

THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

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**RECEIVED**

**Jul 22 2020**

**SC Court of Appeals**

APPEAL FROM THE SOUTH CAROLINA  
WORKERS' COMPENSATION COMMISSION  
APPELLATE PANEL

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Associated Case No. 2018-001364  
Appellate Case No. 2019-000369  
W.C.C. File Nos. 1322451, 1319203, 1420487

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Terry H Capone, Claimant.....Appellant,

v.

City of Columbia, Employer, and

Companion Third Party Administrator, LLC, Carrier, .....Respondents.

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**APPELLANT'S NOTICE OF MOTION TO STAY PRECEEDINGS UNDER THE APA  
AND MOTION TO REMAND VOID DECISION AND ORDER TO LOWER TRIBUNAL  
DUE TO FRAUD ON THE COURT UNDER THE APA AND OTHER VIOLATIONS OF  
LAW**

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TO ALL PARTIES AND THEIR ATTORNEYS OF RECORD: PLEASE TAKE NOTICE that Under the Administrative Procedure Act and any and all other applicable law or authorities, plaintiffs Terry H Capone hereby moves the court by Notice of Motion to Stay Proceedings Under the Administrative Procedure Act (APA) and Notice of Motion to Remand VOID Decision and Order To Lower Tribunal Due to Fraud On The Court Under the APA And Other Violations of Law. For the reasons herein, plaintiffs' motion is so the court will have a full and complete record upon which to decide the legal issue of the above referenced claim that lies at the heart of a **Void Judgment/ Decision and Order**. Time limitation does not apply where the judgment is based on a fraudulent return. (*Washko v. Stewart*, supra, p. 318; *Richert v. Benson*

*Lbr. Co.*, supra, p. 677.).

**PLAINTIFF REQUEST MANDATORY JUDICIAL NOTICE**

**PLEASE TAKE NOTICE**, In Propria Persona, on my own behalf, in person, Plaintiff Terry H Capone (“Capone”), pursuant to the FED R Civ P.201 (c ) (2), (d), hereby respectfully move this court to Take Mandatory Judicial Notice of the following:

**FURTHER NOTICE:** See Attached 7/22/202 Email to South Carolina Workers Compensation Commission.

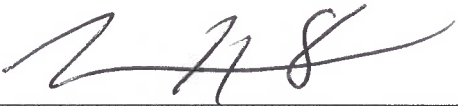
**FURTHER NOTICE:** See, Attached Cover letter and Certificate of Service Form #15 and Motion for Reconsideration memorandum of points and authorities and Sworn declaration of Terry H Capone for Fraud on The Court/Tribunal and New Evidence and Exhibits #1-14, as well , as well as upon such further briefs, argument or other information as may be submitted to the court for review.

**A Party Affected by VOID Judicial Action Need Not APPEAL.** State ex rel. Latty, 907 S.W.2d at 486. It is entitled to no respect whatsoever because it does not affect, impair, or create Legal rights." Ex parte Spaulding, 687 S.W.2d at 745 (Teague, J.,concurring). If an appeal is taken, however, the appellate court may declare void any orders the trial court signed after it lost plenary power over the case, because a void judgment is a nullity from the beginning and is attended by none of the consequences of a valid judgment.

“Obviously a judgment, though final and on the merits, has no binding force and is subject to

collateral attack if it is wholly void for lack of jurisdiction of the subject matter or person, and perhaps for excess of jurisdiction, or where it is obtained by extrinsic fraud. [Citation]"(7 Witkin,, Cal. Procedure, supra, Judgment, § 286, p. 828).

Dated: July 22, 2020

By:   
Mr. Terry H Capone  
Fire Battalion Chief-Retired  
130 Summerlea Drive  
Columbia, South Carolina 29203  
Email: tcapone@liberty.edu  
(803) 622- 6578

-----  
 COLUMBIA  
 1601 ASSEMBLY ST  
 COLUMBIA, SC 29201-9998  
 451804-0202  
 (800)275-8777  
 07/22/2020 01:59 PM  
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Product	Qty	Unit Price	Price
First-Class Mail® Large Envelope Domestic COLUMBIA, SC 29202 Weight:0 Lb 9.90 Oz Estimated Delivery Date Saturday 07/25/2020	1	\$2.80	\$2.80
Cert Mail RstrDel Recipient name CYTHIA DOOLEY USPS Certified Mail # 70183090000117809673			\$9.00
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 Card Name:VISA  
 Account #:XXXXXXXXXXXX9326  
 Approval #  
 Transaction #:040  
 Receipt #:037329  
 Debit Card Purchase:\$17.45  
 Cash Back:\$0.00  
 AID:A0000000980840 Chip  
 AL:US DEBIT  
 PIN:Verified  
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\*\*\*\*\*  
 Due to limited transportation  
 availability as a result of  
 nationwide COVID-19 impacts  
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 \*\*\*\*\*

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COLUMBIA, SC 29202

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 Adult Signature Restricted Delivery \$

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 Street and Apt. No. or PO Box No. *PO Box 1473*  
 City, State, ZIP+4® *Columbia SC 29202*

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

7018 3090 0001 1780 9673



TERRY H. CAPONE  
4209 WOODBRIDGE DR.  
COLUMBIA, SC 29203

67-7873/2539  
05

1485

130 Summerlea

~~DATE~~ 7/22/2020

Pay to the order of

SC WCC

\$ 50.00

**SCU** STATE CREDIT UNION  
SERVING SOUTH CAROLINA'S WORKFORCE  
COLUMBIA, SOUTH CAROLINA 29202

Notice Temporary Comp  
has been stopped (Compensation)  
WCC Form #15-11 New filed  
118

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Security features are included. Details on back.

MP

TERRY H. CAPONE  
4209 WOODBRIDGE DR.  
COLUMBIA, SC 29203

67-7873/2539  
05

1484

130 Summerlea Dr

~~DATE~~ 7/22/2020

Pay to the order of

SC WCC

\$ 50.00

**SCU** STATE CREDIT UNION  
SERVING SOUTH CAROLINA'S WORKFORCE  
COLUMBIA, SOUTH CAROLINA 29202

1319203, 1322451, 1420087  
Fraud on the Court  
Motion for Recusal due for new service  
6 118

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Security features are included. Details on back.

MP

TERRY H. CAPONE  
4209 WOODBRIDGE DR.  
COLUMBIA, SC 29203

67-7873/2539  
05

1483

130 Summerlea Dr

~~DATE~~ 7/22/20

Pay to the order of

SC WCC

\$ 50.00

**SCU** STATE CREDIT UNION  
SERVING SOUTH CAROLINA'S WORKFORCE  
COLUMBIA, SOUTH CAROLINA 29202

Notice Temporary Comp #1319203  
has been stopped - (Additional I-9)  
WCC Form #15-11 New filed  
118

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Security features are included. Details on back.

MP



July 22, 2020

US MAIL OR PERSONAL DELIVERY

South Carolina Workers' Compensation Commission  
Director Cannon and Records Manager  
1333 Main Street Suite 500  
P.O. Box 1715  
Columbia, South Carolina 29202-1715

Re: Form#15 –Temporary Compensation Report: Motion For Reconsideration Fraud On The  
Court/Tribunal –Denial of Due process and Equal Protections Under the Color of Law  
Employer: Terry Capone v. City of Columbia SC WCC File Case No.:1319203, 1322451, 1420487

Dear SC WCC Judicial Dept:

Please see attached Temporary Compensation Report and Request for Hearing/Motion for Reconsideration and I have attached the \$100.00 Filing fee Check #1483 and \$1484 in amount of \$50.00 Each. I was never informed by the South Carolina Workers' Compensation Commission of the process or procedure my employer/carrier needed to follow before stopping compensation, and was due to Fraud On The Court/Tribunal and a denial of Procedural due process and Equal protection under the color of law. I am under disability under the law, no rights are lost and I am not a lawyer. Based on new developments/ evidence a remand is necessary for reconsideration accept this as a motion. Thank you for your assistance with this matter, please contact me if you have any questions. Please consider the attached evidence.

