

RECEIVED
FEB 15 2018
SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA
In The Court Of Appeals

APPEAL FROM SOUTH CAROLINA WORKER'S COMPENSATION
FULL APPELLATE PANEL

Case No. 2016-000598

Clarence B. Jenkins Jr., Employee,Appellant,

v.

Amazon.Com DEDC, LLC, Employer and
American Zurich Ins. Co., Carrier,Respondents.

APPELLANT'S MOTION TO SUBMIT PERTINENT
DOCUMENTS AGAINST RESPONDENTS DISTORTIONS
DECLARING VIOLATIONS OF RULE 4.1 AND RULE 8.2

Appellant is providing this COURT again with verification of distortions that was submitted by Respondents to deceived which was granted. Respondents and South Carolina Worker's Compensation Commission had pertinent documents. Appellant was required to disregard documentations by this COURT with an ORDER dated October 25, 2016 and others. Appellant was denied submission to South Carolina Worker's Compensation Commission at May 21, 2015 and December 14, 2015 hearings. Appellant was required to resubmit documentations without pertinent facts to the COURT because of distortions that was costly, financial burdensome and pure harassment. Appellant is again declaring attorneys for Respondents to be in violations of Rule 4.1 and Rule 8.2.

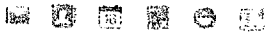
Appellant has spent substantial amount of money to submit motions in fighting distortions by Respondents and should not be required to provide this COURT with any additional fees but argued that a refund is due to me because of a continued fight against injustice that has been extremely costly when being of indigent status and prior notification was provided. Furthermore, Respondents has admitted to this COURT by most recent motions some of their distortions. Respondents and South Carolina Worker's Compensation Commission had these medical records through submission or by a subpoena. Appellant has been denied a proper defense of his worker's compensation claim. See attachments

WHEREFORE, Appellant's request this COURT received additional verifications of pertinent documentations of Respondents' distortions to deny fairness and justice which should be declared as violations of Rule 4.1 and Rule 8.2.

February 13, 2018



Clarence B. Jenkins Jr.
Clarence B. Jenkins Jr.
945 Wire Rd.
Neeses, South Carolina 29107
(803) 263-4514
Pro Se Appellant



Compose

Search results Delete Move Spam More Collapse All

Please reply (3)

Shopping

Clarence Jr To elliotm@amazon.com

Jul 23, 2013

Dear Michele:

I just spoke with safety manager (Mr. Carter) and he stated that my return date can not be allowed until more information is received from the Dr. Eden. It is my understanding that Dr. Eden will not return until July 29, 2013 and will receive more information at that time from Amazon. Mr. Carter stated that he has informed Trina Smith and human resources about the situation with Dr. Eden medical documentation. Mr. Carter stated that Ms. Trina also needed more clarification from Dr. Eden on medical documentation and had advised that I speak with human resources to determine any other matters at this time.

Please send a response.

Thanks,

Clarence Jenkins Jr.

Reply, Reply All or Forward | More

Elliott, Michele To Clarence Jr CC Smith, Trina

Jul 23, 2013

Hi Clarence,

Correct. Trina has advised the site that you are to remain off work until Dr. Eden returns back to the office and is able to provide clarification regarding your restrictions.

I'm am not aware of any additional information that HR needs at this time.

Thanks, Michele

Show original message

Reply, Reply All or Forward | More

Clarence Jr Thanks

Jul 23, 2013

Click to reply all

Send icons for text formatting and attachments

- Inbox (240) Drafts (112) Sent Spam (331) Trash (60) Smart Views Unread Starred People Social Travel Shopping Finance

- > Folders > Recent



More Games »

amazon

Health Care Provider Request for Medical Information (RMI)

NWR (SK)

4/23/13

NOTE TO EMPLOYEE: You must provide a copy of this completed report to the HR LOA Team by

SECTION I: COMPLETED BY THE EMPLOYEE/PATIENT

Employee Name (Please Print): CLARENCE JENKINS	Employee Phone Number: 803 747-4185	Date: Injury/Illness Commenced: 2/10/2013
HR Contact Name / Phone Number	Scan/Email	Tax Number (toll-free): 791-6536

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

SECTION II: COMPLETED BY THE HEALTH CARE PROVIDER

Patient's Name (Please Print): CLARENCE M JENKINS	Date of Examination (month/day/year): 5/7/2013
Identify the injury or illness for which treatment is sought: POST CONCUSSION SYNDROME	
Approximate beginning date of the period of incapacity: 2/10/2013	Approximate end date of the period of incapacity: UNDETERMINED
<input checked="" type="checkbox"/> Work-Related <input type="checkbox"/> Not Work-Related <input type="checkbox"/> Undetermined	<input type="checkbox"/> Pre-Existing Injury/Illness <input checked="" type="checkbox"/> New Injury/Illness <input type="checkbox"/> Undetermined
Was medication, other than over-the-counter medication prescribed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If the patient will be under the influence of the medication during working hours, please describe side effects that could impair the patient's ability to work:
Will additional treatments be required? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please provide a description of the general type of treatment you anticipate: REFERRAL VIA WORKMEN'S COMP. TO NEUROLOGIST
Does this condition substantially limit the patient's ability to perform major life activities? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please identify the major life activity (or activities) affected, and describe how the condition substantially limits that major life activity: UNDETERMINED

SELECT ONE (1) OPTION:

<input checked="" type="checkbox"/> UNABLE TO RETURN TO WORK: Please note: If you check this box, Amazon will require an additional update before the employee is released.	Estimated Return to Work Date: UNDETERMINED TO BE DECIDED BY NEUROLOGIST	Date of Next Visit: PENDING
<input type="checkbox"/> EMPLOYEE CAN RETURN TO WORK:	Date Employee is Released to Return to Work Without Restrictions:	
<input type="checkbox"/> WITHOUT WORK RESTRICTIONS Please complete page 1 only		
<input type="checkbox"/> WITH WORK RESTRICTIONS Please complete page 2 AND indicate how long the restrictions are in place.	Date Employee is Released to Return to Work With Restrictions:	

SECTION III: HEALTH CARE PROVIDER SIGNATURE AND CONTACT INFORMATION

Health Care Provider's Name/Title (Print): SHARON I EDEN MD	Address: 1241 Solomon Blatt Blvd
Health Care Provider's Signature: <i>[Signature]</i>	City, State, ZIP: Denmark SC 29042
Date: 5/7/13	Phone: (803) 793-4232
	Fax: (803) 793-6346

NWR JK 4/23/13

Employee Name (Please Print):

Hours worked per shift:

