

April 23, 2018

Jenny Kitchings, Clerk  
PO Box 11629  
Columbia, SC 29211

Atty. Helen Hiser  
PO Box 650007  
Columbia, SC 29465

Clarence B. Jenkins Jr.  
945 Wire Rd.  
Neeses, SC 29107  
(803) 263-4514

**RECEIVED**  
APR 24 2018  
SC Court of Appeals

REF: Clarence B. Jenkins v. Amazon.com and American Zurich Insurance

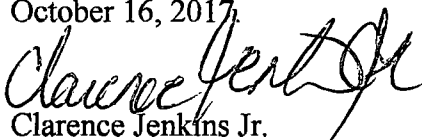
Ms. Kitchings:

I was approved by the COURT on October 16, 2017 to submit a Second Supplemental Record On Appeal. The Second Supplemental Record On Appeal was submitted after verifications was provided to dispute distortions by Amazon and American Zurich. Appellant was not able to submit Final Second Supplemental Record On Appeal which was granted because of being indigent status (receiving food stamps), constantly disputing distortions from Respondents with documentations to COURT as of February 13, 2018 and now on April 23, 2018 which became a financial hardship and current medical problems.

Appellant wanted to input Final Second Supplemental Record On Appeal with Final Supplemental Record On Appeal but after speaking with Ms. Mary Catherine of S.C. Court of Appeals stating ORDER of February 28, 2018 did not mentioned or grant approval for additional submission.

The case#2016-000598 that is before S.C. Court Of Appeals is because of unlawful violations of R67-611, S.C. Code 42-9-10 and S.C. 42-17-60. S.C. Worker's Compensation and Respondents has not complied with S.C. Code 42-17-60 therefore is in violation. See letter from SCWCC Director, Cannon dated December 17, 2014 per documentations dated December 5, 2014..

Appellant is requesting permission to submit Second Supplemental Record On Appeal which are pertinent documentations to dispute distortions by Respondents per ORDER of October 16, 2017.

  
Clarence Jenkins Jr.

# The South Carolina Court of Appeals

Clarence B. Jenkins, Employee, Appellant,

v.

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

Appellate Case No. 2016-000598

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## ORDER

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Appellant's motion is granted to the extent that within ten days, Appellant may serve and file a second supplemental record containing the attachments to the Form 50 referenced in Appellant's motion. Appellant's motion is otherwise denied. This court will consider the merits of this case after final briefing is complete.



FOR THE COURT

Columbia, South Carolina

cc:  
Clarence B. Jenkins  
J. Russell Goudelock, II, Esquire  
Helen F Hiser, Esquire

**FILED**

October 16, 2017

*State of South Carolina*

1333 Main Street, 5<sup>th</sup> Floor  
P.O. Box 1715  
Columbia, S.C. 29202-1715



TEL: (803) 737-5700  
[www.wcc.sc.gov](http://www.wcc.sc.gov)

*Workers' Compensation Commission*

December 17, 2014

Mr. Clarence Jenkins, Jr.  
945 Wire Road  
Neeses, SC 29107

Re: WCC file# 1303989

Dear Mr. Jenkins:

This is in response to your letter dated December 5, 2014 appealing reconsideration of the Decision and Order rendered by the Commission Appellate Panel on November 18, 2014.

The procedure to appeal Decision and Orders of the Appellate Panel is found in Section 42-17-60 of the South Carolina Code. The statute states: (entire statute is enclosed)

...either party to the dispute, within thirty days from the date of the award or within thirty days after receipt of notice to be sent by registered mail of the award, but not after, whichever is the longest, may appeal from the decision of the commission to the court of appeals.....

The Court of Appeals address is:

South Carolina Court of Appeals  
1015 Sumter Street  
Columbia, SC 29201  
803-734-1890  
[www.judicial.state.sc.us](http://www.judicial.state.sc.us)

Sincerely,

A handwritten signature in cursive script that reads "Gary M. Cannon".

Gary M. Cannon  
Executive Director

**SECTION 42-17-60. Conclusiveness of award; appeals; payment of compensation during appeal; accrual of interest.**

The award of the commission, as provided in Section 42-17-40, if not reviewed in due time, or an award of the commission upon the review, as provided in Section 42-17-50, is conclusive and binding as to all questions of fact. However, either party to the dispute, within thirty days from the date of the award or within thirty days after receipt of notice to be sent by registered mail of the award, but not after, whichever is the longest, may appeal from the decision of the commission to the court of appeals. Notice of appeal must state the grounds of the appeal or the alleged errors of law. In case of an appeal from the decision of the commission on questions of law, the appeal does not operate as a supersedeas and, after that time, the employer is required to make weekly payments of compensation and to provide medical treatment ordered by the commission involved in the appeal or certification until the questions at issue have been fully determined in accordance with the provisions of this title. Interest accrues on an unpaid portion of the award at the legal rate of interest as established in Section 34-31-20(B) during the pendency of an appeal.