With The Highest Regards,

Enclosure(s) Evidence sheet as stated, attached #1-14  
Cc: Cynthia C Dooley  
Carmelo B. Sammataro Attorney for Respondents

Mr. Terry H. Capone  
Fire Battalion Chief-Retired  
130 Summerlea Drive  
Columbia, SC 29203  
803.622.6578  
Email: [tcapone@liberty.edu](mailto:tcapone@liberty.edu)

**CERTIFICATE OF SERVICE**

The undersigned hereby certifies that he served the forgoing court copy referenced "Terry Capone v. City of Columbia SC WCC File Case No.:1319203, 1322451, 1420487

SC Court of Appeals Appellant Case. No. 2019-000369

July 22, 2020 Claimant

- Form#15 –Temporary Compensation Report: Employer: Terry Capone v. City of Columbia: No Form 15 II Has Not been Received
- Motion for Reconsideration July 22, 2020

by depositing a copy of the same in the United States Mail, Certified postage prepaid or better or personal delivery on July 22, 2020 to the following addressed to the Defendant Legal Representative known to be:

Cythia C Dooley

P.O.Box 1473

Columbia, SC 29202

This 22<sup>th</sup> day of July 2020.



---

Mr. Terry H Capone  
Fire Battalion Chief-Retired  
130 Summerlea Drive  
Columbia, SC 29203  
803.622.6578  
Email: tcapone@liberty.edu

Columbia, South Carolina

THE STATE OF SOUTH CAROLINA  
WORKERS' COMPENSATION COMMISSION

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W.C.C. File Nos. 1322451, 1319203, 1420487  
Associated Case No. 2018-001364  
Appellate Case No. 2019-000369

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Terry H Capone, Claimant.....Claimant,

v.

City of Columbia, Employer, and

Companion Third Party Administrator, LLC, Carrier, .....Defendants.

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**MOTION FOR RECONSIDERATION BASED ON FRAUD UPON THE  
COURT/TRIBUNAL AND NEW EVIDENCE**

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TO ALL PARTIES AND THEIR ATTORNEYS OF RECORD: PLEASE TAKE NOTICE that Under the Administrative Procedure Act and all applicable authorities, Claimant Terry H Capone hereby move the court by this Motion for Reconsideration Based On Fraud Upon The Court/Tribunal And New Evidence And Other Violations Of Law. For the reasons herein, Claimants' motion is so the court will have a full and complete record upon which to decide the legal above referenced claim that lies at the heart of this case. This motion is based on the accompanying memorandum of points and authorities, the declaration of Terry H. Capone and evidence attached thereto, as well as upon such further briefs, argument or other information as may be submitted to the court.

## MEMORANDUM OF POINTS AND AUTHORITIES

### SWORN DECLARATION

STATE OF SOUTH CAROLINA §

COUNTY OF RICHLAND §

Pursuant to 28 U.S.C. 1746, I Terry H Capone, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge, information and belief and In opposition, Plaintiff states as follows:

1. I was never informed by the South Carolina Workers' Compensation Commission of the process or procedure ny employer/carrier needed to follow before stopping compensation, and was due to Fraud On the Court/Tribunal and denial of Procedural Due Process and Equal Protection under the color of law.
2. 10/29/2015 My Email that I not only wanted to appeal ,but that I thought my case was admitted. I believe I "substantially complied" with giving notice of appeal at that time. The Commission and Attorney for the City was communicating with me by email in an informal fashion. Fits squarely into the case of Cit of Columbia Fire Captain James "Woody" Goodman case Goodman v. City of Columbia 318 S.C. 488 (S.C. 1995) 458 S.E.2d 531.
3. The failure of The Employer/Carrier to provide payment prior to the 79<sup>th</sup> day of injury in South Carolina Workers Compensation procedures where a denial of due process
4. The Illegal stopping of the South Carolina Workers Compensation benefits without proper procedures and service was an illegal taking and a denial of due process
5. SC WCC 67-504 (A)(B). Employer failed to follow procedures for stopping benefits; (A) employers did not file form 15 "immediately" with the claims Department and/or serve form 15 after compensation was terminated, and employer did not serve the form 15 "immediately" on the claimant pursuant to 67-211 with documentation attached as to the reason for termination or suspension.(B) to terminate or suspend compensation pursuant to section 42-9-260(B)(2) the Employer's representative "must" obtain a signed form 17, they did not complete these Services. INEFFECTIVE SERVICE OF PROCESS NEVER COMPLETED!
6. Allowing Defendant's Lawyers and employees to compete your agency orders and decision is a denial of Due Process and Equal protection under Law

This Single Commissioner and Commission relied on the omitted evidence and altered the medical

records (Specifically Dr. Linds medical opinion) in its decision to deny/ devaluation of benefits (property)

and such reliance was prejudicial to the Appellants/ Claimants claim, the Single Commissioner Gene

Henry McCaskill in his Workers' Compensation Scheme denied Mr. Capone Due Process, Procedural and

Substantive Due Process and Justice for non-discretionary and statutorily –mandated Workers'

Compensation disability benefits (property) Mr. Capone has a substantial property right /interest in, by

the due process clause of the Fifth Amendment entitling him to a full and fair impartial hearing.

Cushman v. Shinseki, 576 F.3d 1290 (Fed. Cir 2009). The due process clause of the Fifth Amendment

only applies to property interest. It is well settled that an individual's disability benefits are protected that

may not be discontinued without process of law.

Even if employer could have stopped workers' compensation claimant's temporary total disability benefits after claimant was cleared by orthopedic surgeon to return to work without restrictions, employer failed to follow procedures for stopping benefits; employer did not file and serve Form 15 for at least 18 days after compensation was terminated, and employer failed to attach supporting documentation to form. Martin v. Rapid Plumbing (S.C. App. 2006) 631 S.E.2d 547, 369 S.C.278, rehearing denied. Workers' Compensation ↔ 2021 p.439

Stopping payment on temporary award-This rule and Code 1962 § 72-352 contemplate that if the insurance carrier desires to stop further payments of compensation under a temporary award., application should be made to the commission for permission to do so and the employee should

receive notice of application. *Halks v. Rust Engineering Co.* (1946) 208 SC 39, 36 SE2d 852.  
Workers' Compensation ← 2013. P. 439

The Supreme Court stated in *Abbott Laboratories v. Gardner*, 387 U.S. 136, 87 S. Ct. 1507, 18 L. Ed. 2d 861 (1967), that "a survey of our cases shows that judicial review of a final agency action by an aggrieved person will not be cut off unless there is a persuasive reason to believe that such was the purpose of Congress." *Id.* at 140, 87 S. Ct. at 1511.

As the Supreme Court told us in *Goldberg v. Kelly* 397 U.S. 254(1970, in almost every setting where important decisions turn on questions of fact, due process requires an opportunity to confront and cross-examine adverse witnesses.

"We have previously recognized that entitlement to workers' compensation benefits constitutes a property interest". *Orszula v. Orszula*, 292 S.C. 264, 356 S.E. (2d) 114 (1987).

*Goodman v. City of Columbia* 318 S.C. 488 (S.C. 1995) 458 S.E.2d 531

Fire Captain James "Woody" Goodman (White ) retired after 25 years of service as a Fire Captain with the City of Columbia Fire Department. Files a worker's comp claim against City of Columbia (the City) claiming an onset of severe mental stress and depression caused by job stress. Who wrote a letter of his desire to appeal, finding his letter constituted substantial compliance S.C. Code Ann 42-17-50."..."The letter unquestionably gave notice of intent to appeal". [ I guess White Privilege]?

Obviously a judgment, though final and on the merits, has no binding force and is subject to collateral attack if it is wholly void for lack of jurisdiction of the subject matter or person, and perhaps for excess of jurisdiction, or where it is obtained by extrinsic fraud. [Citation]"(7  
*Witkin., Cal. Procedure, supra, Judgment, § 286, p. 828*

Whenever any officer of the court commits fraud during a proceeding in the court, he/she is engaged in "fraud upon the court". In *Bulloch v. United States*, 763 F.2d 1115, 1121(10th Cir. 1985), the court stated "Fraud upon the court is fraud which is directed to the judicial machinery itself and is not fraud between the parties or fraudulent documents, false statements or perjury.... It is where the court or a member is corrupted or influenced or influence is attempted or where the judge has not performed his judicial function --- thus where the impartial functions of the court have been directly corrupted.