SECTION IV: WORK RESTRICTIONS

Ability of Patient: (percentages indicate the proportion of the patient's shift the patient can perform the function)		Fully Restricted	25%	50%	75%	Not Restricted	If Temporary Restricted Until?	Permanent
1	a. Lift up to 5 lbs. (circle one) Left, Right, Both	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	b. Lift 5 - 10 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	c. Lift 11 - 20 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	d. Lift 21 - 30 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	e. Lift 31 - 50 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
2	a. Push/Pull up to 5 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	b. Push/Pull 5 - 10 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	c. Push/Pull 11 - 20 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	d. Push/Pull 21 - 30 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	e. Push/Pull 31 - 50 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
3	a. Overhead Reach L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	b. At Sho	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	c. Below	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	d. Rotatio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
4	a. Bend/t	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	b. Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	c. Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	d. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
5	a. Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	b. Stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	c. Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	d. Climb s	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	e. Climb l	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
6	a. Use hai	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	b. Do simp such as gr	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	c. Do force such as us (>15 inch-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
7	a. See	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	b. Hear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	c. Talk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

Intentionally left blank only page 1 needed to be completed



8 Can the patient work more than 40 hours within a week? YES NO
If no, please indicate the number of hours the patient can work: _____ hours/day _____ hours/week

9 Can the patient drive commercial machinery such as a delivery van, forklift, reach truck, scissor lift or truck? YES NO

10 Does the patient have any work restrictions related to a psychological or mental condition? YES NO

11 Please describe any other recommended work restrictions or temporary work accommodations, whether related to the patient's mental or physical condition, medication, or treatment considerations:

SECTION V: ADDITIONAL TREATMENT CONSIDERATIONS (check and describe if applicable)

Splint/Brace Crutches Neck/Lumbar Support Location and description of device (soft or hard, open toe or closed toed boot, arm, wrist, etc.):

Heat Ice Elevate Physical Therapy Duration and frequency:

Request For Medical Information Letter

Amazon.com

Date: August 14, 2013
To: Clarence Jenkins
From: Michelle Doyle
Subject: Request for Medical Information

On August 14, 2013, we became aware of your medical condition/restrictions that may limit your current physical capabilities to perform your normal job duties. We would like to work with you to ensure we fully understand these medical restrictions so as to be able to correctly evaluate their impact on your current job duties. As such, we need to ask you to provide additional information from your healthcare provider.

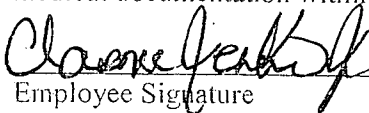
The Request for Medical Information (RMI) form is necessary for us to evaluate the jobs you may be able to safely perform. By the way of this letter,

- **we are provisionally placing you off work for a period of time no longer than seven (7) calendar days until we receive a Request for Medical Information (RMI) form completed by your healthcare provider.**

For your convenience, a Request for Medical Information (RMI) form is attached to this letter. Please return the signed and completed Request for Medical Information (RMI) form to HR within seven calendar days from the date of this letter. Failure to return this form with seven calendar days may result in unexcused absences from work and disciplinary action, up to and including termination may occur. If you have any questions or concerns, please feel free to contact any member of the HR department.

In addition, a copy of the Health Care Provider Request for Medical Information (RMI) form is enclosed, and is to be completed by your health care provider. The RMI is due on or before August 21, 2013. The form can be faxed to 803.791.6583.

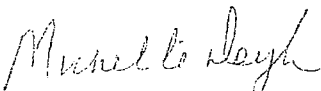
I acknowledge that I have reviewed the contents of this letter and understand that I must return the requested medical documentation within seven calendar days.


Employee Signature

8-14-13
Date

Please feel free to contact me if you any questions or concerns.

Sincerely,



Michelle Doyle, HRBP
Human Resources, Amazon.com
Phone Number: 803.791.6554
Fax Number: 803.791.6583
Email Address: doylemic@amazon.com

Attachments:

Health Care Provider Request for Medical Information (RMI) form

Health Care Provider Request for Medical Information (RMI)

To Be Used For Disability Accommodation & Fitness for Return to Work
Please return completed form via fax 803-791-6511 or email cae1-hr@amazon.com

NOTE TO EMPLOYEE: You must provide a copy of this completed report to the LOAA Team as specified in the accompanying letter or prior to the end of your leave of absence and before return to work.

SECTION I: EMPLOYEE/PATIENT INFORMATION: THIS SECTION TO BE COMPLETED BY THE EMPLOYEE/PATIENT

Employee Name (Please Print) Clarence Jenkins Jr		Employee Login: JenkinsC	Date Injury/Illness Commenced (month/day/year) 2-10-13
HR Contact Name Michelle Doyle		Scan/E-Mail doylemic@amazon.com	FAX Number (toll-free) 803-791-6511
Employee Phone Number 803.791.6554	Employee Signature <i>Clarence Jenkins Jr</i>	Date 8-16-13	Employee Email Address (if available):

NOTE TO HEALTH CARE PROVIDER: Amazon uses this form for multiple purposes: to collect medical information when our employees report an injury or illness for which they must seek medical care, to determine if the employee is released to work with restrictions and is seeking an accommodation or if our employee can return to full duty. Complete and accurate information is much appreciated. *The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.*

SECTION II: TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Patient's Name (Please Print) CLARENCE JENKINS, JR.	Date of Most Recent Visit (month/day/year) 08/16/2013
Identify any limitations on performing the essential functions of this employee's job. Headaches, dizziness, visual changes are intermittent	
Injury is: <input checked="" type="checkbox"/> Work-Related <input type="checkbox"/> Not Work-Related <input type="checkbox"/> Undetermined	
State the approximate date that the limitation commenced. 02-10-2013	

HEALTH CARE PROVIDER RECOMMENDATIONS

NOTE TO HEALTH CARE PROVIDER: Please select 1 of the 3 recommendations listed below and follow the appropriate instructions.

<input type="checkbox"/> RETURN TO WORK WITH NO LIMITATIONS Please complete Section III	Date Examined	Expected Return to Work Date
<input type="checkbox"/> UNABLE TO RETURN TO WORK Please complete Section III	Date Examined	Expected Return to Work Date
<input checked="" type="checkbox"/> RETURN TO WORK WITH LIMITATIONS Please complete Sections III, IV & V (page 2)	Date Examined 08/16/2013	Expected Return to Work Date 08/18/2013

SECTION III: HEALTH CARE PROVIDER SIGNATURE AND CONTACT INFORMATION

Health Care Provider's Name/Title (Print): SHARON I EDEN MD	Address: 7061 NORWAY RD
Health Care Provider's Signature: <i>Sharon Eden</i>	City, State, ZIP NEESER, SC 29107
Date: 8/16/2013	Phone (803) 263-4086
	Fax (803) 263-4097

Might any medications prescribed to Treat This Impairment/Condition limit the employee's ability to perform the essential functions of the employee's job?
 Yes No

