pulse is 70. HEENT: Head is atraumatic. Eyes: PERRLA, EOMI. Ears: Tympanic membranes are clear bilaterally. Nose is hyperemic with swollen turbinates, clear mucoid secretions, no septal deviation. There had been polyps noted. Neck is supple without adenopathy and no thyromegaly. Throat is without erythema. There is postnasal drainage. Chest is symmetrical. Lungs are clear to auscultation, however on multiple occasions wheezing has been known particularly with force expiration. Heart: Regular rhythm with murmur. Abdomen is soft, no masses and no organomegaly. Bowel sounds are normoactive and nontender to palpation in all quadrants. Genitalia revealed normal male with testes descended bilaterally. Rectal exam revealed good tone. Musculoskeletal revealed good range of motion and good tone. Spine is without scoliosis. Extremities revealed good range of motion without deformities. Neurological: Cranial nerves II-XII are grossly intact. DTRs are 2+ bilaterally and negative Babinski, negative Romberg. Cerebellar is within normal limits. Motor and sensory are intact. Skin is without lesions.

LABORATORY AND X-RAY DATA: CBC, RPR, urinalysis and chest x-ray were normal. CT scan revealed that there was lobular areas of mucoperiosteal thickening seen in the maxillary antrum bilaterally. These may represent either mucous retention cyst or polyps. There is also a soft tissue mass seen in it to extend from the posterior aspect of the right middle turbinate which I suspects represents a nasal polyp. This has caused some displacement of the adjacent bony structures as described above.

Inhalant skin test revealed 2-4+ reaction to trees, 4+ reaction to molds. Spirometry was as follows: On 25 April 1997 baseline FVC was 3.66 liters (67.07%), FEV1 was 2.88 liters (63.44%), PEF was 6.58 liters per second (66.99%), FEF25-75 was 2.51 liters per second (51.93%). Post study obtained on that same date showed a FVC of 3.61 liters (66.01%), FEV1 was 3.33 liters (73.32%), PEF was 8.47 liters per second (86.16%), FEF25-75 was 4.32 liters per second (89.33%).

CONSULTATIONS: ENT service

HOSPITAL COURSE: The patient was evaluated as an outpatient.

Limone C. Collins

LIMONE C. COLLINS, COL, MC

☐ HISTORY & PHYSICAL EXAMINATION (SF 504, SF 505, & SF 506)	☐ OPERATION REPORT (SF 516)	NAME: GUICE, ALEXANDER SGT	
☐ CONSULTATION SHEET (SF 513)	☐ NARRATIVE SUMMARY (SF 502)	REGISTER NO. WARD	SSN
☐ CHRON RECORD OF MEDICAL CARE (SF 600)	☐ AUTOPSY PROTOCOL (SF 503)	UNIT: 0187 IN BN 01 HHC	
☐ PROGRESS NOTE (SF 509)		DATE DICT: 25 JUN 97	DATE TYPED: R:26 JUN 97/kw F:29 JUL 97/kw

BACH, FT CAMPBELL, KY 42223-5349

MEDICAL EVALUATION BOARD

PRESENT STATUS: This patient has bronchial asthma with multiple triggers to include airway allergens and exercise. He is not able to run without experiencing chest symptoms. His asthma has been exacerbated by multiple factors to include upper respiratory infections, pollen, and weather changes. He currently requires medication on a daily basis and in order to perform his physical training requirements. Despite treatment daily with multiple inhaled anti-asthma medication he continues to experience exercise related dyspnea. The persistence and chronicity of his condition for the past three years makes his prognosis for improvement unlikely. His reliance on medication in order to perform the standard physical training requirements of the United States Army makes him unacceptable for continual active duty military service.

DIAGNOSIS:
1) Bronchial asthma, adult onset, multiple triggers to include exercise and aero-allergens
2) Perennial allergic rhinitis
3) Nasal polyposis

PROFILE: P U L H E S
3 1 1 1 1 1

DUTY RESTRICTIONS: PT at own pace and distance.

RECOMMENDATIONS: It is my opinion that this individual is medically unacceptable under the provisions of AR 40-501, paragraph 3-27a, and his case should therefore be presented to the Physical Evaluation Board.

Limone C. Collins

LIMONE C. COLLINS, COL, MC

☐ HISTORY & PHYSICAL EXAMINATION (SF 504, SF 505, & SF 506)
☐ CONSULTATION SHEET (SF 513)
☐ CHRON RECORD OF MEDICAL CARE - (SF 600)
☐ PROGRESS NOTE (SF 509)
☐ OPERATION REPORT (SF 516)
☒ NARRATIVE SUMMARY (SF 508)
☐ AUTOPSY PROTOCOL (SF 508)
☐

NAME: GUICE, ALEXANDER SGT
REGISTER NO.: WARD
SSN:
UNIT: 0187 IN BN 01 HHC
DATE DICT: 25 JUN 97
DATE TYPED: P:26 JUN 97/kw P:29 JUL 97/kw

BACH, FT CAMPBELL, KY 42223-5349

ATT. P

5-27-04 STATEMENT

WHILE I WAS replacing the DUCTERS BACK in PLACE ON TRL 812, The top ceiling from the rear of the trailer CAME DOWN, hitting me in my upper BACK. I told my immediate Supervisor Carl PEAVY, who then, while I was present, Informed Mike SANDERS. A screw that was holding the CEILING UP WAS recovered by me from the ground, AND I turned it in to CARL PEAVY. I informed CARL PEAVY AND MIKE SANDERS that At the present time, I felt I DID not need to go to the Doctor or be checked. End of STATEMENT.