It is fundamental that no judgment or order affecting the rights of a party to the cause shall be made or rendered without notice to the party whose rights are to be affected." *Tyron Fed. Sav. & Loan Ass'n v. Phelps*, 307 S.C. 361, 362, 415 S.E.2d 397, 398 (1992). Generally, a person against whom a judgment or order is taken without notice may rightly ignore it and may assume that no court will enforce it against his person or property. The requirements of due process not only include notice, but also include an opportunity to be heard in a meaningful way, and judicial review. *Grannis v. Ordean*, 234 U.S. 385, 394 (1914) ("The fundamental requisite of due process of law is the opportunity to be heard."); *S.C. Dep't of Soc. Servs. v. Holden*, 319 S.C. 72, 78, 459 S.E.2d 846, 849 (1995).

Executed on this date June 22, 2020

Dated: July 22, 2020

Enclosures Exhibits 1-14 as stated.

By: 

Mr. Terry H Capone

Fire Battalion Chief-Retired

130 Summerlea Drive

Columbia, South Carolina 29203

Email: tcapone@liberty.edu

(803) 622- 6578

MOTION FOR RECONSIDERATION

FRAUD UPON THE COURT/TRIBUNAL –DENAIL OF DUE PROCESS AND EQUAL PROTECTIONS UNDER THE COLOR OF LAW

EVIDENCE ENCLOSED

Terry Capone v. City of Columbia SC WCC File Case No.:1319203, 1322451, 1420487

SC Court of Appeals Appellant Case. No. 2019-000369 July 22, 2020

Form#15 –Temporary Compensation Report: Employer: Terry Capone v. City of Columbia: No Form 15 II Has Not been Received

EXHIBITS # 1-14

1. SC WCC Form# 15
2. 10/29/2015 Thye Dana (City of Columbia) 2015 RE: 1420487, 1319203, 1322451 Appeal Information/10/29/2015 (Claimant Terry Capone) TCAPONE 1420487, 1319203, 1322451 Appeal Information
3. 1/14/2014 and 12/19/2013 Dr. Fulton Attending Physician Statement-Guardian Life Insurance LTD and UNUM Provident Agency Inc
4. 10/29/2015 Falls, Kim {SC WCC) RE: 1420481, 1319203, 1322451 Appeal Information
5. 10/29/2015 (Claimant Terry Capone) TCAPONE 1420487, 1319203, 1322451 Appeal Information
6. 3/10/2014 SC Retirement Systems Notice of Approval of continuing Disability Retirement
7. 3/6/2014 SC Disability Determination Services: Disability Rational SC Retirement System
8. 2/10/2014 City of Columbia Human Resources Approves Family Medical Leave
9. 2/6/2014 Dr. Praylow, MD Envision Wellness Medical Group completes and faxes FMLA papers to City of Columbia
10. 2/6/2014 City of Columbia Carrier Email Doris Mccubbins TPA Companion- Excerpts’: “At your most recent appointment on 1/21/2014, Dr. Fulton released you to return to work with restrictions and the City has offered accommodations to these restrictions effective 2/3/2014. Therefore, as of 2/3/14 your weekly temporary total benefits which you were receiving through is have been terminated”.
11. Three Checks - SC workers Compensation DOI -10/12/2013 Not paid until 1/06/2014
12. 01/15/2014 City of Columbia Human Resources Transmits Form 6253 Employer’s Disability Employment Status Report “Electronically
13. 12/30/2013 From Albert Owusu 2014 Annual Fire Brigade Physicals TCapone 12/6 Ortho Albert K.Owusu, Health and Safety Officer Fire Department excerpts: “ Chief Capone.....with regards to the completion of your fire brigade physical and your request for restricted duty, you are out due to **multiple physical and psychological conditions** you have

brought to the forefront. The Fire Department will need clearances from licensed medical professionals that address **each and every** one of the issues you have brought to light.”

14. October 29, 2013-P#2 Claim #64949 TCApone Return to work status Oct 29 2013, Albert Owusu, excerpts: “ Chief Capone...I have reviewed your return to work status note from Carolina Occupational Healthcare LLC. **The note clears you for light duty.** Unfortunately, there is no light duty available. **Therefore you will have to use your accrued permissive leave until such time as the doctor clears you for “Full Firefighting Duties”.**
15. The Fire Department Tele Staff calendar shows I was made to use my own Sick Leave (SL) Time starting October 21, 2013, I was not placed on SC Workers Compensation until January 4, 2014.

*ZHS*  
*7/20/20*

# EXHIBIT

#1



Claimant's Name: TERRY H CAPONE Employer's Name: CITY OF COLUMBIA  
Address: 130 SUMMERLEA DRIVE Address: PO BOX 667  
City: COLUMBIA State: SC Zip: 29203 City: COLUMBIA State: SC Zip: 29217  
Home Phone: 803 622 6578 Work Phone: \_\_\_\_\_ Insurance Carrier: SELF/COMPANION TPA (803)737-4242  
Preparer's Name: TERRY H CAPONE Law Firm: N/A Preparer's Phone #: 803 622 6578

Date of injury: 10/12/2013 (m/d/yyyy) Date of Notice to Employer of Injury: 10/25/2013 (m/d/yyyy)

- I. Payment of Temporary Compensation** Check one:  Initial period  Additional period  Corrected compensation rate  
(choose A, B, or C)
- A. Temporary Total at the compensation rate of \$2,611.20 per week. For this period of disability, disability began on 10/21/2013 (m/d/yyyy) and the date of first payment was \_\_\_\_\_ (m/d/yyyy).
- B. Temporary Partial at the compensation rate of \_\_\_\_\_ per week. Note: When the Temporary Partial compensation rate will vary, report the first payment here. Supplement this report throughout the period of Temporary Partial compensation by filing a **Form 15S** with the **Form 18**, which shall be filed six months after the date of injury and each six months thereafter until the file is closed. For this period of disability, disability began on \_\_\_\_\_ (m/d/yyyy), and the date of first payment was \_\_\_\_\_ (m/d/yyyy).

Calculation of Temporary Partial Rate:

Average weekly wage before injury

-	Current weekly wage	_____
=	Difference in wages before injury and now	\$0.00
x	.6667	\$0.00
	<b>Temporary Partial Compensation Rate</b>	<b>\$0.00</b>

- C. Salary in lieu of Temporary  Total  Partial (choose one) compensation in the amount of \$ \_\_\_\_\_ per week. For this period of disability, disability began on \_\_\_\_\_ (m/d/yyyy) and the date of first payment of salary in lieu of temporary compensation was \_\_\_\_\_ (m/d/yyyy).

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

**II. Termination of Temporary Compensation** Temporary compensation payments were stopped on \_\_\_\_\_ (m/d/yyyy) for the following reason:

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

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

\_\_\_\_\_  
Signature of Claims Administrator

\_\_\_\_\_  
Date (m/d/yyyy)

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

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

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

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

\_\_\_\_\_  
Signature of Claimant or Legal Representative

7/22/2020

\_\_\_\_\_  
Date (m/d/yyyy)

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



Claimant's Name: TERRY H CAPONE Employer's Name: CITY OF COLUMBIA  
Address: 130 SUMMERLEA DRIVE Address: PO BOX 667  
City: COLUMBIA State: SC Zip: 29203 City: COLUMBIA State: SC Zip: 29217  
Home Phone: 803 622 6578 Work Phone: \_\_\_\_\_ Insurance Carrier: SELF/COMPANION TPA (803)737-4242  
Preparer's Name: TERRY H CAPONE Law Firm: N/A Preparer's Phone #: 803 622 6578

Date of injury: 10/12/2013 (m/d/yyyy) Date of Notice to Employer of Injury: 10/25/2013 (m/d/yyyy)

I. Payment of Temporary Compensation Check one:  Initial period  Additional period  Corrected compensation rate  
(choose A, B, or C)  
 A. Temporary Total at the compensation rate of \$2,611.20 per week. For this period of disability, disability began on 10/21/2013 (m/d/yyyy) and the date of first payment was \_\_\_\_\_ (m/d/yyyy).  
 B. Temporary Partial at the compensation rate of \_\_\_\_\_ per week. Note: When the Temporary Partial compensation rate will vary, report the first payment here. Supplement this report throughout the period of Temporary Partial compensation by filing a Form 15S with the Form 18, which shall be filed six months after the date of injury and each six months thereafter until the file is closed. For this period of disability, disability began on \_\_\_\_\_ (m/d/yyyy), and the date of first payment was \_\_\_\_\_ (m/d/yyyy).