**HISTORY:** 1962 Code Section 72-356; 1952 Code Section 72-356; 1942 Code Section 7035-63; 1936 (39) 1231; 1988 Act No. 677, Section 3, eff June 27, 1988; 1990 Act No. 439, Section 1, eff April 24, 1990; 2007 Act No. 111, Pt I, Section 30, eff July 1, 2007, applicable to injuries that occur on or after that date.

December 5, 2014

WCC# 1303989

Gary Cannon, Director  
SC Worker's Compensation Commission  
PO Box 1715  
Columbia, SC 29202-1715

Clarence Jenkins Jr  
945 Wire Rd.  
Neeses, SC 29107  
(p) 803-263-4514  
(E) [upscale81@yahoo.com](mailto:upscale81@yahoo.com)

Dear

I am writing to speak directly to the incompetence of SC Worker's Compensation Appeal Panel that consist of Com. R. Michael Campbell, II, Com. Susan Barden and Com. Aisha Taylor that presided over the September 15, 2014 hearing regarding unauthorized medical office visits and unauthorized mileage. In the SC Worker's Compensation Appeal Panel finding of fact only suggested that defendants provided medical records which is not true because I submitted numerous medical documents which was kept by Com. Roche at the March 12, 2014 hearing in Lexington, SC with originals being mailed back to me by SC Worker's Commission.

The SC Worker's Appeal Panel upheld the ruling of Com. Roche stating that unauthorized medical office visits could not receive mileage reimbursement. The commission stated the mileage reimbursement for medical office visit with Dr. Sharon Eden, Dr. Paysinger and other should not be payable which is not based on facts. Dr. Sharon Eden of Norfield Medical Centers provided the original diagnosis of post traumatic concussion on 4/22/2014 because of the work related head injury on 2/10/2013 and provided Amazon with their Request for Medical Information that place me work restrictions. I was taken out of work by Dr. Eden on 4/22/2013 and did not return until 8/6/2013 due post traumatic concussion which was accepted by Amazon. And furthermore to validate Amazon had accepted Dr. Sharon Eden findings of a post traumatic concussion because of continuing medical problems was provided a Certification Of Health Care Provider to be completed by her. The Certification Of Health Care Provider form is provided on Amazon letterhead which was completed by Dr. Eden on 9/10/2013. I was approved and accepted for Family Medical Leave Act stating restrictions and accommodations are temporary up to 2 years under Amazon which was submitted with previous documents. SC Worker's Commission Appeal Panel was totally incompetent with written documents and understanding the facts. I received medical care from Dr. Mohammed upon the recommendations of Dr. Eden while continuing regular appointments with her as my family physician. Dr. Eden continued to provide Amazon with Request for Medical Information with regards to health condition and work restrictions per their asking. By Dr. Eden and staff continued to provide care up to 1/16/2014 which was accepted by Amazon so the notion of not being informed or approved of medical care is a complete distortions of the facts accepted by SC Worker's Compensation Commission.

I obtained the services of Dr. Paysinger after already receiving the same procedure from Dr. Eden several days earlier. Dr. Eden as being the primary physician that provided continued care which was accepted and approved by Amazon therefore base on her medical expertise advised to seek additional care if blood in ear return which did.

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DEC 11 2014

S. C. WORKERS' COMP. COMM.  
EXECUTIVE DIRECTOR

amazon

Health Care Provider Request for Medical Information (RMI)

NWR (JK)

4/23/13

NOTE TO EMPLOYEE: You must provide a copy of this completed report to the HR LOA Team by 1/1

**SECTION I: COMPLETED BY THE EMPLOYEE/PATIENT**

Employee Name (Please Print): <b>CLARENCE JENKINS</b>	Employee Phone Number: <b>803 747-4185</b> Scan/Email	Date Injury/Illness Commenced: <b>2/10/2013</b>
HR Contact Name / Phone Number		Fax Number (toll-free): <b>791-6536</b> 791-6511 (VT)

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): <b>CLARENCE M JENKINS</b>	Date of Examination (month/day/year): <b>5/7/2013</b>
Identify the injury or illness for which treatment is sought: <b>POST CONCUSSION SYNDROME</b>	
Approximate beginning date of the period of incapacity: <b>2/10/2013</b>	Approximate end date of the period of incapacity: <b>UNDETERMINED</b>
<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: <b>REFERRAL VIA WORKMEN'S COMP. TO NEUROLOGIST</b>
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: <b>UNDETERMINED</b>