ALEXANDER EUICE

Alex [illegible]

ASSOCIATE INJURY/ILLNESS REPORT FORM

MAC 1st Report Fax #: 1-800-498-7768

U.S. Foodservice Safety Fax #: 1-864-213-8258 or E-mail to safety@usfood.com

All reports must be sent to MAC & Corp. Risk Management within 24 hours of the incident.

vision Name:	US FOODSERVICE	**Location Code:**	09-45
ıte employed:	SOUTH CAROLINA	**Date of Accident:**	5/27/04
se number from OSHA Log:			

Employer Information:

vision Address:	US FOODSERVICE - COLUMBIA DIVISION - 120 LONG POND ROAD LEXINGTON S.C. 29072
siness Phone Number & Extension:	803-845-8825
ture of Business:	FOODSERVICE DIST.

Confirmation Redirect: (Please send claim confirmation to Facility Contact:)

me:	PETE GARCIA - SAFETY CO-ORDINATOR		
one:	803-845-8825 EXT. 223	**E-mail Addr:**	
mments:			

Employee Information:

me:	Alexander Guice	**Social Security #:**	- -
dress:	2996 Gaston Dr.		
y, State and Zip:	Loris S.C. 29569		
sidence Phone:	843-756-6479	**Business Phone &Ext.:**	843-347-4691
te of Birth:		**Sex:** Male	**Marital Status:** Married
cupation or Job:	Foodservice --Delivery driver		**Shift:** Day
ter regular job title, not the specific activity he was performing at the time of injury			
gular Department:	Transportation		
pervisor:	Carl Peavy	**Date of Hire:**	10/1/01
g. Wkly Wage:	$1,146	**Is Employee - Hourly:** X	**Salaried:**
ıs work time lost?	No	**OSHA Recordable?** Yes	
ıt Day Worked:	5/27/04	**Days Away from Work:** None	
te Ret. to Work:	6/1/04	**Time Associate began work day:** 5:00 AM	**am/pm**
ıstricted Duty?	Yes	**Total Restricted Days:** 2-days	

APPELLANT'S EXHIBIT

A PAGE 1 OF 10

. Accident Information:

this an Injury? Yes **Illness?** **Type of Illness:**

ime of event: 2:45 PM **am/pm** **Date Reported:** 5/27/04

ame of supervisor/manager accident reported to: Carl Peavy

here did the event occur? e.g. loading dock north end Inside of trailer

as accident at Employer's Premises? No **If no, give location name:** Calabash West

ity, State and Zip Code: 2177 Roberts Ave. Lumberton N.C. 28359

this questionable? No **Is this a Fatality?** No **Date of Fatality:**

ctivity just before incident occurred: Employee was replacing center dividers in the trailer

Describe the activity, as well as the tools, equipment or material the employee was using

escription of accident: Employee was replacing center divider sections in the trailer when a rear section of the

Describe fully the events which resulted in the accident

iling section apparently came loose and fell striking him on the back

/hat caused the accident to occur: A support screw that was holding up the ceiling section had apparently

Name any objects or substances involved and tell how they were involved

me loose-

hat was the direct cause of injury: The ceiling support screws had come out allowing the ceiling to fall

Machine, tool, object or substance - *Example* - crane hoist, power saw, concrete floor, stairs, acid, chlorine, etc.

/hat were the secondary causes: As the center dividers were put back in this motion must have finished jarring

Give details on factors that contributed to the accident

se the ceiling section that had loose or defective support screws- Screws had backed out and fell to the floor

escribe injury or illness: Employee complains of soreness in his back and small of his neck

Tell body part affected & how affected. Indicate right or left if appropriate. *Ex* - strained back, chemical burn on left hand, etc.