If yes, list the manner in which medication might limit the employee's ability to perform the essential functions of the employee's job:
NOT AT THIS TIME

Will this Impairment/Condition Require any therapeutic activities during the workday?
 Yes No

Duration and Frequency
NOT AT THIS TIME

Health Care Provider Request for Medical Information (RMI)

To Be Used For Disability Accommodation & Fitness for Return to Work
Please return completed form via fax 803-791-6511 or email cae1-hr@amazon.com

Amazon has a written policy regarding transitional duty and early RTW and seeks to meet restrictions as part of a well-managed recovery

Employee Name (Please Print): Clarence Jenkins Jr

Hours worked per shift: 10 hrs

SECTION IV: WORK RESTRICTIONS

Ability of Patient: (percentages indicate the proportion of the patient's shift the patient can perform the function)		Fully Restricted	25%	50%	75%	Not Restricted	If Temporary Restricted Until?	Permanent
1	a. Lift up to 5 lbs. (circle one) Left, Right, Both	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<u>To be determined</u>	<input type="checkbox"/>
	b. Lift 5 - 10 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	c. Lift 11 - 20 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	d. Lift 21 - 30 lbs. L, R, B	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	e. Lift 31 - 50 lbs. L, R, B	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
2	a. Push/Pull up to 5 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	b. Push/Pull 5 - 10 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	c. Push/Pull 11 - 20 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	d. Push/Pull 21 - 30 lbs. L, R, B	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	e. Push/Pull 31 - 50 lbs. L, R, B	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
3	a. Overhead Reach L, R, B	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	b. At Shoulder Reach L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	c. Below Shoulder Reach L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	d. Rotation of Head/Neck	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
4	a. Bend/twist	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	b. Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	c. Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	d. Squat	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
5	a. Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	b. Stand	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	c. Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	d. Climb stairs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	e. Climb ladders	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
6	a. Use hands for repetitive motion L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	b. Do simple grasping, turning such as grasping hand scanner (<15 inch-pounds) L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	c. Do forceful grasping, turning such as using a packaging tape dispenser (>15 inch-pounds) L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
7	a. See	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	b. Hear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	c. Talk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

- 8 Can the patient work more than 40 hours within a week? YES NO
If no, please indicate the number of hours the patient can work: 10 hours/day 40 hours/week
- 9 Can the patient drive commercial machinery such as a delivery van, forklift, reach truck, scissor lift or truck? YES NO
- 10 Does the patient have any work restrictions related to a psychological or mental condition? YES NO

SECTION V: ADDITIONAL TREATMENT CONSIDERATIONS (check and describe if applicable)

<input type="checkbox"/> Splint/Brace <input type="checkbox"/> Crutches <input type="checkbox"/> Neck/Lumbar Support	Location and description of device (soft or hard, open toe or closed toed boot, arm, wrist, etc.): <u>N/A</u>
<input type="checkbox"/> Heat <input type="checkbox"/> Ice <input type="checkbox"/> Elevate <input type="checkbox"/> Physical therapy	Duration and frequency: <u>N/A</u>

CLARENCE JENKINS, Gender: M, DOB: 8/14/1968, Encounter Date and Time: 9/20/2013 10:19AM, Examiner: Sharon Eden, MD

Chief complaint

The Chief Complaint is: Pt c/o dizziness, headache and not feeling well this AM. DBJamison, RN.

History of present illness

CLARENCE JENKINS is a 45 year old male. Source of patient information was patient.

Visit location: Norfield Medical Center.

PAIN LOCATION: __Headache Pt presents today with c/o intermittent dizziness and headaches again. Has not had MRI as recommended by neurologist per pt as he states his attorney was awaiting approval by Workman's Compensation. He describes headache as pressure like and on top of head and back of neck. He has taken Lortab (given for his recent cauliflower ear) w/o relief. He admits to compliance with betablocker for HTN/HA. Has intermittent dizziness when HA is severe. He additionally c/o weakness in both of lower legs this am with them nearly collapsing. He is feeling a little better at this time, but states he still feels weak in his legs.

COMPREHENSIVE PAIN ASSESSMENT.

DURATION: intermittent.

QUALITY: throbbing.

Medication(s) Taken: __Flexeril.

INTERFERES WITH: SLEEP.

Current medication

Cyclobenzaprine by Oral route 10 mg - 1 tablet at bedtime.

Bupap by Oral route 650-50 MG 1 by moun every 4 to 6 hours.

Cephadyn 50-650 mg Tab 1 tablet by Oral route every 4-6 hours.

Metoprolol succinate 25 mg Tb24 1 tablet by Oral route 1 time per day FOR HEADACHE AND BP.

Toradol 10 mg Tab 10 mg by Oral route every 6 hours PRN pain.

- hydrocodone-acetaminophen. by Oral route 5-325 mg - Take one to two tablets by mouth every 4 to 6 hours PRN pain

Personal history

Behavioral: No coffee consumption. Daily tea consumption. No cola consumption, no chocolate consumption, not a current smoker, and not a former smoker. Never a smoker. Not chewing nicotine-containing substances.

Alcohol: A social drinker.

Drug Use: Not using drugs.

Review of systems

Systemic: No fever.

Head: Headache.

Eyes: No eye pain.

Otolaryngeal: No sore throat.

Cardiovascular: No chest pain or discomfort.

Gastrointestinal: No abdominal pain.

Neurological: Lightheadedness. No memory lapses or loss. Motor disturbances.

Psychological: No depression and not thinking about suicide.

Physical findings

Vital Signs:

Vital Signs/Measurements	Value	Date
Tympanic membrane temperature	98	9/20/2013
RR	20 per min	9/20/2013
PR	87 bpm	9/20/2013
Blood pressure	132/89 mmHg	9/20/2013
Pain level (0-10)	8	9/20/2013
Weight	165 lbs	9/20/2013
Body mass index	25.8 kg/m ²	9/20/2013
Height	67 in	9/20/2013

Standard Measurements:

- Body surface area was 1.9 9/20/2013 10:20:00AM. ° Patient was not observed to be obese.

General Appearance:

- General appearance: appears to not feel well. ° Alert. ° Oriented to time, place, and person. ° Well developed.
- ° In no acute distress.

Head:

- ° Normal.
- Injuries:* ° No evidence of a head injury.
- Appearance:* ° Head showed no temporal wasting.
- Skull Tenderness:* ° No skull tenderness.

Neck:

- ° Normal minimal SCM spasms.
- Suppleness:* ° Neck demonstrated no decrease in suppleness.

Eyes:**General/bilateral:**

- Extraocular Movements:* ° Normal.
- Pupils:* ° Normal.

Ears:**General/bilateral:**

- Hearing:* ° No hearing abnormalities.

Nose:**General/bilateral:**

- Sinus Tenderness:* ° No sinus tenderness.