**SELECT ONE (1) OPTION:**

<input checked="" type="checkbox"/> <b>UNABLE TO RETURN TO WORK:</b> Please note: If you check this box, Amazon will require an additional update before the employee is released.	Estimated Return to Work Date: <b>UNDETERMINED TO BE DECIDED BY NEUROLOGIST</b>	Date of Next Visit: <b>PENDING</b>
<input type="checkbox"/> <b>EMPLOYEE CAN RETURN TO WORK:</b>	Date Employee is Released to Return to Work Without Restrictions: <b>DEC 11 2014</b>	
<input type="checkbox"/> <b>WITHOUT WORK RESTRICTIONS</b> Please complete page 1 only →	Date Employee is Released to Return to Work With Restrictions: <b>EXECUTIVE DIRECTOR</b>	
<input type="checkbox"/> <b>WITH WORK RESTRICTIONS</b> Please complete page 2 AND indicate how long the restrictions are in place. →		

**SECTION III: HEALTH CARE PROVIDER SIGNATURE AND CONTACT INFORMATION**

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

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/b	<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 k	<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 forc 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:

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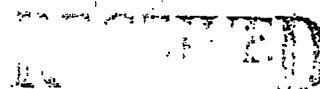
## CONSULTS

**Patient Name:** Jenkins, Clarence B.  
**Chart No:**  
**Phone:** (803) 747-4185  
**DOB:** 08/14/1968 (44 yrs)

**Date 1st Visit:** 04/22/2013  
**Date Latest Visit:** 05/07/2013  
**Examining Clinician:** Sharon Eden

Date	Description	Specialty	ICD9 Code	Associated Problem	Date Performed
05/07/2013	Neurology		339.20	Post-traumatic Headache, Unspecified	
			368.8	Other Specified Visual Disturbances	
			780.2	Syncope And Collapse	

*Possible post concussion syndrome*



DEC 11 2014

S. C. H. ... COMM.  
 DIRECTOR



**CERTIFICATE FOR RETURN TO WORK OR SCHOOL**

<b>MAIN SITE</b> 3310 Magnolia Street Orangeburg, SC 29115 (803) 531-6900 (803) 531-6907-Fax	<b>DEPARTMENT/UNIT SEEN</b> _____  <b>PHONE NUMBER VERIFIED</b> _____	<b>DENMARK MED CTR</b> 1241 Solomon Blatt Blvd. Denmark, SC 29042 (803) 793-4282 (803) 793-6346-Fax	<b>HOWARD MDL SCHOOL</b> 1255 Belleville Road Orangeburg, SC 29115 (803) 533-6534 (803) 535-1606-Fax
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**NORFIELD MED CTR**  
7061 Norway Road  
Neeses, SC 29107  
(803) 263-4086  
(803) 263-4097-Fax

**ST GEORGE MED CTR**  
401 Rodge Street  
St. George, SC 29477  
(843) 563-5315  
(843) 563-8229-Fax

**ST MATTHEWS MED CTR**  
558 Chestnut Street  
St. Matthews, SC 29135  
(803) 874-2006  
(803) 874-1998-Fax

**VANCE MED CTR**  
10278 Old #6 Hwy  
Vance, SC 29163  
(803) 492-3031  
(803) 492-9156-Fax

**NAME:** Clarence Jenkins DOB 8/14/68

has been under my care from 5/7/2013 to present and

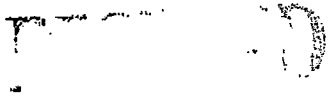
NOT is able to return to work/school on: \_\_\_\_\_

**Remarks:**  
Pt still under care from accident in 2/2011  
and cannot be released to work until  
cleared by neurology/ophthamology =

[Signature]  
**PROVIDER'S SIGNATURE**

5/23/2013  
**Date**

SHARON I. EDEN MD



DEC 11 2014  
Rev. 12/2009

FAMILY HEALTH CENTERS, INC.

Clarence Jenkins 144919  
Patient Name (Chart # or Patient #)

Circle which office Patient is to be seen for appointment.