Calculation of Temporary Partial Rate:

Average weekly wage before injury	
- Current weekly wage	
= Difference in wages before injury and now	\$0.00
x .6667	\$0.00
<b>Temporary Partial Compensation Rate</b>	<b>\$0.00</b>

C. Salary in lieu of Temporary  Total  Partial (choose one) compensation in the amount of \$ \_\_\_\_\_ per week. For this period of disability, disability began on \_\_\_\_\_ (m/d/yyyy) and the date of first payment of salary in lieu of temporary compensation was \_\_\_\_\_ (m/d/yyyy).

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

II. Termination of Temporary Compensation Temporary compensation payments were stopped on \_\_\_\_\_ (m/d/yyyy) for the following reason:  
 Claimant has returned to work at least 15 days and no temporary partial compensation is due.  
 Claimant agrees he/she is able to return to work and has signed a Form 17.  
 Based on a good faith investigation, the claim is denied. Reason for denial:  
  
 Claimant has been released to return to work without restrictions and employment has been offered.  
 Claimant has been released to work at limited duty and employer has provided limited duty work consistent with the terms upon which the Employee has been released.  
 Claimant has refused medical treatment, examination, or evaluation. Note: Benefits must be resumed if claimant accepts the treatment, examination, or evaluation. Additional report must be filed if compensation is resumed.

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

Signature of Claims Administrator \_\_\_\_\_ Date (m/d/yyyy) \_\_\_\_\_

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

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

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

Signature of Claimant or Legal Representative \_\_\_\_\_ Date 7/22/2020 (m/d/yyyy) \_\_\_\_\_

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

# EXHIBIT

#2

**RE: TCAPONE 1420487 , 1319203, 1322451 Appeal Information**

Thye, Dana &lt;dmthye@columbiasc.net&gt;

Thu 10/29/2015 8:20 AM

To: Capone, Terry &lt;tcapone@liberty.edu&gt;; Lindler, Kellie &lt;klindler@wcc.sc.gov&gt;; Falls, Kim &lt;kfalls@wcc.sc.gov&gt;

Cc: James, Wendy M &lt;wmjames@columbiasc.net&gt;

Mr. Capone, what you received are the findings of the Commissioner that I have been asked to put into a formal order. I will prepare the Order as instructed and submit to the Commissioner with a copy to you. When the Commissioner signs an Order, you will have the opportunity to appeal that Order as it then decides the case. I would continue to encourage you to seek counsel to assist you on appeal.

Dana Thye

Sent from my Verizon Wireless 4G LTE smartphone

----- Original message -----

From: "Capone, Terry" &lt;tcapone@liberty.edu&gt;

Date: 10/29/2015 12:05 AM (GMT-05:00)

To: "Lindler, Kellie" &lt;klindler@wcc.sc.gov&gt;, "Falls, Kim" &lt;kfalls@wcc.sc.gov&gt;

Cc: "Thye, Dana" &lt;dmthye@columbiasc.net&gt;, "James, Wendy M" &lt;wmjames@columbiasc.net&gt;

Subject: TCAPONE 1420487 , 1319203, 1322451 Appeal Information

Hello,

I received the notice this evening with the findings of the hearing, I am confused, as I thought carpal tunnel was an admitted injury and Dr Greens most recent assesement & date was not included in the summary? I would like a copy of the transcript and written directions on how to appeal these findings please; I know its \$150.00 fee. Thank you

Terry Capone

CONFIDENTIAL &amp; PRIVILEGED

The preceding email message, including any attachments, may be confidential and/or protected by the attorney-client or other applicable privileges. It is intended for the sole use of the individual or entity named above. If the reader of this transmission is not the intended recipient, please notify the sender immediately and destroy any copies, electronic, paper or otherwise, that you may have of this communication. Any unauthorized review, use, disclosure or distribution is strictly prohibited and may be unlawful.

# EXHIBIT

#3

**RE: TCAPONE 1420487 , 1319203, 1322451 Appeal Information**

Falls, Kim &lt;kfalls@wcc.sc.gov&gt;

Thu 10/29/2015 8:53 AM

To: Thye, Dana <dmthye@columbiasc.net>; Capone, Terry <tcapone@liberty.edu>; Lindler, Kellie <klindler@wcc.sc.gov>  
Cc: James, Wendy M <wmjames@columbiasc.net>

Mr. Capone,

Like Ms. Thye stated, there will be a formal Order that you will be able to Appeal. Once you have received the formal Order, you will have 14 days to Appeal. The 14 days start from the date on the certificate of service of the Order. You can go to our website, [www.wcc.sc.gov](http://www.wcc.sc.gov), and print off a form 30 to Appeal the Order. It is a \$150.00 filing fee. If you cannot afford the \$150.00, you can fill out a form 32 to send with the 30. The 32 will be sent to the Chairman and he will decide as to whether or not your fee can be waived.

As far as the transcript goes, the Commission does not Order the transcript. You will have to contact the court reporter and pay for a copy of the transcript. The court reporters are not employees of the Commission and the transcripts are how they make a living. We will also need a copy of the transcript if you wish to Appeal.

Kellie, can you please provide Mr. Capone with the contact information for the court reporter?

Let me know if you have any more questions.

Thanks!

Kim Falls  
SC Workers' Compensation Commission  
Judicial Analyst - Appeals Division  
1333 Main Street, Suite 500  
Post Office Box 1715  
Columbia, SC 29202-1715  
Phone: 803-737-5739  
kfalls@wcc.sc.gov

**From:** Thye, Dana [mailto:dmthye@columbiasc.net]  
**Sent:** Thursday, October 29, 2015 8:19 AM  
**To:** Capone, Terry; Lindler, Kellie; Falls, Kim  
**Cc:** James, Wendy M  
**Subject:** RE: TCAPONE 1420487 , 1319203, 1322451 Appeal Information

Mr. Capone, what you received are the findings of the Commissioner that I have been asked to put into a formal order. I will prepare the Order as instructed and submit to the Commissioner with a copy to you. When the Commissioner signs an Order, you will have the opportunity to appeal that Order as it then decides the case. I would continue to encourage you to seek counsel to assist you on appeal.  
Dana Thye

Sent from my Verizon Wireless 4G LTE smartphone

# EXHIBIT

#4

Send to: Group Long Term Disability Claims, P.O. Box 26025, Lehigh Valley, PA 18002-5025  
For Customer Service: (800) 538-4583 Fax: (610) 807-8221  
Secure E-mail: www.GuardianAnytime.com, click Secure Channel, select Group\_LTD\_Claims@glic.com

**EMPLOYEE SECTION**

1. Employee Name <u>Terry H Capone</u>	2. DOB <u>6/10/70</u>	3. Plan Number	4. Claim Number
4. Address <u>4209 Woodridge Drive Columbia SC 29203</u>	City <u>Columbia</u>	State <u>SC</u>	Zip <u>29203</u>
5. Phone # <u>(803) 799 7688</u>	7. Occupation <u>Fire Battalion Chief</u>		
6. Employer Name <u>City of Columbia Fire Department</u>			

**AUTHORIZATION**

I authorize any physician, medical practitioner, hospital, clinic, other health facility, consumer reporting agency, the Social Security Administration, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information in its possession about me to The Guardian Life Insurance Company of America or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me. I understand that Guardian will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. Guardian will not release any information obtained to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be lawfully required or permitted, or as I may further authorize. I know that I may request and receive a copy of this authorization. I agree that a photocopy of this authorization shall be as valid as the original. I have the right to cancel this authorization in writing at any time. I agree that this authorization shall be valid for the duration of my claim.

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. In New York the person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

Signature [Signature] Date 12/30/13

**PHYSICIAN SECTION** Completion of this form will help to expedite processing of the claim and reduce additional requests and follow up. Your patient is responsible for the cost of completing this form.