as employee removed via ambulance? No

Physician/Hospital Information:

ame of Physician or Facility where treatment provided: Coastal Family Medicine

ddress: 8014 Myrtle Trace Drive **City:** Conway **State:** S C **Zip:** 29526

as employee treated in emergency room? No

as employee hospitalized overnight as an in-patient? No

Prevention/Corrective Action:

hat corrective actions have been taken to prevent a future occurrence? Raise awareness levels to all

vers of checking over these areas- Let the truck shop know of this type of problems to have them repaired- A VCR was

tten up to have the problem repaired- The piece of equipment was deadlined until this item could be repaired

viewed JSA Sec: **Date CA Compl.:** **By:**

Witness/Employee Information:

ame: None **Business Phone & Ext.:**

ddress: **City:** **State:** **Zip:**

itness / employee suggestion for prevention:

gnature: **Date:**

General Loss Information:

ame & Title of person reporting accident: Mike Sanders- Transportation Manger

eneral Remarks:

pprovals/Date **Manager:** 5/28/04 **Central Safety Committee:**

APPELLANT'S EXHIBIT

A PAGE 2 OF 10

Mike Sanders

05/28/2004 12:21 PM

To: John VanSteenbergh/5D/USFOOD/US/Ahold, Rick Bennett/5D/USFOOD/US/Ahold, Juan Nunez/5D/USFOOD/US/Ahold, Pete Garcia/5D/USFOOD/US/Ahold, Sean OBrien/5D/USFOOD/US/Ahold
cc: Alonzo Sarvis/5D/USFOOD/US/Ahold, Carl Peavy/5D/USFOOD/US/Ahold
Subject:

Sean,

Recently we have had two ceiling panels this week come loose from the ceilings in two of the trailers. One of which (trl 812) was the result of a Worker Comp injury. The Driver (Alex Guice) had finished for the day and was in the process of replacing a center panel that had been removed to allow more access to the rear of the trailer during the unloading process. At the end of the day as he put back in the center section the lowered ceiling panel came down on him. Apparently the mounting screws had worked loose during the day and allowed this last smaller section to come down. The Doctor said his muscle strain was probably from trying to get out of the way instead of the actual weight of the ceiling panel. The driver will probably be back to work monday if everything goes good. We had this trailer deadlined in Lexington until repairs can be made. The mounting screws were self tapping screws that were laying loose on the floor. Our plan is to use this in our next weekly safety meeting and will ask drivers to pay extra attention to these mountings and to write up on VCR's if they need repairing. You may want to pass on this info to the shop to pay extra attention to these on PM's. There seems to have been a few of these lately, maybe there is another way to secure these going forward.

Thanks,
Mike Sanders
Transportation Manager
Conway Region

PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS FORM

ent Name (First)	(Middle)	(Last)	Date of Injury/Illness:
Alexander		Garcia	5/27/04

TO BE COMPLETED BY ATTENDING PHYSICIAN

gnosis/Condition: acute muscle strain

ication: Lortab, Ibuprofen, Flexeril

ntial Side Effects:

v and treated this patient on 5/28/04 (Date) and based on the above description of the patient's current medical problem:

✓ Recommended his/her return to regular duty on 5/31/04 (Date)

✓ He/She may return to work on 5/29 capable of performing the degree of work checked below.

___ Unable to work with anticipated time off work _____

CHECK ONLY AS RELATED TO ABOVE CONDITIONS

___ **MEDIUM HEAVY WORK**
Lifting 65 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 40 lbs.

___ **MEDIUM WORK**
Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.

___ **LIGHT MEDIUM WORK**
Lifting 30 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 20 lbs.

___ **LIGHT WORK**
Lifting 20 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 10 lbs.

✓ **SEDENTARY WORK**
Lifting 10 lbs. maximum and occasionally lifting and/or carrying such articles as papers ledgers or small tools.

In an 8 hour work day patient may work a combined total of:

A. Stand/Walk: None; (1-4 Hours); 4-6 Hours; 6-8 Hours

B. Sit: (1-3 Hours); 3-5 Hours; 5-8 Hours

C. Drive: 1-3 Hours; 3-5 Hours; 5-8 Hours

Patient is able to:

	1-33% Occasionally	34-36% Frequently	37-100% Constantly
A. Bend	✓		
B. Squat	✓		
C. Climb	✓		
D. Twist	✓		
E. Reach	✓		
F. Push/Pull	✓		
G. Fine Manip.		✓	
H. Handling	✓		

ments/Other Restrictions:

If restricted, these restrictions are in effect until 5/31/04

s it probable the employee will return to their pre-injury occupation ✓ Yes ___ No ___ If no, please explain:

This patient will be reevaluated on as needed (Date)

[signature] (Date) 5/28/04

ian's Signature

5/28/04Return to work form-USFJSA

FROM :US FOODSERVICE   FAX NO. :843 347 3080   Jun. 01 2004 10:24AM P2

JONATHAN L DIETER M.D.
3014 MYRTLE TRACE DR
CONWAY, SC 29526

Tel 347 7...

Name Alexander Bruce   Age

Address

BELOW MUST APPEAR GREEN Date 6-1-04

R

DEA #

Return to full
duty 6-2-04

☐ Label

Refill ___ times PHN NR

M.D.   M.D.

Dispense as Written   Substitution Permitted

843-347-7271

YSICIAN'S RETURN TO WORK RECOMMENDATIONS

Name (First)	(Middle)	(Last)	Date of Injury/Illness:
Heather		Guack	5/27/04

TO BE COMPLETED BY ATTENDING PHYSICIAN

osis/Condition: R/o muscle strain - (C) rhomboid

ation: Vicodin 5/325 daily for 4 days - 25 pills prescribed

tial Side Effects: None of employment consequence

and treated this patient on 6/07/04 and based on the above description of the patient's current medical problem:
Date

Recommended his/her return to regular duty on 6/10/04
Date

✓ He/She may return to work on 6/08/04 capable of performing the degree of work checked below.