Lymph Nodes:

- ° Normal. ° No adenopathy.

Chest:

- ° Normal.

Lungs:

- ° Normal. ° Respiration rhythm and depth was normal.

Cardiovascular:

- ° System: normal.

Musculoskeletal System:

- General/bilateral:* • Musculoskeletal system:

Functional Exam:

- General/bilateral:* ° Ambulation was not limited.

Neurological:

- Speech:* ° Normal.
- Sensation:* ° No sensory exam abnormalities were noted. ° No sensory exam abnormalities were noted.
- Motor:* • A motor exam demonstrated dysfunction. • A motor exam demonstrated dysfunction. • Strength was reduced. • Weakness of the legs. • Weakness of both legs was observed.
- Gait And Stance:* • Abnormal. • An ataxic gait was observed.
- Reflexes:* ° Normal.
- Peripheral Nerves:* ° No peripheral neuropathy was noted.

Psychiatric:

- Mood:* ° Euthymic.

Skin:

° General appearance was normal. ° No skin lesions.

Assessment

- Postconcussion syndrome
- Hypertension
- Post-traumatic headache
- Bilateral leg weakness
- Muscle spasm
- Visit to issue a certificate of disability

Therapy

- Medication List Reconciled.

Allergies Reviewed.

Allergies and Adverse Reactions

No Known Allergies.

Counseling/Education

- Instructions for patient - HYPERTENSION
This is a condition where the blood pressure is elevated. This may occur silently without symptoms, or when very elevated, may be associated with headaches, dizziness or lightheadedness. A low salt diet is essential to management. Poorly treated high blood pressure leads to stroke, heart attacks and heart failure
- Patient education about medication
- Patient education about adverse reactions to medication
- Education: medication instruction
- Patient information sheet: Peripheral Nerve Problems-Brief

Plan

- Bupap by Oral route 650-50 MG 1 by mouth every 4 to 6 hours.. DISCONTINUED BY: DIANNE JAMISON.
REASON: Course Complete
- Cephadyn 50-650 mg Tab 1 tablet by Oral route every 4-6 hours. DISCONTINUED BY: DIANNE JAMISON.
REASON: Course Complete
- metoprolol succinate 25 mg Tb24 1 tablet by Oral route 1 time per day FOR HEADACHE AND BP.
DISCONTINUED BY: DIANNE JAMISON. REASON: Course Complete
- Toradol 10 mg Tab 10 mg by Oral route every 6 hours PRN pain. DISCONTINUED BY: DIANNE JAMISON.
REASON: Course Complete
- Modify drug dosage
- Physical activity restrictions - lifting see scanned forms for Amazon and disability
- Follow-up for re-examination 1 months

Post concussion syndrome/headaches/dizziness/HTN/lower extremity weakness- BP slightly elevated today in office and may be contributing to his sx's. Rec. increase metoprolol to 50 mgm/day. Pt to take 2 of his current pills daily. He is to recheck BP at work or come by office for recheck in 1 week. If sx's worsen, he is to go to ER. He was instructed as well to contact neurologist due to his lower extremity sx's now. PVU and stated he would call.

Notes

Documented by: Sharon Eden, MD.

Practice Management

Estab outpatient expanded h&p - low complexity decisions.

Signoff Information

Electronically Signed By: SHARON EDEN, MD on 09/22/2013 at 10:20 PM.



ATTORNEYS AT LAW

Reply To
FERN W. POTTER
Direct Dial: (803) 227-2246
fpotter@mgclaw.com
COLUMBIA

November 6, 2013

Benjamin D. Paysinger, M.D.
2750 Laurel Street - Suite 203
Columbia, South Carolina 29204

Attn: Medical Records

RE: Clarence B. Jenkins v. Amazon.com and Ins. Co. State of Pennsylvania c/o Sedgwick Claims Management Services, Inc.
Date of Accident: February 10, 2013
Claim No.: 30130262998
WCC File No.: 1303989
Our File No.: 20194.13164

Dear Sir or Madam:

This firm represents the employer and carrier in the worker's compensation claim referenced above. It is my understanding that you have treated or evaluated Clarence B. Jenkins (DOB: 08/14/68; SS#: 248-41-1391). Please send us the following information:

A complete copy of your medical chart, to include intake and/or history forms, hospital admission records and summaries, office and/or other narrative notes, incident reports, test results, medical records and/or the narrative reports of any diagnostic studies, including x-rays, CT Scans, MRI's, myelograms, EMG's, nerve conduction studies, etc., computer printouts, and correspondence, etc.

We have enclosed a Subpoena Duces Tecum which will allow you to release this information to us.

The Health Insurance Portability and Accountability Act (HIPAA) requires, in some instances, patient authorization before a medical provider may disclose protected health information. However, the HIPAA Privacy Rule does not apply in workers' compensation cases (45 CFR 164.512(l)) and permits medical providers to disclose protected health information to entities involved in the workers' compensation system without the individual's authorization. The HIPAA Rule works in conjunction with §42-15-80 and §42-15-95 of the S.C. Code of Laws and Rule 67-1301 of the South Carolina Workers' Compensation Commission which provides that there is no patient/physician privilege precluding the production of existing medical records in workers' compensation cases.

South Carolina law provides that copying costs for existing records can be charged at \$.65 per page for the first 30 pages and \$.50 per page for all other pages. Also, the maximum clerical fee for searching and handling is not to exceed \$15.00 per request, plus actual postage and applicable sales tax. **If total copy costs are to exceed \$200.00 for this request, please contact our office for approval before processing.**

We certainly appreciate the cooperation and prompt assistance in this matter. Please contact our office should you have any questions regarding the HIPAA Privacy Rule.

Very truly yours,

Fern W. Potter
Paralegal to Elizabeth F. Render

/fwp

Enclosure

cc: Curtis Whitmer
Trina Smith
Clarence Jenkins
Kathy Cook

South Carolina Workers' Compensation Commission

P.O. Box 1715 • 1333 Main Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 1303989
Carrier File # 30130262998
Carrier Code # _____
Employer FEIN _____

Clarence B. Jenkins 248-41-1391
Claimant's Name SSN
945 Wire Road Neeses, South Carolina 29107
Address City State Zip

Amazon.Com.dedc, LLC
Employer's Name
7200 Discovery Drive Chattanooga, Tennessee 37421
Address City State Zip

Home Phone # _____
Work Phone # _____
Elizabeth F. Render
Preparer's Name

Insurance Company State of Pennsylvania c/o Sedgwick
Claims Management Services, Inc.
Insurance Carrier
(803) 227-2308
Phone Number

TO: Benjamin D. Paysinger, M.D.

YOU ARE COMMANDED to appear before the above named Commission at the place, date and time specified below to testify in the above case.