1. Diagnosis (including any complications) <u>carpal tunnel syndrome</u>	ICD9 or DSM IV Codes: <u>354.0</u>
2. Medical evidence that substantiates or contributes to this patient's inability to work (please attach results of x-rays, MRIs, EKGs, etc.) <u>Nerve conduction study shows mild carpal tunnel syndrome bilaterally</u>	
3. Subjective Complaints <u>Bilateral hand numbness and dysfunction.</u>	

**CONDITION HISTORY**

4. Patient's symptoms are the result of (check all that apply)

<input checked="" type="checkbox"/> Employment	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Other Accident
<input type="checkbox"/> Illness	<input type="checkbox"/> Motor Vehicle Accident	<input type="checkbox"/> Other

5. Date symptoms first appeared or accident occurred  
10/12/13

6. Date of your first evaluation for this condition  
12/6/13

7. Frequency of visit/treatment for this condition  
 Weekly  Monthly  Other

8. Date of most recent visit/treatment for this condition  
12/6/13

9. If inability to work is due to pregnancy, please indicate  expected  actual (check one) delivery date: \_\_\_/\_\_\_/\_\_\_  
Type of delivery (if applicable)  Vaginal  C-section  Single Birth  Multiple Births

10. Has this patient ever had a similar or related condition?  Yes  No  
If "Yes", when \_\_\_/\_\_\_/\_\_\_ Explain:

11. Was this patient referred to you by another physician?  Yes  No If "Yes", please supply physician's complete name and address, specialty, phone # and fax #:  
John Clavel MD, 104 Saluda Pointe Drive Lexington SC 29072, 803 227 8127 (H) 803 227 8227

12. Did you refer this patient to another physician/or provider for treatment of this or a related condition?  Yes  No  
If "Yes", please supply the physician's/provider's complete name and address, phone # and fax #:

13. Please supply complete name, address and specialty of any other treating physicians or hospitals including phone # and fax #.

Name	Specialty	Address	Phone #	Fax #	From	To

If additional space is needed, please attach a separate sheet

**TREATMENT**

14. Describe this patient's treatment program: (including any surgeries with date and CPT codes) obtain NCS which showed mild bilateral CTS, pt has Rx 1/27/14 to discuss treatment plan  
 Medications \_\_\_\_\_ Counseling \_\_\_\_\_  
 Therapies \_\_\_\_\_ Vocational rehabilitation \_\_\_\_\_

**PROGRESS**

15. Patient has  Recovered  Not Changed  Improved  Retrogressed  
 16. Patient is  Ambulatory  House Confined  Other \_\_\_\_\_  
 Bed Confined  Hospital Confined

17. Did you place the patient on off work status?  Yes  No  
 18. If yes, what date? 1/13/14

19. Has patient been released to return to work?  Yes  No  
 If "Yes", date patient was released to return to work? 12, 4, 13  
 Part Time  Usual Occupation  Other Occupation  
 Full Time  Other Occupation  
 Other light duties pushing & pulling limit of 25lb  
 Now work @ heights lifting & carrying 10 lb of 25 lb

20. If not yet released to return to work, when do you anticipate a release? \_\_\_/\_\_\_/\_\_\_  Part Time  Full Time  Never

21. Physical LIMITATIONS that preclude RETURN TO WORK  
 Class 1 No limitation of functional capacity; capable of heavy work\* no restrictions (0-10%)  
 Class 2 Medium manual activity\* (15-30%)  
 Class 3 Slight limitation of functional capacity; capable of light work\* (35-55%)  
 Class 4 Moderate limitations of functional capacity; capable of clerical/administrative (sedentary\*) activity (60-70%)  
 Class 5 Severe limitations of functional capacity; incapable of minimal (sedentary\*) activity (75-100%)

Remarks  
Now work @ heights lifting & carrying limit of 10lbs, pushing & pulling limit of 25lb.  
 \*As defined in the Federal Dictionary of Occupational Titles

22. Degree of mental/nervous impairment Current GAF (Global Assessment of Functioning) \_\_\_\_\_/90 Please attach mental status exam.  
 Axis 1 \_\_\_\_\_ Axis 3 \_\_\_\_\_ N/A  
 Axis 2 \_\_\_\_\_ Axis 4 \_\_\_\_\_

23. Do you believe that this patient is competent to endorse checks and direct the use of the proceeds?  Yes  No N/A

24. Degree of Cardiac Functional Capacity (American Heart Association)  
 Class 1 (No Limitation)  Class 2 (Slight Limitation)  Class 3 (Marked Limitation)  Class 4 (Complete Limitation) N/A  
 Please supply patient's: height \_\_\_\_\_ weight \_\_\_\_\_ blood pressure \_\_\_\_\_

PLEASE ATTACH PERTINENT MEDICAL RECORDS INCLUDING BUT NOT LIMITED TO PROGRESS NOTES, DIAGNOSTIC TEST RESULTS, DISCHARGE SUMMARIES, OPERATIVE REPORTS, CONSULTATION REPORTS AND MENTAL STATUS EXAM (IF APPLICABLE). THIS WILL HELP TO EXPEDITE PROCESSING OF CLAIM AND REDUCE ADDITIONAL REQUESTS AND FOLLOW UP. YOUR PATIENT IS RESPONSIBLE FOR THE COST OF THE MEDICAL RECORDS.

**PHYSICIAN INFORMATION**

25. Physician's Name David B Fulton  
 26. Degree MD 27. Specialty orthopedic surgery  
 28. Address 104 Saluda Pointe Drive  
 29. City Lexington 30. State SC 31. Zip 29072  
 32. Telephone # (803) 227 8124 33. Fax # (803) 227 8224 34. Tax ID # 270743474

35. Remarks

**FRAUD NOTICE**

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes Employee and Attending Physician portions of the form.

\*  
 Signature of Physician (no stamp) [Signature] Date 1, 13, 14



**DISABILITY CLAIM** (PLEASE HAVE ALL SECTIONS COMPLETED)  
 Provident Agency, Inc ; 272 Alpha Drive; P.O. Box 11588  
 Pittsburgh, PA 15238  
 Phone 800-447-0360 Fax 412-963-0148

acc # 174 1000  
 mail to company & patient  
 Paid

**A. ATTENDING PHYSICIAN'S STATEMENT (PLEASE PRINT)**

Organization Name SCSFA Policy Number: DCC-7504289

1. Name of Patient Terry Capone Date of Birth 6

**2. Diagnosis - Please include the primary diagnosis and list any secondary conditions**

Date of Last Examination 12/16/13 Diagnosis (including any complications) include ICD CODE and/or DSM IV Multi Evaluation Nomenclature and Code Number Pain & Numbness in hands T82.0

Physical findings (including current x-rays, EKGs, psychiatric testing, laboratory data and any clinical findings) NO Tendon or intrinsic atrophy

Reported Symptoms full ROM, mild dysesthesia in forearm, normal two-point discrimination

Reported Symptoms intermittent numbness, pain in hands, night-time waking due to symptoms.

Is this condition due to  an Accident  a Sickness? Date symptoms first appeared or accident occurred.

Is the accident or sickness related to the patient's involvement with their Emergency Service Organization?  Yes  No  Unknown

Date restrictions and limitations began 12/16/13 Has patient ever been treated for the same or similar condition?  Yes  No If yes, state when and describe.

**3. Information About the Patient's Ability to Work - this information is critical to understanding your patient's condition**

Has patient been released to work in his/her occupation?  Yes  No in any occupation?  Yes  No

If the patient has demonstrated a loss of function, please provide restrictions and limitations and the date they began in the space provided below

Fully describe restrictions and limitations

RESTRICTIONS (What the patient should not do)  
unable to perform full fire-fighter duties  
25lb push/pull limit, 10lb lift/carry limit, NO work at heights NO  
Depot duty  
working out of unit

LIMITATIONS (What the patient cannot do)  
same as above

When should the patient be able to return to work? Full Time, ambulatory further testing results. Part Time.