Dept/Unit: _____ 144919 St Denmark SC 29114 Phone: 803-492-1111	Special Appointment Phone: _____ At: _____	DENMARK 1241 S. Main St Denmark SC 29042 Phone: 803-703-4202 Fax: 803-703-4341	
<b>NORFIELD</b> 7001 Norway Road Norfolk SC 20107 Phone: 803-293-1086 Fax: 803-293-1087	ST GEORGE 401 Ridge Street St George SC 29477 Phone: 803-501-0315 Fax: 803-501-0220	ST MATTHEWS 550 Chestnut Street St Matthews SC 29135 Phone: 803-874-2006 Fax: 803-874-1910	VANCE 10278 Old Hwy Vance SC 29163 Phone: 803-492-3031 Fax: 803-492-9156

Next Office Visit: 1 mo Weeks Months

Our Next Appointment Will Be:  
E: THURS JUNE 27, 2013 TIME: 830

FAMILY HEALTH CENTERS, INC.  
Phone: (803) 531-6900

DEA #: \_\_\_\_\_ LIC #: 12853  
 Name: Clarence Jenkins Date: 6/6/13  
 Address: \_\_\_\_\_ Age: \_\_\_\_\_  
 Refill 1 2 3 4 5 PRN [ ] Do not refill [ ]

R ① Opthamology appt → Orangeburg Eye Center  
DX: Persistent blurry vision

② Neurology consult → Dr. Abu Ata  
DX: Poss. postconcussion syndrome;  
Headaches after head trauma

Label [ ]

*[Signature]*

DISPENSE AS WRITTEN

SUBSTITUTION PERMITTED

FHC-0003

03/2010

DEC 11 2014

PHARM  
DIRECTOR

**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) <b>Clarence Jenkins Jr</b>	Employee Login: <b>JenkinsC</b>	Date Injury/Illness Commenced (month/day/year) <b>2-10-13</b>
IR Contact Name <b>Michelle Doyle</b>	Scan/E-Mail <b>doylemic@amazon.com</b>	FAX Number (toll-free) <b>803-791-6511</b>
Employee Phone Number <b>03.791.6554</b>	Employee Signature <i>Clarence Jenkins Jr</i> Date <b>2-16-13</b>	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 Information Discrimination 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 individual's family member receiving assistive reproductive services.

**SECTION II: TO BE COMPLETED BY THE HEALTH CARE PROVIDER**

Patient's Name (Please Print) <b>CLARENCE JENKINS, JR.</b>	Date of Most Recent Visit (month/day/year) <b>08/16/2013</b>
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Identify any limitations on performing the essential functions of this employee's job.  
**Headaches, dizziness, visual changes are intermittent**

Injury is:  
 Work-Related  Not Work-Related  Undetermined  
 Indicate 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 <b>08/16/2013</b>	Expected Return to Work Date <b>08/18/2013</b>

**SECTION III: HEALTH CARE PROVIDER SIGNATURE AND CONTACT INFORMATION**

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

Do 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**

Does 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>None</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 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 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 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: 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 toe 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>

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CERTIFICATION OF HEALTH CARE PROVIDER for Leave of Absence

Employee's Name: Clarence Jenkins Jr Employee Phone Number: 803-747-4185

Employee Login: jenkinsl

Patient's Name: Relationship: Self DOB: 8-14-68 (if different from employee) (if requesting for child)

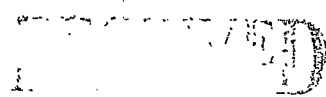
Instructions for Health Care Provider: Complete, sign and fax to 888-253-2885 or email LOA@amazon.com Please answer, fully and completely, all applicable parts. Be as specific as you can. Incomplete forms may not be sufficient to determine FMLA coverage. Please return this form no later than

NOTE: If this request is for an employee's family member, please complete questions 1, 2, 4 and 5 only.

Health Care Provider eligible to complete certification include doctors of medicine or osteopathy authorized to practice medicine or surgery by the State in which the doctor practices, podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist), nurse practitioners, nurse-midwives, clinical social workers, Christian Science practitioners listed with the First Church of Christ, Scientist in Boston, MA, any health care provider recognized under the company health plan and/or a health care provider listed above who practices in a country other than the United States and who is authorized to practice under the laws of that country.

1) A "serious health condition" under the Family and Medical Leave Act (FMLA) means an illness, injury, impairment, or physical or mental condition that involves one of the categories below. Does the patient's condition qualify under any of the categories described? If so, please check the applicable categories:

- Hospital Care - Inpatient care (i.e. overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.
Absence plus Treatment - A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:
Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.
Pregnancy - Any period of incapacity due to pregnancy, or for prenatal care. Estimated due date:
Chronic Condition Requiring Treatments - A chronic condition which:
Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
Continues over an extended period of time (including recurring episodes of a single underlying condition); and
May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).
Permanent/Long-Term Condition Requiring Treatment - A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.
Multiple Treatments (Non-Chronic Condition) - Any period of absence to receive multiple treatments (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment such as cancer (chemotherapy, radiation, etc), severe arthritis (physical therapy), kidney disease (dialysis).
None of the Above