PLACE OF TESTIMONY: _____ ROOM: _____
DATE AND TIME: _____

YOU ARE COMMANDED to appear at the place, date and time specified below to testify at the taking of a deposition in the above case.

PLACE OF DEPOSITION: _____ DATE AND TIME: _____

YOU ARE COMMANDED to produce and permit inspection and copying of the following documents or objects in your possession, custody or control at the place, date and time specified below (list documents or objects):

Any and all medical records, including, but not limited to, all intake and/or history forms, hospital admission records and summaries, office and/or other narrative notes, incident reports, test results, medical records and/or the narrative reports of any diagnostic studies, including x-rays, CT Scans, MRI's, myelograms, EMG's, nerve conduction studies, etc., computer printouts, and correspondence regarding Clarence B. Jenkins (SSN: 248-41-1391, DOB: 08/14/68).

PLACE: McAngus Goudelock & Courie, PO Box 12519, Columbia, SC 29211-2519 DATE AND TIME: 11/16/13 at 5:00 pm

YOU ARE COMMANDED to permit inspection of the following premises at the date and time specified below.

PREMISES: _____ DATE AND TIME: _____

THIS SUBPOENA SHALL REMAIN IN EFFECT UNTIL YOU ARE GRANTED PERMISSION TO DEPART BY THE COMMISSIONER OR AN OFFICER ACTING ON BEHALF OF THE COMMISSIONER. QUESTIONS CONCERNING THIS SUBPOENA SHOULD BE ADDRESSED TO THE ISSUING OFFICER

Elizabeth F. Render Attorney for Defendants (803) 227-2308 November 6, 2013
ISSUING OFFICER'S SIGNATURE AND TITLE PHONE # DATE

Serve this form according to R.67-212b. Refer to R.67-212 and R.67-214 for additional information. Procedural questions may be addressed to the Judicial Department (803/737-5675).



ATTORNEYS **Reply To**

FERN W. POTTER
Direct Dial: (803) 227-2246
fpotter@mgclaw.com
COLUMBIA

January 20, 2014

John B. Tomarchio, M.D.
Family Health Centers, Inc.
3310 Magnolia Street
Orangeburg, South Carolina 29115-1466

Attn: Medical Records

RE: Clarence B. Jenkins v. Amazon.com and Insurance Company State of Pennsylvania c/o Sedgwick
Claims Management Services, Inc.
Date of Accident: February 10, 2013
Claim No.: 30130262998
WCC File No.: 1303989
Our File No.: 20194.13164

Dear Sir or Madam:

This firm represents the employer and carrier in the worker's compensation claim referenced above. It is my understanding that you have treated or evaluated Clarence B. Jenkins (DOB: 08/14/68; SS#: 248-41-1391). Please send us the following information:

A complete copy of your medical chart, to include intake and/or history forms, hospital admission records and summaries, office and/or other narrative notes, incident reports, test results, medical records and/or the narrative reports of any diagnostic studies, including x-rays, CT Scans, MRI's, myelograms, EMG's, nerve conduction studies, etc., computer printouts, and correspondence, etc. FOR 2008 TO PRESENT.

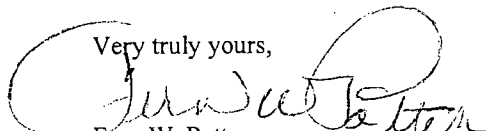
We have enclosed a Subpoena Duces Tecum which will allow you to release this information to us.

The Health Insurance Portability and Accountability Act (HIPAA) requires, in some instances, patient authorization before a medical provider may disclose protected health information. However, the HIPAA Privacy Rule does not apply in workers' compensation cases (45 CFR 164.512(l)) and permits medical providers to disclose protected health information to entities involved in the workers' compensation system without the individual's authorization. The HIPAA Rule works in conjunction with §42-15-80 and §42-15-95 of the S.C. Code of Laws and Rule 67-1301 of the South Carolina Workers' Compensation Commission which provides that there is no patient/physician privilege precluding the production of existing medical records in workers' compensation cases.

South Carolina law provides that copying costs for existing records can be charged at \$.65 per page for the first 30 pages and \$.50 per page for all other pages. Also, the maximum clerical fee for searching and handling is not to exceed \$15.00 per request, plus actual postage and applicable sales tax. **If total copy costs are to exceed \$200.00 for this request, please contact our office for approval before processing.**

We certainly appreciate the cooperation and prompt assistance in this matter. Please contact our office should you have any questions regarding the HIPAA Privacy Rule.

Very truly yours,



Fern W. Potter
Paralegal to Russell L. Goudelock, II

/fwp
Enclosure

cc: Clarence B. Jenkins
Curtis Whitmer
Trina Smith
Kathy Cook
Alicia Keisler

South Carolina Workers' Compensation Commission

P.O. Box 1715 • 1333 Main Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 1303989
Carrier File # 30130262008
Carrier Code _____
Employer _____

Clarence B. Jenkins 248-41-1391
Claimant's Name SSN
945 Wire Road Neeses, South Carolina 29107
Address City State Zip
(803) 263-4514 (803) 791-6542
Home Phone # Work Phone #
 J. Russell Goudelock, Jr.
 Preparer's Name

Amazon.Com.dedc, LLC
Employer's Name
7200 Discovery Drive Chattanooga, TN 37421
Address City State Zip
Insurance Company State of Pennsylvania c/o
Sedgwick Claims Management Services, Inc.
Insurance Carrier
(803) 227-2222
Phone Number

TO: John B. Tomarchio, M.D.

YOU ARE COMMANDED to appear before the above named Commission at the place, date and time specified below to testify in the above case.

PLACE OF TESTIMONY: _____ ROOM: _____
DATE AND TIME: _____

YOU ARE COMMANDED to appear at the place, date and time specified below to testify at the taking of a deposition in the above case.

PLACE OF DEPOSITION: _____ DATE AND TIME: _____

YOU ARE COMMANDED to produce and permit inspection and copying of the following documents or objects in your possession, custody or control at the place, date and time specified below (list documents or objects):

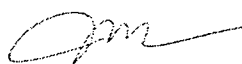
Any and all medical records, including, but not limited to, all intake and/or history forms, hospital admission records and summaries, office and/or other narrative notes, incident reports, test results, medical records and/or the narrative reports of any diagnostic studies, including x-rays, CT Scans, MRI's, myelograms, EMG's, nerve conduction studies, etc., computer printouts, and correspondence regarding Clarence B. Jenkins (SSN: 248-41-1391, DOB: 08/14/68) FROM 2008 TO PRESENT.

PLACE: McAngus Goudelock & Courie, PO Box 12519, Columbia, SC 29211-2519 DATE AND TIME: 01/30/14 at 5:00 pm

YOU ARE COMMANDED to permit inspection of the following premises at the date and time specified below.