Unable to work with anticipated time off work _____

CHECK ONLY AS RELATED TO ABOVE CONDITIONS

MEDIUM HEAVY WORK
Lifting 65 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 40 lbs.

MEDIUM WORK
Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.

LIGHT MEDIUM WORK
Lifting 30 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 20 lbs.

✓ **LIGHT WORK**
Lifting 20 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 10 lbs.

SEDENTARY WORK
Lifting 10 lbs. maximum and occasionally lifting and/or carrying such articles as paper ledgers or small tools.

In an 8 hour work day patient may work a combined total of:

A. Stand/Walk: None; 1-4 Hours; 4-6 Hours; (6-8 Hours)

B. Sit: 1-3 Hours; 3-5 Hours; (5-8 Hours)

C. Drive: (1-3 Hours); 3-5 Hours; 5-8 Hours

Patient is able to :

	1-33% Occasionally	34-36% Frequently	37-100% Constantly
A. Bend			
B. Squat			
C. Climb			
D. Twist			
E. Reach			
F. Push/Pull			
G. Fine Manip.			
H. Handling			✓

mments/Other Restrictions:

If restricted, these restrictions are in effect until 6/10/04

Is it probable the employee will return to their pre-injury occupation ✓ Yes ____ No ____ If no, please explain:

This patient will be reevaluated on as needed
Date

[signature]
ysician's Signature

6/07/04
Date

12/31/03Return to work form-USFJSA

ATT. Q

GENEX
Solving the Cost/Care Equation

Initial Report: Medical Case Management

Report Date: September 23, 2005

Larry Grant
MAC Risk Management, Inc.
P O Box 200001
Woodstock, GA 30189-0400

Claimant Name: Alexander Guice
Social Security Number:
Claim #: 104/0000/5899/01-US
GENEX Case #: CNG38B
Employer: U S Food Service
Date of Injury: 05-May-2005
Date of Referral: 31-Aug-2005
Activity Dates: August 31st to September 23rd, 2005
Customer Name: MAC Risk Management, Inc.
GENEX Branch #: 141
Line of Insurance: Workers' Compensation
Case Type: FCM
Diagnosis:

846	SPRAINS&STRAINS SACROILIAC REGION

Date of Disability	RTWM Date	RTWF Date

Referral Reason: Medical case management services are requested to facilitate approved, appropriate, cost effective medical care and return the client to work.

Anticipated Case Results:

Results	Target Date	Completed Date
The Claimant will return to work in their pre-injury position with the insured	10/1/2005	
The Claimant will reach MMI	11/30/2005	

Case Management Interventions:

Activity Date: 31-Aug-2005 - 23-Sep-2005

Activity Date	Activity Note
8/31/2005	An introductory and disclosure letter was mailed to the client. The confirmation letter was sent to the carrier.
9/2/2005	I spoke to the adjuster and was advised that the EMG had been authorized. She requested I speak with Leeanne, paralegal for Mr. Bacon regarding authorization to contact the client.

GENEX
Solving the Cost/Care Equation

9/2/2005	I spoke with Leeanne, paralegal for Mr. Robert Bason, and received authorization to call and meet with the client. She stated that the client's concerns were the TTD checks, and she agreed to continue working on that concern.
9/2/2005	I spoke with Becky Padgett, who confirmed that the client is working light duty as a receiver in the Conway Warehouse. She stated that "permanent light duty" is not available, and that the client's light duty availability will expire in November. She stated that the client had been employed with them as a driver/deliverer since 2001. She agreed to provide a written job description.
9/2/2005	I received and reviewed the 6-page job description.
9/2/2005	I called Dr. Tamadon's office and confirmed the September 15th follow-up appointment for Mr. Alexander Guise.
9/2/2005	I attempted to call the client and received a busy signal.
9/14/2005	I called to confirm the client's follow up appointment. He will have the EMG and then I can meet with the client and Dr. Tamadon.
9/14/2005	I spoke with Mr. Guice and reminded him of the appointment for the EMG with Dr. Tamadon. I agreed to meet him at the appointment, and the location was confirmed. He continues to have right low back pain, headaches and neck pain, and right knee pain.
9/15/2005	I drove to the appointment to meet with Mr. Guice and Dr. Tamadon.
9/15/2005	I received and reviewed 12 pages of medicals dated June 16th, July 7th and 21st, August 18th and 25th, from Dr. Tamadon.
9/15/2005	I met with Mr. Guice and he agreed to discuss his medical condition with me, but declined signing the medical release authorization form. Mr. Guice continued working full time light duty, being paid at a different wage than his full time position. He is sending the adjuster copies of his check stub. Mr. Guice continues reporting right low back pain, which radiates to the buttocks. His pain increases with bending. He also has right neck pain, which worsens with turning his head to the right. He has headaches in the back of his head, and has right hand and knee pain.
9/15/2005	Dr. Tamadon diagnosed "head/neck pain, right knee pain, and right low back pain". I provided Dr. Tamadon with a copy of the full time job description. He recommended Mr. Guice return to work without restrictions on September 19th, 2005. Dr. Tamadon advised that physical therapy, oral medications and job modifications have been tried. He stated the EMG showed right carpal tunnel syndrome. He stated that if Mr. Guice continued to decline, that permanent restrictions may be necessary. A five-week follow-up appointment was coordinated for October 19th at 10:30 AM.
9/16/2005	I received and reviewed the September 15tth EMG study, and September 15th office documentation from Dr. Tamadon. The EMG shows "no electrodiagnostic evidence of acute cervical or lumbosacral motor radiculopathy; right carpal tunnel syndrome, and no evidence of other peripheral neuropathy, mononeuropathy, or plexopathy".
9/17/2005	I received a call from Alex (assistant to Dr. Tamadon), to confirm my receipt of the medicals. I rescheduled the follow up appointment for Mr. Guice to October 13th at 9:45AM.
9/19/2005	I provided a detailed update to the carrier, and agreed to forward a brief written