Height/Weight 5'7" 242 Blood Pressure Last Visit \_\_\_\_\_ If Pregnancy, Expected Delivery Date \_\_\_\_\_ If Delivered, Actual Delivery Date \_\_\_\_\_ Delivery Type  Normal  C-Section

Date of first visit for this illness or injury 12/16/13 Date of next visit pending authorization Date of last visit 12/16/13 Frequency of visits one time

Is patient  Ambulatory  Bed Confined  House Confined  Hospital Confined Has patient been admitted to hospital?  Yes  No

If Hospital Confined, give name and address of hospital

Have you completed claim forms regarding this patient for other insurance carriers?  Yes  No If yes, state date and name of insurance company

**4. Names and Addresses of Other Treating Physicians**

Referring physician or other treating physicians (names, address, phone #'s):  
Thomas Plotycka, M.D. 803 791 3626  
Blanchard St. Columbia SC

REQUIRED ATTACHMENTS AND SIGNATURES  
 Please make sure that office notes, test results, and discharge summaries are attached. This will help reduce additional requests.

**FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Attending Physician portions of the claim form.**

The above statements are true and complete to the best of my knowledge and belief.

Print or Type Name David J. Fulton Degree M.D. Medical Specialty Orthopedics  
 Street Address Old Saluda Pointe Dr. Phone Number (803) 287-8224  
 City Lexington State SC Zip Code 29072 Fax (803) 287-8224  
 Signature of Physician [Signature] Date 12/19/13

# EXHIBIT

#5

# South Carolina Retirement Systems

*THIS DOCUMENT CONTAINS IMPORTANT INFORMATION ABOUT YOUR BENEFITS. DO NOT DISCARD.*

## NOTICE OF APPROVAL OF CONTINUING DISABILITY RETIREMENT

TERRY H CAPONE  
4209 WOODRIDGE DRIVE  
COLUMBIA SC 29203

System: PORS  
Type: Disability  
Date: March 10, 2014

The South Carolina Retirement Systems has approved your claim for disability retirement as a member of the Police Officers Retirement System. However, your claim was approved with the stipulation that it be reevaluated on 03/01/2017 to determine if your medical condition has improved. We will send you the appropriate materials for completion approximately 60 days before that date.

Before you can begin receiving disability retirement benefits, your employer must certify to South Carolina Retirement Systems the last day that you earned compensation or expect to earn compensation. We have contacted your employer and requested that we receive this information as quickly as possible so that your retirement benefits will not be delayed. Once your employer certifies your last day on payroll, we will send you a notice informing you of your effective date of retirement, service credit through that date, and estimated monthly benefit.

If you are still on your employer's payroll, please be aware that Sections 9-1-1540, 9-9-65, and 9-11-80 of the South Carolina Code of Laws require that a disability retiree have an effective retirement date no earlier than 30 days after the application was filed with South Carolina Retirement Systems and no later than 9 months after the application filing date. Our records indicate that we received your application for disability retirement benefits on 12/16/2013. If you do not come off your employer's payroll within 9 months of the date on which we received your application, no retirement benefits can be paid and our office will stop processing your claim.

Your effective date for disability retirement will therefore be either the thirtieth day after we received your disability application or the day after your last day on your employer's payroll, whichever is later. If you return to work or decide that you do not wish to retire, please notify us in writing immediately. We will then cancel your retirement application.

Please call SCRS Customer Service at 800-868-9002 or 803-737-6800 if you have any questions.

**SC Public Employee Benefit Authority • South Carolina Retirement Systems**  
Fontaine Business Center • 202 Arbor Lake Drive • Post Office Box 11960 • Columbia, South Carolina 29211  
803-737-6800 • 800-868-9002

# EXHIBIT

#6

**DISABILITY RATIONALE  
SOUTH CAROLINA RETIREMENT SYSTEM**

NAME: TERRY H CAPONE

CLAIM TYPE: SCRS

MEDICAL SOURCES

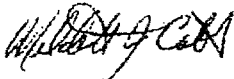
MOORE ORTHOPAEDIC CLINIC, 01/27/14  
ENVISION WELLNESS MEDICAL GROU, 02/27/14  
ELLIS PHYSICAL THERAPY ASSOCS, 02/21/14  
PALMETTO RICHLAND MEM HOSPITAL, 02/17/14  
THIRD PARTY REPORT, 02/24/14  
SLEEPMED INC, 02/06/14  
ENVISION WELLNESS MEDICAL GROU,  
MOORE ORTHOPAEDIC CLINIC PA,

RATIONALE

This 43-year-old applicant alleges disability from 10/21/13 due to PTSD, anxiety and injuries to his hand. The applicant is a firefighter, Battalion chief. This occupation is skilled work requiring heavy physical exertion and capacity. The applicant states that difficulties began after an incident in October 2013 where he suffered an injury to his hand during the performance of duties. He stated he developed reduced grip strength and numbness in his arms and hand. The applicant also reports symptoms and experiences related to PTSD. The record documents several other situations where the applicant sustained injuries and was involved in dangerous threatening situations. The medical records document the diagnosis of carpal tunnel symptoms that affect the use and function of his hands. The also experiences weakness of grip and pain in his hands. Nerve conduction studies document mild carpal tunnel syndrome. The evidence documents continued treatment for PTSD symptoms associated with multiple events and work-related stressors. The applicant also has symptoms of depression, anxiety, panic attacks and mood ability. The treating source also documents excessive rumination, paranoia and hyperarousal. The applicant is also expressed homicidal and passive suicidal ideation. Current evidence documents moderate functional limitations with respect to his daily activities, social function and maintaining concentration and pace. The applicant exhibits moderate limitations with his ability to understand and remember detailed instruction, carry out detailed instructions as well as maintaining attention and concentration for extended periods. The also has difficulty working in close proximity of other employees and his ability to maintain a normal workday and workweek without interruptions from psychologically based symptoms is limited. Due to his mental condition, the applicant would have significant difficulty with function in a stressful work environment requiring skilled, concentration and attention. He is able to make simple work related decisions and adjustments but only in unskilled work situations. Recommendation for allowance of this claim is made, recommended onset 10/21/13. He does not retain the functional capacity to perform duties of his past work as a Firefighter. The record documents the applicant is continuing to receive psychiatric treatment and therapy. It is expected that with continued treatment his medical condition may improve. A medical re-examination date of 2/2017 is indicated.

DDS Examiner

March 6, 2014



Claim No:

**RECEIVED**

MAR 10 2014

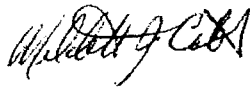
**CUSTOMER CLAIMS**

**DISABILITY RECOMMENDATION TO SCRS**

MCB\232

Claim Level IN	Claim Type SCRS	Filing Date 12/16/13	SSN		
		S/A Receipt Date 01/21/14	Date of Birth 06/10/70		
Address of Originating Office S C RETIREMENT SYSTEM P O BOX 11960 CAPITOL STATION COLUMBIA SC 29211			Name and Address of Claimant TERRY H CAPONE 4209 WOODRIDGE DR COLUMBIA SC 29203		
Claimant Disabled		B. Onset		C. Diary	
A. ALLOWED		Disability Began 10/21/13		Type MRN	
		Disability Ceased		Mo/Yr 3/2017 2/2017	
Claimant Not Disabled					
A.		Primary Diagnosis	Code 12	Body Sys 3000	Secondary Diagnosis
		Anxiety Related Disorders		Affective/Mood Disorders	
B. Disability Ceased		Basis Code BC		Reason MED/VOC PREVENTS JOB DUTIES	
VR Action		A. Screen In	B. Screen Out	X	C. Prev. Ref.

Remarks



Mitchell J. Cribb, Disability Examiner

Date: 03/06/14

SCRS Action Date: 3/10/14

Disability Approved as Recommended

Disability Disapproved as Recommended

Other Action Disapproved  
w/CDR Date 3/11/17

SCR99 (7/05)

**RECEIVED**

MAR 10 2014

CUSTOMER CLAIMS

# EXHIBIT

#7



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We Are Columbia

---

Human Resources Department

1225 Lady Street • PO Box 147 • Columbia, SC 29217 • (803) 545-3005 • Fax (803) 343-8752

February 10, 2014

Mr. Terry Capone  
4209 Woodridge Drive  
Columbia, SC 29203

Dear Mr. Capone:

You have been approved for Family Medical Leave of Absence, effective **02/06/14 up to 04/30/14 or (480 hours)**, along with your workers compensation leave. Attached you should find "Your Rights Under the Family and Medical Leave Act of 1993" publication which should answer most of your questions concerning the Family Leave Act.