PREMISES: _____ DATE AND TIME: _____

THIS SUBPOENA SHALL REMAIN IN EFFECT UNTIL YOU ARE GRANTED PERMISSION TO DEPART BY THE COMMISSIONER OR AN OFFICER ACTING ON BEHALF OF THE COMMISSIONER. QUESTIONS CONCERNING THIS SUBPOENA SHOULD BE ADDRESSED TO THE ISSUING OFFICER

 Attorney for Defendants (803) 227-2308 January 20, 2014
ISSUING OFFICER'S SIGNATURE AND TITLE PHONE # DATE

Serve this form according to R.67-212b. Refer to R.67-212 and R.67-214 for additional information. Procedural questions may be addressed to the Judicial Department (803/737-5675).



Health Care Provider Request for Medical Information (RMI)

To Be Used For Disability Accommodation & Fitness for Return to Work
Please return completed form via fax 803-791-6511 or email cae1-hr@amazon.com

NOTE TO EMPLOYEE: You must provide a copy of this completed report to the LOAA Team as specified in the accompanying letter or prior to the end of your leave of absence and before return to work.

SECTION I: EMPLOYEE/PATIENT INFORMATION: THIS SECTION TO BE COMPLETED BY THE EMPLOYEE/PATIENT		
Employee Name (Please Print) Clarence Jenkins	Employee Login:	Date Injury/Illness Commenced (month/day/year) 1/20/14
HR Contact Name Amanda Hummel	Scan/E-Mail	FAX Number (toll-free) 803-791-6583
Employee Phone Number	Employee Signature	Employee Email Address (if available):
	Date	

NOTE TO HEALTH CARE PROVIDER: Amazon uses this form for multiple purposes: to collect medical information when our employees report an injury or illness for which they must seek medical care, to determine if the employee is released to work with restrictions and is seeking an accommodation or if our employee can return to full duty. Complete and accurate information is much appreciated. *The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.*

SECTION II: TO BE COMPLETED BY THE HEALTH CARE PROVIDER	
Patient's Name (Please Print) Clarence Jenkins	Date of Most Recent Visit (month/day/year) 1/16/2014
Identify any limitations on performing the essential functions of this employee's job. Possible headache of cervical origin and - This will require limitations in exposure to loud noises/bright lights as migraine is also possible when symptoms are present.	
Injury is: <input type="checkbox"/> Work-Related <input type="checkbox"/> Not Work-Related <input checked="" type="checkbox"/> Undetermined	
State the approximate date that the limitation commenced. 2013	

HEALTH CARE PROVIDER RECOMMENDATIONS		
NOTE TO HEALTH CARE PROVIDER: Please select 1 of the 3 recommendations listed below and follow the appropriate instructions.		
<input type="checkbox"/> RETURN TO WORK WITH NO LIMITATIONS Please complete Section III	Date Examined	Expected Return to Work Date
<input type="checkbox"/> UNABLE TO RETURN TO WORK Please complete Section III	Date Examined	Expected Return to Work Date
<input checked="" type="checkbox"/> RETURN TO WORK WITH LIMITATIONS Please complete Sections III, IV & V (page 2)	Date Examined 1/16/2014	Expected Return to Work Date 1/21/2014

SECTION III: HEALTH CARE PROVIDER SIGNATURE AND CONTACT INFORMATION			
Health Care Provider's Name/Title (Print): John B Tomarechio MD	Address		
Health Care Provider's Signature: 	Date 1/21/14	City, State, ZIP	Phone ()
			Fax ()

Might any medications prescribed to Treat This Impairment/Condition limit the employee's ability to perform the essential functions of the employee's job? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, list the manner in which medication might limit the employee's ability to perform the essential functions of the employee's job:
Will this Impairment/Condition Require any therapeutic activities during the workday? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Duration and Frequency



Health Care Provider Request for Medical Information (RMI)

To Be Used For Disability Accommodation & Fitness for Return to Work
Please return completed form via fax 803-791-6511 or email cae1-hr@amazon.com

Amazon has a written policy regarding transitional duty and early RTW and seeks to meet restrictions as part of a well-managed recovery

Employee Name (Please Print): Clarence Jenkins

Hours worked per shift: 10 Hours

SECTION IV: WORK RESTRICTIONS

	Ability of Patient: (percentages indicate the proportion of the patient's shift the patient can perform the function)	Fully Restricted	25%	50%	75%	Not Restricted	If Temporary Restricted Until?	Permanent
1	a. Lift up to 5 lbs. (circle one) Left, Right, Both	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	b. Lift 5 - 10 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	c. Lift 11 - 20 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	d. Lift 21 - 30 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	e. Lift 31 - 50 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
2	a. Push/Pull up to 5 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	b. Push/Pull 5 - 10 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	c. Push/Pull 11 - 20 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	d. Push/Pull 21 - 30 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	e. Push/Pull 31 - 50 lbs. L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
3	a. Overhead Reach L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	b. At Shoulder Reach L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	c. Below Shoulder Reach L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	d. Rotation of Head/Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
4	a. Bend/twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	b. Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	c. Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	d. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
5	a. Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	b. Stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	c. Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	d. Climb stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	e. Climb ladders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
6	a. Use hands for repetitive motion L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	b. Do simple grasping, turning such as grasping hand scanner (<15 inch-pounds) L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	c. Do forceful grasping, turning such as using a packaging tape dispenser (>15 inch-pounds) L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
7	a. See	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	b. Hear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	c. Talk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>

8 Can the patient work more than 40 hours within a week? YES NO
If no, please indicate the number of hours the patient can work: _____ hours/day _____ hours/week

9 Can the patient drive commercial machinery such as a delivery van, forklift, reach truck, scissor lift or truck? YES NO

10 Does the patient have any work restrictions related to a psychological or mental condition? YES NO

SECTION V: ADDITIONAL TREATMENT CONSIDERATIONS (check and describe if applicable)

<input type="checkbox"/> Splint/Brace <input type="checkbox"/> Crutches <input type="checkbox"/> Neck/Lumbar Support	Location and description of device (soft or hard, open toe or closed toed boot, arm, wrist, etc.): None
<input type="checkbox"/> Heat <input type="checkbox"/> Ice <input type="checkbox"/> Elevate <input type="checkbox"/> Physical Therapy	Duration and frequency: None