GENEX
Solving the Cost/Care Equation

	medical update.
9/23/2005	I spoke to the client who reported an increase in his pain and muscle soreness, since being back at work for the past week. He is taking the Ibuprofen three times per day, but not always with meals. He reports some gastrointestinal irritation, and I advised him to always take the Ibuprofen with food. He is taking two Hydrocodone in the evening and is doing his exercises. He reported continued headaches and shoulder muscle tightness, and moist heat and exercises were recommended. He stated that he uses Bengay and Biofreze, which helps with his pain. He voiced concern of not being as &fast with deliveries & quot as before. I advised Mr. Guice that he should see a gradual improvement with his symptoms and muscle strength, with time. I informed Mr. Guice of the change in appointments for October 13, 2005. He agreed to attend.
9/23/2005	A medical update was prepared for the carrier.
9/23/2005	The medical update was faxed to the adjuster.
9/23/2005	The medical update was faxed to Mr. Robert Bacon, attorney.
9/23/2005	Correspondence was forwarded to the client to keep him apprised of the follow up appointment with Dr. Guice.
9/23/2005	The initial report was completed.

Current Medical Status: Mr. Guice continues with cervical and lumbar pain, headaches, muscle spasms, right knee pain, headaches, and right arm pain. He was working full time light duty, and returned to work without restrictions on September 19th. He reports an increase in his symptoms since the limitations have been lifted

Past Medical History: Mr. Guice smokes a pack of cigarettes per week, and has an occasional alcohol beverage. He has asthma and uses an over the counter inhaler.

Current Treatment Plan:

Provider	Service	Frequency	Cost	Start Date	Anticipated Duration	End Date
Dr. Tamadon		Monthly			NA	10/05

Name	Dosage	Purpose	Prescribing Physician	End Date
Flexeril	10 mg	muscle relaxant	Dr. Tamadon	11/30/2005
Hydrocodone	10/650	pain management	Dr. Tamadon	11/30/2005
Ibuprofen	200 mg	anti-inflammatory	Dr. Tamadon	11/30/2005

ADL/Safety: Mr. Guice denied any safety issues.

Socioeconomic: Mr. Guice is married to Pamela.

Current Work Status: Full Duty

GENEX
Solving the Cost/Care Equation

Vocational History:

Employer	Job Title	SOC Code	Years Employed	Salary Duration	Salary Amount	Job at Time of Injury	Job Functions
U S Foods	driver/ delivery		4			N	Drives 32'-38' trailer and delivers food products.
Creek Carrier	truck driver		1			N	long haul driver
Transport America			1 1/2			N	truck driver

Institution	Degree/Diploma/Certification	Years Attended
Brandon High School	none obtained	11
Technical College	GED	1

Legal: Mr. Guice is represented by Mr. Robert Bacon.

Case Management Plan

Case Management Issues:

Issue	Date Identified	Date Resolved
Long term treatment needs to be identified.	9/15/2005	
Work restrictions, if any, need to be clarified.	9/15/2005	
MMI and PPI need to be defined.	9/15/2005	

Case Management Goals:

Goals	Target Date	Completed Date
LTG: The Claimant will return to their pre-injury position with the insured.	10/1/2005	
STG: The Claimant will verbalize understanding of treatment plan	10/15/2005	
LTG: The Claimant will reach MMI/PPI	11/30/2005	

GENEX
Solving the Cost/Care Equation

Case Management Recommendations:

1. I will maintain contact with the client to assess his response to the current treatment plan, by September 30, 2005.
2. I will discuss any employment issues with the insured by September 30, 2005.
3. I will attend the October 13th appointment with Dr. Tamadon and the client to confirm long term treatment, work restrictions, MMI and PPI.
4. I will copy all reports and correspondence to Mr. Bacon and be available for4 phone consultation should the need arise by October 15, 2005.
5. I will provide an update to the adjuster and discuss file direction by October 14, 2005.