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2) If none of the above is checked, describe below the medical facts:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

a. Approximate date condition commenced: \_\_\_\_\_ Probable duration of condition: \_\_\_\_\_

b. Does this condition require the employee to be absent from work? YES  NO

3) What does the employee need? Check all applicable sections and complete in their entirety:

Full/Continuous Leave Start Date: \_\_\_/\_\_\_/\_\_\_ Estimated End Date: \_\_\_/\_\_\_/\_\_\_

Intermittent Leave/Reduced Work Schedule (Occasional/periodic for planned and/or unanticipated absences, typically less than 3 consecutive days) Start Date: 09/02/13 Estimated End Date: 09/02/14

If intermittent time off is needed, check and complete all that apply:

Intermittent time needed for episodic flare-ups YES  NO

Frequency: 1 times per 1 week(s) OR \_\_\_\_\_ times per \_\_\_\_\_ month(s)

Duration \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

Periodic treatment from a healthcare provider YES  NO

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) OR 1 times per 1-2 month(s)

Duration \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per visit

Reduced schedule needed YES  NO

4 hour(s) per day; 4 days per week, until \_\_\_/\_\_\_/\_\_\_

Restrictions/Accommodations

Is employee able to perform the essential functions of the job? YES  NO

Were you provided a job description when completing this form? YES  NO  If no, Amazon or your patient may reach out to you for more information as needed.

Restrictions/Accommodations are:  Permanent  Temporary with anticipated duration of: up to 2 years

What are the current difficulties requiring support?

Chronic headaches due to post-concussion syndrome  
Dizziness

If there are restrictions or limitations, please list below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Health Care Provider Request for Medical Information (RMI)

Claim # 2156711003

NOTE TO EMPLOYEE: You must provide a copy of this completed report to the HR LOA Team by 1/1/13

SECTION I: COMPLETED BY THE EMPLOYEE/PATIENT

Employee Name (Please Print): <i>Clarence Jenkins Jr</i>	Employee Phone Number: <i>803-791-6542</i>	Date Injury/Illness Commenced: <i>2-11-13</i>
Workers Compensation Specialist Contact Name / Phone Number: <i>Trina Smith (wk) 216-272-1147 (cell) 216-702-4020</i>	Scan/Email: <i>cae1-amcare@amazon.com</i>	Fax Number (toll-free): <i>803-791-6542</i>

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): <i>CLARENCE JENKINS</i>	Date of Examination (month/day/year): <i>09/20/2013</i>
---	--

Identify the injury or illness for which treatment is sought:

*BILATERAL LEG WEAKNESS; HEADACHE; POSTCONCUSSION SYNDROME*

Approximate beginning date of the period of incapacity: <i>FEBRUARY 2013</i>	Approximate end date of the period of incapacity: <i>UNDETERMINED</i>
---	--

Work-Related    Not Work-Related    Undetermined    Pre-Existing Injury/Illness    New Injury/Illness    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: <i>OFFICE VISITS; RADIOLOGICAL TESTS; LABWORK</i>
--	--

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: <i>LIFTING, STANDING, WALKING EXTENDED PERIODS</i>
--	---

SELECT ONE (1) OPTION:

<input 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: <i>9/22/2013</i>	Date of Next Visit: <i>4 weeks</i>
<input type="checkbox"/> EMPLOYEE CAN RETURN TO WORK: <input type="checkbox"/> WITHOUT WORK RESTRICTIONS Please complete page 1 only	Date Employee is Released to Return to Work Without Restrictions: <i>N/A</i>	
<input checked="" 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: <i>9/22/2013</i> S.O. W... EXECUTIVE DIRECTOR	

SECTION III: HEALTH CARE PROVIDER SIGNATURE AND CONTACT INFORMATION

Health Care Provider's Name/Title (Print): <i>SHARON I EDEN MD</i>	Address: <i>7061 NORWAY RD</i>
Health Care Provider's Signature: <i>[Signature]</i>	City/State, ZIP: <i>NEESSEY, SC 29107</i>
Date: <i>9/20/13</i>	Phone: <i>803 531-6900</i>
	Fax: <i>803 263 4097</i>

Claim # 2136917ms



Health Care Provider Request for Medical Information (RMI)

Employee Name (Please Print): \_\_\_\_\_ Hours worked per shift: \_\_\_\_\_

**SECTION IV: WORK RESTRICTIONS**

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

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:  
*see above*

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

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

Clara Jent  
945 W. 10th  
Neeses, SC 29107



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