Please be aware that your workers' compensation leave may count towards Family Medical Leave.

If you normally pay a portion (*dependent coverage*) of the premiums for your health insurance, you will need to make arrangements to pay the premium payments as follows:

Start Date: The first pay period you do not receive a regular paycheck  
Amount Due: **\$64.95(Health), \$5.93(Dental), \$5.23(Vision) - Bi-weekly**

If you would like to temporarily drop dependent coverage until you begin receiving a full payroll check, please give Natasha Taylor a call at 545-3007.

If you have voluntary payroll deduction(s) coming out of your check (i.e., life insurance), you will need to make arrangements with that company to pay the premiums.

If you have any questions or concerns, please give me a call at 545-3003.

Sincerely,

Libba Duncan  
Human Resources Department

Cc: AFC James Helms  
Wilfred Roach  
Natasha Adams

# EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

## Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

## Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness\*, or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.\*

\*The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".

## Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

## Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months\*, and if at least 50 employees are employed by the employer within 75 miles.

\*Special hours of service eligibility requirements apply to airline flight crew employees.

## Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and

a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

## Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

## Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

## Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

## Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

## Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under, or relating to, FMLA.

## Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

**FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.**



For additional information:  
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627  
[WWW.WAGEHOUR.DOL.GOV](http://WWW.WAGEHOUR.DOL.GOV)

U.S. Department of Labor | Wage and Hour Division



WHD Publication 1475 - Revised February 2011

# EXHIBIT

#8



# CITY OF COLUMBIA

**Libba Duncan**  
Human Resources Specialist  
Human Resources Department

1225 Lady Street P.O. Box 147 / Columbia, SC 29217  
Office (803) 345-3003 / Fax (803) 343-8752  
Email: lduncan@columbiase.net



Certification of Health Care  
Employee's Serious Health  
(Family and Medical Leave)

Control Number: 1235-0003  
Expires: 2/28/2015

### SECTION I: For Completion by the EMPLOYER

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: City of Columbia Libba Duncan / HR specialist  
Employee's job title: Fire Battalion Chief Regular work schedule: reg.  
Employee's essential job functions: see job description  
Check if job description is attached:

### SECTION II: For Completion by the EMPLOYEE

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections, 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request, 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form, 29 C.F.R. § 825.305(b).

Your name: Terry H Capone  
First Middle Last

### SECTION III: For Completion by the HEALTH CARE PROVIDER

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: Tiona Praylaw, Envision Wellness  
Type of practice / Medical specialty: Psychiatry  
Telephone: (256) 0101 Fax: ( )

PART A: MEDICAL FACTS

1. Approximate date condition commenced: 10/2013

Probable duration of condition: chronic

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

No  Yes. If so, dates of admission:

Date(s) you treated the patient for condition:

10/2013 - present

Will the patient need to have treatment visits at least twice per year due to the condition?  No  Yes.

Was medication, other than over-the-counter medication, prescribed?  No  Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?  No  Yes. If so, state the nature of such treatments and expected duration of treatment:

outpatient therapy should be ongoing

2. Is the medical condition pregnancy?  No  Yes. If so, expected delivery date: \_\_\_\_\_

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition?  No  Yes.

If so, identify the job functions the employee is unable to perform:

Firefighting, supervising subordinates, emergency response, reasoning.

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

Pt. meets criteria for diagnosis of PTSD. He is being prescribed anxiolytics and anti-depressants. His wife provides collateral information that confirms obsessive rumination, paranoia, and hyperarousal. Currently, he meets criteria for MDD as well and has reported HI and passive SI on prior assessments.

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?  No  Yes.

If so, estimate the beginning and ending dates for the period of incapacity: indeterminate

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition?  No  Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?  
 No  Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Estimate the part-time or reduced work schedule the employee needs, if any:

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?  No  Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?  
 No  Yes. If so, explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

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

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

5. Throughout course of evaluating + treating Mr. Capone it is my belief that the severity of PTSD symptoms reported that have resulted from his job duties make it unsafe for pt. and other employees to return to work in this capacity. Symptoms such as paranoia, flashbacks, hyperarousal, and insomnia impair his cognition and judgement.

Returning to duty at this time will likely exacerbate his condition.

  
Signature of Health Care Provider

2/6/14  
Date

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years: 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

# EXHIBIT

#9

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From: DORIS.MCCUBBINS@companiongroup.com  
[DORIS.MCCUBBINS@companiongroup.com]  
Sent: Thursday, February 6, 2014 5:58 PM  
To: Capone, Terry  
Subject: RE: TCAPONE Claim: 700000004250

Hello Mr. Capone. I have now reviewed all your emails. The denial letter that we sent you was in response to the attached claim you submitted. As a practical matter and because you have another claim with us with the same date of accident of 10/12/13, we felt it was best to reference the letter as "Post Traumatic Stress Disorder" claim in order to distinguish the two claims. To clarify, our denial encompasses ALL conditions mentioned in the attached which you sent to the City which and was forwarded to Companion for further handling.

Regarding the light duty matter, this applies to your other claim also with date of injury 10/12/13 and which is to your hands/wrists. As you are aware, Dr. Fulton has diagnosed you with mild bilateral carpal tunnel and we have authorized treatment for this. At your most recent appointment on 1/21/14, Dr. Fulton released you to return to work with restrictions and the City has offered accommodations to these restrictions effective 2/3/14. Therefore, as of 2/3/14 your weekly temporary total benefits which you were receiving through us have been terminated. While we are on the temporary total benefits topic, I wanted to inform you that we ceased these benefits and paid only through 1/9/14, because we learned from the City that there had been a duplicate payment issued to you. Per the City, they paid you for period 12/6/13- 1/2/14 (4 weeks) as did we. Because you cannot receive duplicate payment for time out of work under workers' compensation, we applied that 4 week TTD credit to the period of TTD 1/10/14- 2/6/14 (4 weeks). Since you are only entitled to TTD through 2/2/14, this now leaves of 4 days on your claim (period 2/3/13- 2/6/13) or \$389.92. If this sounds confusing or you need clarification on this, please do not hesitate to call me directly to discuss at 803-264-4262. I did try contacting you previously to explain all this and left a voicemail, but did not hear back.

Lastly, regarding your reaction to the injection that Dr. Fulton provided, this is

an issue that you will have to take up with Dr. Fulton. If you have any medical issues or questions regarding your treatment, this needs to be addressed with the treating physician. Please note that any treatment that workers compensation does not pre-authorize will not be covered by us.

I hope that I have addressed your concerns and please do not hesitate to contact me regarding your claim.

Doris J. McCubbins, AIC, AIS  
Senior Claims Adjuster  
Companion P&C  
Phone: 1-800-845-2724 ext 44262  
Fax: (803) 870-8944

-----Original Message-----

From: Capone, Terry [<mailto:tcapone@liberty.edu>]  
Sent: Thursday, February 06, 2014 9:54 AM  
To: DORIS MCCUBBINS  
Subject: RE: TCAPONE Claim: 700000004250

Hello Ms.Mccubbins,

That shot that Dr,Fulton gave that caused me to have a severe allergic reaction also caused an infection on my face and has let two scars, but are continuing to heal, again do I need to fillout an injury report of some kind. The puse is out sunday night, I am putting attibacterial ointment and coco butter at this time.

Terry Capone

---

From: Capone, Terry  
Sent: Tuesday, February 4, 2014 10:04 PM  
To: DORIS.MCCUBBINS@companiongroup.com  
Subject: TCAPONE Claim: 700000004250

Hello Ms.Mccubbins,

# EXHIBIT

#10

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND - NOT A WHITE BACKGROUND  
THE BACK OF THIS DOCUMENT CONTAINS AN ARTIFICIAL WATERMARK - HOLD AT AN ANGLE TO VIEW



City of Columbia Workers Compensation  
COMPANION TPA, LLC - ADMINISTRATOR  
P. O. BOX 100159 COLUMBIA, SC 29202-3165

No. 0000151461

32-1  
1310

CLAIM NO: 700000004250-0001 LOSS DATE: 10/12/13  
POLICY NO: CCW 0000001 INSURED'S NAME: CITY OF COLUMBIA

DATE: 01/06/14 CHECK NO.: 0000151461  
CLAIMANT NAME: TERRY CAPONE

TWO THOUSAND SEVEN HUNDRED TWENTY NINE & 48/100

DOLLARS \$2,729.48

PAY TO THE ORDER OF: TERRY CAPONE

• Void after 6 months

CASHIER: For your protection,  
require two IDs from payee.