Next Report Date: October 15, 2005

Submitted By: Cathy Dayton, RN, CCM
(704)-568-7187, 3623

Supervised By: Debra Gray, BA, M Ed, CRC, CCM

CD/sbm

cc. Robert Bacon
P O Box 2740
Myrtle Beach, SC 29578-2740

ATT. R

MAYO CLINIC

Drugs and Supplements

Hydrocodone And Acetaminophen (Oral Route)

Description and Brand Names

Drug information provided by: Micromedex

US Brand Name

Anexsia
Ceta Plus
Co-Gesic
Dolorex Forte
Hycet
Lorcet
Lortab
Maxidone
Norco
Stagesic
Vicodin HP
Zydone

Descriptions

Hydrocodone and acetaminophen combination is used to relieve moderate to moderately severe pain.

Acetaminophen is used to relieve pain and reduce fever in patients. It does not become habit-forming when taken for a long time. But acetaminophen may cause other unwanted effects when taken in large doses, including liver damage.

Hydrocodone belongs to the group of medicines called narcotic analgesics (pain medicines). It acts on the central nervous system (CNS) to relieve pain, and stops or prevents cough.

When hydrocodone is used for a long time, it may become habit-forming, causing mental or physical dependence. However, people who have continuing pain should not let the fear of dependence keep them from using narcotics to relieve their pain. Mental dependence (addiction) is not likely to occur when narcotics are used for this purpose. Physical dependence may lead to withdrawal side effects if treatment is stopped suddenly. However, severe withdrawal side effects can usually be prevented by gradually reducing the dose over a period of time before treatment is stopped completely.

This medicine is available only with your doctor's prescription.

This product is available in the following dosage forms:

- Tablet
- Solution
- Syrup
- Elixir
- Capsule
- Liquid

Before Using

In deciding to use a medicine, the risks of taking the medicine must be weighed against the good it will do. This is a decision you and your doctor will make. For this medicine, the following should be considered:

Allergies

Tell your doctor if you have ever had any unusual or allergic reaction to this medicine or any other medicines. Also tell your health care professional if you have any other types of allergies, such as to foods, dyes, preservatives, or animals. For non-prescription products, read the label or package ingredients carefully.

Pediatric

Appropriate studies have not been performed on the relationship of age to the effects of hydrocodone and acetaminophen capsules and tablets in the pediatric population. Safety and efficacy have not been established.

Appropriate studies performed to date have not demonstrated pediatric-specific problems that would limit the usefulness of hydrocodone and acetaminophen oral solution in children. However, safety and efficacy have not been established in children younger than 2 years of age.

Geriatric

Appropriate studies performed to date have not demonstrated geriatric-specific problems that would limit the usefulness of hydrocodone and acetaminophen combination in the elderly. However, elderly patients are more likely to have confusion and drowsiness, and age-related liver, kidney, or heart problems, which may require caution and an adjustment in the dose for patients receiving hydrocodone and acetaminophen combination.

Pregnancy

- Adults—
  - Lortab®: One tablet every 4 to 6 hours as needed. Your doctor may increase your dose as needed. However, the dose is usually not more than 6 tablets per day.
  - Generic: Dose depends on the strength of the tablet and must be determined by your doctor.
- Children—Use and dose must be determined by your doctor.

Missed Dose

If you miss a dose of this medicine, take it as soon as possible. However, if it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do not double doses.

Storage

Store the medicine in a closed container at room temperature, away from heat, moisture, and direct light. Keep from freezing.

Keep out of the reach of children.

Do not keep outdated medicine or medicine no longer needed.

Ask your healthcare professional how you should dispose of any medicine you do not use.

Precautions

It is very important that your doctor check the progress of you or your child while using this medicine. This will allow your doctor to see if the medicine is working properly and to decide if you or your child should continue to take it.

It is against the law and dangerous for anyone else to use your medicine. Keep your unused tablets in a safe and secure place. People who are addicted to drugs might want to steal this medicine.

This medicine will add to the effects of alcohol and other CNS depressants (medicines that can make you drowsy or less alert). Some examples of CNS depressants are antihistamines or medicine for allergies or colds, sedatives, tranquilizers, or sleeping medicine, other prescription pain medicine or narcotics, medicine for seizures or barbiturates, muscle relaxants, or anesthetics, including some dental anesthetics. Also, there may be a greater risk of liver damage if you drink three or more alcoholic beverages while you are taking acetaminophen. Do not drink alcoholic beverages, and check with your doctor before taking any of these medicines while you are using this medicine.

This medicine may be habit-forming. If you feel that the medicine is not working as well, do not use more than your prescribed dose.

Check with your doctor right away if you have pain or tenderness in the upper stomach, pale stools, dark urine, loss of appetite, nausea, unusual tiredness or weakness, or yellow eyes or skin. These could be symptoms of a serious liver problem.