John B. Tomarchio
OFFICE: FAMILY HEALTH CENTERS, INC

3310 MAGNOLIA ST
ORANGEBURG, SC 291151466

phone: (803) 531-6900

fax: (803) 531-6900

RX: FT2788175

State Reg # SC 33514

CS # 233514

DEA # FT2788175

NPI # 1043480932

FOR: **Clarence B. Jenkins**

DATE: January 16, 2014

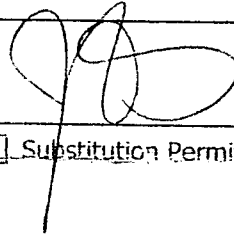
ADDRESS: 945 Wire Road
Neeses, SC 29107

DOB: 08/14/1968

RX: **Dispense:** **Sig:** **Refill:**

No Loud Noises And No Prolonged Standing

Avoid Loud Environments that trigger severe symptoms



Dispense As Written

Substitution Permitted

Reply To

FERN W. POTTER
Direct Dial: (803) 227-2246
fpotter@mgclaw.com

January 20, 2015

Family Health Centers
7061 Norway Road
Neeses South Carolina 291107

Attn: Medical Records

RE: Clarence B. Jenkins v. Amazon.com and Insurance Company of the State
of Pennsylvania c/o Sedgwick Claims Management Services, Inc.
Date of Accident: February 10, 2013 WCC File No.: 1303989
Claim No.: 30130262998 Our File No.: 20194.13164

Dear Sir or Madam:

This firm represents the employer and carrier in the worker's compensation claim referenced above. It is my understanding that you have treated or evaluated Clarence B. Jenkins (DOB: 08/14/68; SS#: 248-41-1391). Please send us the following information:

Complete records on this patient after January 15, 2015.

We have enclosed a Subpoena Duces Tecum which will allow you to release this information to us.

The Health Insurance Portability and Accountability Act (HIPAA) requires, in some instances, patient authorization before a medical provider may disclose protected health information. However, the HIPAA Privacy Rule does not apply in workers' compensation cases (45 CFR 164.512(l)) and permits medical providers to disclose protected health information to entities involved in the workers' compensation system without the individual's authorization. The HIPAA Rule works in conjunction with §42-15-80 and §42-15-95 of the S.C. Code of Laws and Rule 67-1301 of the South Carolina Workers' Compensation Commission which provides that there is no patient/physician privilege precluding the production of existing medical records in workers' compensation cases.

South Carolina law provides that copying costs for existing records can be charged at \$.65 per page for the first 30 pages and \$.50 per page for all other pages. Also, the maximum clerical fee for searching and handling is not to exceed \$15.00 per request, plus actual postage and applicable sales tax. **If total copy costs are to exceed \$200.00 for this request, please contact our office for approval before processing.**



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



WCC File # 1303989
Carrier File # 30130262998
Carrier Code # _____
Employer FEIN _____

Clarence B. Jenkins
Claimant's Name SSN _____
South Carolina 29107
Address City State Zip
(803) 263-4514 (803) 791-6542
Home Phone # Work Phone #
J. Russell Goude-lock, II
Preparer's Name

Amazon.Com.dedc, LLC
Employer's Name
7200 Discovery Drive Chattanooga, Tennessee 37421
Address City State Zip
Insurance Company of the State of Pennsylvania
Insurance Carrier
(803) 227-2222
Phone Number

SUBPOENA

To: Family Health Centers

YOU ARE COMMANDED to appear before the above named Commission at the place, date and time specified below to testify in the above case.

PLACE OF TESTIMONY: _____ ROOM: _____

DATE AND TIME: _____

YOU ARE COMMANDED to appear at the place, date and time specified below to testify at the taking of a deposition in the above case.

PLACE OF DEPOSITION: _____ DATE AND TIME: _____

YOU ARE COMMANDED to produce and permit inspection and copying of the following documents or objects in your possession, custody or control at the place, date and time specified below.

LIST OF DOCUMENTS:

Any and all medical records, including, but not limited to, all intake and/or history forms, hospital admission records and summaries, office and/or other narrative notes, incident reports, test results, medical records and/or the narrative reports of any diagnostic studies, including x-rays, CT Scans, MRI's, myelograms, EMG's, nerve conduction studies, etc., computer printouts, and correspondence regarding Clarence B. Jenkins (SSN: 248-41-1391, DOB: 08/14/68) FOR DATES OF TREATMENT JANUARY 16, 2015 TO PRESENT.

PLACE: McAngus Goude-lock & Courie, PO Box 12519, Columbia, SC 29211- DATE AND TIME: 01/30/15 at 5:00 pm

YOU ARE COMMANDED to permit inspection of the following premises at the date and time specified below.

PREMISES _____ DATE AND TIME: _____

THIS SUBPOENA SHALL REMAIN IN EFFECT UNTIL YOU ARE GRANTED PERMISSION TO DEPART BY THE COMMISSIONER OR AN OFFICER ACTING ON BEHALF OF THE COMMISSIONER. QUESTIONS CONCERNING THIS SUBPOENA SHOULD BE ADDRESSED TO THE ISSUING OFFICER.

Attorney for Defendants

ISSUING OFFICER'S SIGNATURE AND TITLE

(803) 227-2222

PHONE #

January 20, 2015

DATE

Serve this form according to R.67-211(C). Refer to R.67-211 and R.67-214 for additional information. Procedural questions may be addressed to the Judicial Department at 803-737-5765.

1/15/15

Clarence Jenkins 8/14/68

Pt presents ± N/V, photophobia, voice int clearece, memory loss, & vision, chest discomfort, sinusitis, pain in Rt leg & foot, numbness in fingers, phantom smelling (bad smells).

3/P head trauma while at work. Pt. has had long lasting 3/5 of cranial nerve equinox

The pt. states he is to have a repeat MRI of the brain, neuro testing, and an appointment i a Columbus neurologist. Says he is having difficulty getting his calculations paid for. Expressing frustration over physical symptoms and their lack of resolution.

Impression: Consistent with aftermath of TBI. Would be very difficult to create set of symptoms exhibited by the patient without a true injury.

Thyly NP

1/15/2015 10:16:00 AM

**CLARENCE JENKINS, Gender: M, DOB: 8/14/1968, Encounter Date and Time: 1/15/2015
10:16AM, Examiner: Jeanne Gonzalez, NP**

Chief complaint

The Chief Complaint is: Pt here with right lower leg pain. Pt stated that it gets worse when walking. BWilliams,RN...Progress note scanned to Misc. index- Correspondence.DWashington,MOA.

Referred here

Primary physician: Jeanne Gonzalez, NP.

Current medication

Propranolol 20 mg tab take 1 tablet by Oral route 2 times per day.

Physical findings**Vital Signs:**

Vital Signs/Measurements	Value	Date
Oral temperature	97.7	1/15/2015
RK	18 per min	1/15/2015
PR	88 bpm	1/15/2015
Blood pressure	134/82 mmHg	1/15/2015
Weight	162 lbs	1/15/2015

Laboratory Studies:

Pulmonary Tests:	Value	Date
Oxygen saturation	100% percent	1/15/2015

Allergies and Adverse Reactions

No Known Allergies.