Serious skin reactions can occur with this medicine. Check with your doctor right away if you have blistering, peeling, or loose skin, red skin lesions, severe acne or skin rash, sores or ulcers on the skin, or fever or chills while you are using this medicine.

This medicine may cause a serious type of allergic reaction called anaphylaxis. Anaphylaxis can be life-threatening and requires immediate medical attention. Call your doctor right away if you have a rash, itching, hoarseness, trouble breathing, trouble swallowing, or any swelling of your hands, face, or mouth while you are using this medicine.

This medicine may make you dizzy, drowsy, or lightheaded. Make sure you know how you react to this medicine before you drive, use machines, or do anything else that could be dangerous if you are dizzy or not alert.

Using narcotics for a long time can cause severe constipation. To prevent this, your doctor may direct you or your child to take laxatives, drink a lot of fluids, or increase the amount of fiber in your diet. Be sure to follow the directions carefully, because continuing constipation can lead to more serious problems.

Before you or your child have any medical tests, tell the medical doctor in charge that you are taking this medicine. The results of certain tests may be affected by this medicine.

Do not change your dose or suddenly stop using this medicine without first checking with your doctor. Your doctor may want you or your child to gradually reduce the amount you are using before stopping it completely. This may help prevent worsening of your condition and reduce the possibility of withdrawal symptoms, such as abdominal or stomach cramps, anxiety, fever, nausea, runny nose, sweating, tremors, or trouble with sleeping.

Using this medicine while you are pregnant may cause the neonatal withdrawal syndrome in your newborn baby. Tell your doctor right away if your child has the following symptoms: an abnormal sleep pattern, diarrhea, a high-pitched cry, irritability, shakiness or tremors, sneezing, weight loss, vomiting, yawning, or failure to gain weight.

Do not take other medicines unless they have been discussed with your doctor. This includes prescription or nonprescription (over-the-counter [OTC]) medicines and herbal or vitamin supplements.

Side Effects

Along with its needed effects, a medicine may cause some unwanted effects. Although not all of these side effects may occur, if they do occur they may need medical attention.

Check with your doctor immediately if any of the following side effects occur:

More common

- Dizziness
- lightheadedness

Incidence not known

- Back, leg, or stomach pains
- black, tarry stools
- bleeding gums
- blood in the urine or stools
- blood in vomit
- bluish lips or skin
- chills
- choking
- cough or hoarseness
- dark urine
- decrease in the frequency of urination
- decrease in urine volume
- difficult or troubled breathing
- difficulty in passing urine (dribbling)
- difficulty with breathing
- difficulty with swallowing
- fast heartbeat
- fever
- fever with or without chills
- general body swelling
- general feeling of tiredness or weakness
- headache
- irregular, fast or slow, or shallow breathing
- light-colored stools
- loss of appetite
- lower back or side pain
- nausea or vomiting
- nosebleeds
- not breathing
- painful or difficult urination
- pale or blue lips, fingernails, or skin
- pinpoint red spots on the skin
- puffiness or swelling of the eyelids or around the eyes, face, lips, or tongue
- severe or continuing stomach pain
- shortness of breath or troubled breathing
- skin rash, hives, or itching
- sore throat
- sore tongue
- sores, ulcers, or white spots on the lips or in the mouth
- tightness in the chest
- unable to speak
- unusual bleeding or bruising
- unusual tiredness or weakness
- upper right abdominal or stomach pain
- yellow eyes and skin

Get emergency help immediately if any of the following symptoms of overdose occur:

Symptoms of overdose

- Bloody or cloudy urine
- change in consciousness
- chest pain or discomfort

- cold and clammy skin
- decreased awareness or responsiveness
- extreme drowsiness
- general feeling of discomfort or illness
- increased sweating
- irregular heartbeat
- lightheadedness, dizziness, or fainting
- loss of consciousness
- no blood pressure or pulse
- no muscle tone or movement
- not breathing
- severe sleepiness
- slow or irregular heartbeat
- stopping of heart
- sudden decrease in the amount of urine
- unconsciousness
- unpleasant breath odor

Some side effects may occur that usually do not need medical attention. These side effects may go away during treatment as your body adjusts to the medicine. Also, your health care professional may be able to tell you about ways to prevent or reduce some of these side effects. Check with your health care professional if any of the following side effects continue or are bothersome or if you have any questions about them:

More common

- Drowsiness
- relaxed and calm
- sleepiness

Incidence not known

- Belching
- changes in mood
- difficulty having a bowel movement (stool)
- fear or nervousness
- feeling of indigestion
- hearing loss
- impaired hearing
- pain in the chest below the breastbone
- unusual drowsiness, dullness, tiredness, weakness, or feeling of sluggishness

Other side effects not listed may also occur in some patients. If you notice any other effects, check with your healthcare professional.

Call your doctor for medical advice about side effects. You may report side effects to the FDA at 1-800-FDA-1088.

ATT. S

Drugs.com
Know more. Besure.

Flexeril Side Effects

Generic Name: *cyclobenzaprine*

Note: This page contains information about the side effects of cyclobenzaprine. Some of the dosage forms included on this document *may not* apply to the brand name Flexeril.

In Summary

Common side effects of Flexeril include: drowsiness and xerostomia. **Other side effects include:** fatigue. See below for a comprehensive list of adverse effects.

For the Consumer

Applies to cyclobenzaprine: oral capsule extended release, oral suspension, oral tablet

In addition to its needed effects, some unwanted effects may be caused by cyclobenzaprine (the active ingredient contained in Flexeril). In the event that any of these side effects do occur, they may require medical attention.

Major Side Effects

You should check with your doctor immediately if any of these side effects occur when taking cyclobenzaprine:

Rare

- Clumsiness or unsteadiness
- confusion
- fainting
- mental depression
- problems in urinating
- ringing or buzzing in the ears
- skin rash, hives, or itching occurring without other symptoms of an allergic reaction listed above
- unusual thoughts or dreams
- yellow eyes or skin

If any of the following symptoms of overdose occur while taking cyclobenzaprine, get emergency help immediately:

Symptoms of overdose:

- Convulsions (seizures)
- drowsiness (severe)
- dry, hot, flushed skin
- fast or irregular heartbeat
- hallucinations (seeing, hearing, or feeling things that are not there)
- increase or decrease in body temperature
- troubled breathing
- unexplained muscle stiffness
- unusual nervousness or restlessness (severe)
- vomiting (occurring together with other symptoms of overdose)

Minor Side Effects

Some of the side effects that can occur with cyclobenzaprine may not need medical attention. As your body adjusts to the medicine during treatment these side effects may go away. Your health care professional may also be able to tell you about ways to reduce or prevent some of these side effects. If any of the following side effects continue, are bothersome or if you have any questions about them, check with your health care professional:

More common:

- Blurred vision
- dizziness, drowsiness, or lightheadedness
- dryness of the mouth

Less common or rare:

- Bloated feeling or gas, indigestion, nausea or vomiting, or stomach cramps or pain
- constipation
- diarrhea
- excitement or nervousness
- frequent urination
- general feeling of discomfort or illness
- headache
- muscle twitching
- numbness, tingling, pain, or weakness in hands or feet
- pounding heartbeat
- problems in speaking

- trembling
- trouble sleeping
- unpleasant taste or other taste changes
- unusual muscle weakness
- unusual tiredness

For Healthcare Professionals

Applies to cyclobenzaprine: compounding powder, oral capsule extended release, oral tablet, oral and topical kit

General

The most frequently occurring adverse reactions have included dry mouth, dizziness, fatigue, constipation, nausea, dyspepsia, and somnolence.[Ref]

Nervous system

Very common (10% or more): Drowsiness (up to 38%)
Common (1% to 10%): Dizziness, somnolence
Postmarketing reports: Headache, serotonin syndrome, seizures, ataxia, tremors, hypertonia, convulsions, abnormal sensations, paresthesia, ageusia[Ref]

Elderly patients may be particularly susceptible to the sedation and confusion which may accompany cyclobenzaprine therapy.[Ref]

Psychiatric

Common (1% to 10%): Irritability, mental acuity decreased, nervousness
Postmarketing reports: Nervousness, confusion, disorientation, insomnia, depressed mood, anxiety, agitation, psychosis, abnormal thinking and dreaming, hallucinations, excitement[Ref]

Hypersensitivity

Postmarketing reports: Anaphylaxis, angioedema, pruritus, facial edema, urticaria, rash[Ref]

Gastrointestinal

Very common (10% or more): Dry mouth (up to 32%)
Common (1% to 10%): Constipation, nausea, dyspepsia, abdominal pain, acid regurgitation, diarrhea
Postmarketing reports: Unpleasant taste, vomiting, anorexia, gastritis, thirst, flatulence, tongue edema [Ref]

Hepatic

Postmarketing reports: Abnormal liver function, hepatitis, jaundice, cholestasis[Ref]

Cardiovascular

Postmarketing reports: Syncope, tachycardia, arrhythmia, vasodilation, palpitation, hypotension[Ref]

Other

Common (1% to 10%): Fatigue
Postmarketing reports: Asthenia, malaise, vertigo[Ref]

Dermatologic

Postmarketing reports: Sweating[Ref]

Genitourinary

Postmarketing reports: Urinary frequency and/or retention[Ref]

Musculoskeletal

Postmarketing reports: Local weakness, dysarthria, muscle twitching[Ref]

Ocular

Postmarketing reports: Blurred vision, diplopia, tinnitus[Ref]

Respiratory

Common (1% to 10%): Upper respiratory infection, pharyngitis[Ref]

References

1. "Product Information. Amrix (cyclobenzaprine)." A-S Medication Solutions, Chicago, IL.
2. "Product Information. Flexeril (cyclobenzaprine)." Merck & Co, Inc, West Point, PA.

Not all side effects for Flexeril may be reported. You should always consult a doctor or healthcare professional for medical advice. Side effects can be reported to the FDA **here**.