Plan

- Random blood glucose level
 - propranolol 20 mg tab take 1 tablet by Oral route 2 times per day. DISCONTINUED BY: BRITTNEY WILLIAMS.
- REASON: Course Complete. COMMENTS: Pt stated that he has not taken in a while

Signoff Information

Electronically Signed By: JEANNE GONZALEZ, NP on 01/31/2015 at 01:12 PM.

1/27/2015 8:51:00 AM

CLARENCE JENKINS, Gender: M, DOB: 8/14/1968, Encounter Date and Time: 1/27/2015 08:51AM, Examiner: Jeanne Gonzalez, NP

Chief complaint

The Chief Complaint is: Patient in for follow up. C/o tingling to arm and fingers, headaches, and pain to right and left leg. DWashington,MOACalled in prescriptions for the pt per Jeanne Gonzalez,NP. Called in Cyclobenzaprine 10 mg 1 tab 3 times per day dispense 90 with 5 refills and Neurontin 300mg 2 tabs 3 times per day dispense 180 with 5 refills. Called in to Walmart Pharmacy in Orangeburg. BWilliams,RN.

History of present illness

CLARENCE JENKINS is a 46 year old male. Source of patient information was patient.

QUALITY: sharp.

Medication(s) Taken: ___.

Visit location: Norfield Medical Center.

Current medication

Prilosec 20 mg capsule, delayed release (DR/EC) take 1 capsule by Oral route before a meal 1 time per day.

Neurontin 300 mg capsule take 1 capsule (300 mg) by oral route 3 times per day.

Cyclobenzaprine 10 mg tablet take 1 tablet (10 mg) by oral route 3 times per day.

Zofran (as hydrochloride) 4 mg tablet 1 tablet by Oral route every 6 hours PRN For N & V.

Physical findings**Vital Signs:**

Vital Signs/Measurements	Value	Date
Oral temperature	97.5	1/27/2015
RR	20 per min	1/27/2015
PR	77 bpm	1/27/2015
Blood pressure	112/79 mmHg	1/27/2015
Pain level by numeric rating scale	6	1/27/2015
Weight	166 lbs	1/27/2015

Allergies and Adverse Reactions

No Known Allergies.

Plan

A quantitative bilateral screening test of visual acuity.

Signoff Information

Electronically Signed By: JEANNE GONZALEZ, NP on 01/31/2015 at 02:10 PM.



Liberty Life Assurance Company of Boston
Disability Claims
P.O. Box 7209
London, KY 40742-7209
Phone: (800) 320-7585
Secure Fax No.: (603) 422-0119

May 30, 2013

CLARENCE JENKINS
945 WIRE RD
NEESES, SC 29107-0000

RE: AMAZON CORPORATE LLC
Short Term Disability Benefits
Claim #: 3226010

Dear MR. JENKINS

We are pleased to advise you that your claim for Short Term Disability (STD) benefits has been approved based upon your inability to perform your job. Benefits have been approved through 6/7/2013 based upon the medically supported disability date of 4/24/2013.

We will be contacting you by phone to provide further details regarding the approval and to advise of the next steps in the administration of your claim.

If you are unable to return to work, you must submit additional medical information outlining restrictions and limitations beyond 6/7/2013. Please be sure to include copies of corresponding office notes and diagnostic test results. If you have any questions regarding this information, please contact our office at (800) 320-7585 and we will be happy to assist you.

Your employer, Amazon, understands that a disability may affect different areas of your life and wanted you to know that there are resources available to help you through what may be a challenging time. Aetna administers the employee assistance program provided for Amazon employees and their families. It is a benefit offered and pre-paid by your company which provides a wide range of counseling and support services. This is a confidential program. Amazon will not be told if you or one of your household members utilizes this benefit. You may find out more by calling 1-800-AETNA-EAP (1-888-238-6232 or logging onto www.AetnaEAP.com and enter Amazon's company ID "MyAmazon."

Sincerely,

ANDREW WATERHOUSE
Disability Case Manager
Phone: (800) 320-7585
Secure Fax No.: (603) 422-0119



Group Benefits Disability Claims
Liberty Life Assurance Company of Boston
P.O. Box 7209
London, KY 40742-7209
Phone No.: (800) 320-7585
Secure Fax No.: (603) 422-0119

June 28, 2013

Clarence Jenkins
945 Wire Rd
Neeses, SC 29107

RE: Amazon Corporate LLC
Short Term Disability Benefits
Claim #: 3226010

Dear Mr. Jenkins:

We are writing with regard to your claim for Short Term Disability Benefits (STD) under the Amazon Corporate LLC Group STD Plan. Your disability claim is currently approved through June 28, 2013. In order to consider continued disability benefits beyond this date, we are in need of additional medical information.

On June 28, 2013, we contacted Dr. Eden requesting all treatment notes, diagnostic test results and procedure reports from June 15, 2013 to the present in order to support your claim for ongoing disability benefits. Please contact Dr. Eden and request this information be sent to us within the timeframe specified below.

The Amazon Corporate Llc STD Plan requires that, in order to receive ongoing benefits, you provide proof of disability within a required timeframe. Your cooperation in providing the requested information is essential to our claims investigation. We ask that you provide us with this information no later than 45 days from the date of this letter, by August 11, 2013, as required under the terms of your Plan.

If there are any other attending physicians or specialists, including physical therapy providers, please have them forward all of your medical records pertinent to this period of disability within the timeframe stated above.

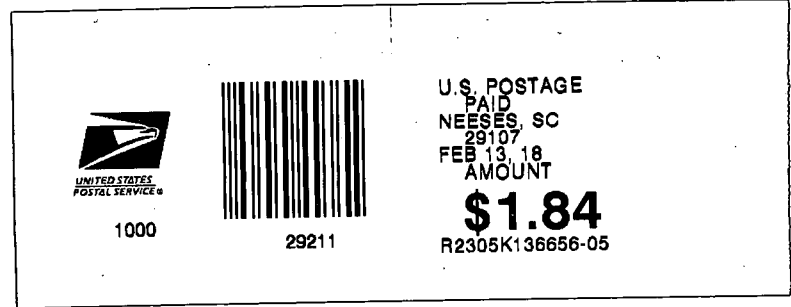
In the absence of this information, we will make a claim determination based on the information in our file.

If you have any questions about your disability benefits, please feel free to contact me.

Sincerely,

Andrew Waterhouse
Disability Claims Case Manager
Phone No.: (800) 320-7585 Ext. 41550
Secure Fax No.: (603) 422-0119

Clarence J. Pitt
945 W. W. Rd
Neeses, SC 29107



RECEIVED
FEB 15 2018
SC Court of Appeals

Jerry Hutchins, Clerk of Court
PO Box 11629
Columbia, SC 29211