AUTHORIZED SIGNATURE

⑈0000151461⑈ ⑆111000012⑆ 442 657 0149⑈

PLEASE TEAR AT PERF TO DETACH CHECK

FEIN: 111111111

Coverage: WORKERS COMPENSATION

Cause of Loss: WORKERS COMPENSATION

Explanation of Payment:

TEMPORARY TOTAL DISABILITY FROM 12/6/13 - 1/2/14 (4WKS)

If you have any questions concerning this payment,  
please contact Doris Quizhpe at ext. 44262



Acct #:

State: 39

MCO: 01

TERRY CAPONE

4209 WOODRIDGE DRIVE  
COLUMBIA, SC

29203

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND - NOT A WHITE BACKGROUND  
THE BACK OF THIS DOCUMENT CONTAINS AN ARTIFICIAL WATERMARK - HOLD AT AN ANGLE TO VIEW



City of Columbia Workers Compensation  
COMPANION TPA, LLC - ADMINISTRATOR  
P. O. BOX 100159 COLUMBIA, SC 29202-3165

No. 0000151494

32-1  
1110

CLAIM NO: 700000004250-0001 LOSS DATE: 10/12/13  
POLICY NO: CCW 0000001 INSURED'S NAME: CITY OF COLUMBIA

DATE: 01/07/14 CHECK NO.: 0000151494  
CLAIMANT NAME: TERRY CAPONE

SIX HUNDRED EIGHTY TWO & 37/100

DOLLARS \$682.37

PAY TO THE ORDER OF: TERRY CAPONE

Void after 6 months

CASHIER: For your protection,  
require two IDs from payee.

AUTHORIZED SIGNATURE

⑈0000151494⑈ ⑆111000012⑆ 442 657 0149⑈

PLEASE TEAR AT PERF TO DETACH CHECK

FEIN: 111111111

Coverage: WORKERS COMPENSATION

Cause of Loss: WORKERS COMPENSATION

Explanation of Payment:

TT TERRY CAPONE 01/03/2014 TO 01/09/2014

If you have any questions concerning this payment,  
please contact Doris Quizhpe at ext. 44262



Acct #:

State: 39

MCO: 01

TERRY CAPONE

4209 WOODRIDGE DRIVE  
COLUMBIA, SC

29203

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND - NOT A WHITE BACKGROUND  
THE BACK OF THIS DOCUMENT CONTAINS AN ARTIFICIAL WATERMARK - HOLD AT AN ANGLE TO VIEW



City of Columbia Workers Compensation  
COMPANION TPA, LLC - ADMINISTRATOR  
P. O. BOX 100159 COLUMBIA, SC 29202-3165

No. 0000151611

31  
11/16

CLAIM NO: 700000004250-0001    LOSS DATE: 10/12/13    DATE: 01/14/14    CHECK NO.: 0000151611  
POLICY NO: CCW 0000001    INSURED'S NAME: CITY OF COLUMBIA    CLAIMANT NAME: TERRY CAPONE

SIX HUNDRED EIGHTY TWO & 37/100

DOLLARS \$682.37

PAY TO THE ORDER OF: TERRY CAPONE

Void after 6 months

CASHER: For your protection,  
require two IDs from payor.

AUTHORIZED SIGNATURE

⑈0000151611⑈ ⑆111000012⑆ 442 657 0149⑈

PLEASE TEAR AT PERF TO DETACH CHECK

FEIN: 111111111

Coverage: WORKERS COMPENSATION

Cause of Loss: WORKERS COMPENSATION

Explanation of Payment:

TT TERRY CAPONE 01/10/2014 TO 01/16/2014

If you have any questions concerning this payment,  
please contact Doris Quizhpe at ext. 44262.

=====  
=====  
=====  
=====  
Acct #:

State: 39

MCO:01

TERRY CAPONE

4209 WOODRIDGE DRIVE  
COLUMBIA SC

29203

# EXHIBIT

#11

Form 8253 Revised 7/9/2012 Print or type in black ink	<b>EMPLOYER'S DISABILITY EMPLOYMENT STATUS REPORT</b> To Be Completed by Applicant's Payroll/Benefits Officer SC Public Employee Benefit Authority South Carolina Retirement Systems Attention: Customer Services Annuity Claims PO Box 11960, Columbia, SC 29211-1960	<input type="checkbox"/> SCRS <input checked="" type="checkbox"/> PORS <input type="checkbox"/> GARS
---	---	--

The individual indicated below has applied for disability retirement benefits. Please complete the information on the remainder of this form, and return it to the address listed above as soon as possible. Upon receipt of this completed form, the employee's application will be processed.

*Revised Ann: Wade Randolph*

Employee Name: <b>TERRY H CAPONE</b>	Social Security Number:
Employer: <b>CITY OF COLUMBIA</b>	Employer Code: <b>740.05</b>
Position Title: <b>FIRE BATTALION CHIEF</b>	

**RECEIVED**  
JAN 15 2014

1. Is the position title shown above correct? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (please explain)	2. Annual salary on date of disability: <b>\$ 54,688.66</b>
3a. Is the employee currently working? <input checked="" type="checkbox"/> No (last day physically worked): <b>10/21/2013</b> (skip to Question 4a) <input type="checkbox"/> Yes (proceed to Question 3b) MM-DD-YYYY	3b. Is the employee performing all regular duties? <input type="checkbox"/> Yes (skip to Question 6a) <input type="checkbox"/> No (proceed to Question 3c)

3c. In what capacity is the employee currently working? <input type="checkbox"/> Light duty* <input type="checkbox"/> Diminished capacity* <input type="checkbox"/> Reduced hours <input type="checkbox"/> Other (please explain):	3d. Date member was placed in status shown at left: MM-DD-YYYY
*Attach letter explaining current duties in relation to normal work functions.	
4a. Is this employee terminated? <input checked="" type="checkbox"/> No (skip to Question 5) <input type="checkbox"/> Yes (date of termination): (proceed to Question 4b) MM-DD-YYYY	

4b. Last day compensation was earned (including pay continuation, using annual and sick leave): MM-DD-YYYY	4c. Amount of lump-sum payments for unused leave Annual leave \$ _____ Sick leave \$ _____	4d. Number of days of unused leave: (complete and proceed to Question 6a) Annual leave _____ Sick leave _____
---	--	---

5. Employee's current payroll status (check one and indicate appropriate date):

<input type="checkbox"/> On annual leave (date leave began): _____	<input type="checkbox"/> On leave without pay (date leave began): _____
<input type="checkbox"/> On sick leave (date leave began): _____	<input type="checkbox"/> Applied for leave under sick leave bank (date leave begins): _____
<input checked="" type="checkbox"/> Other (please explain): <b>WORKERS COMP</b>	

6a. Was this employee injured on the job? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (date of injury): _____ MM-DD-YYYY	6b. Is employee on leave without pay (not terminated) pending settlement of a Workers' Compensation claim? <input type="checkbox"/> No <input type="checkbox"/> Claim settled (date): _____ <input checked="" type="checkbox"/> Yes MM-DD-YYYY
--	--

I hereby certify that to the best of my knowledge, the information above correctly reflects the records of the employing entity.

Prepared by: **CHARLENE HARVEY** Title: **HR SPECIALIST**

Signature: *[Signature]* Date: **01-15-14** Telephone: **545-3027**

Return completed form to the SC Retirement Systems (address above).  
Please call SC Retirement Systems Customer Service with any questions: (803) 868-3002 (in state) or (803) 737-6800

# EXHIBIT

#12

## FW: 2014 Annual Fire Brigade Physicals TCapone 12/6 Ortho Status

Owusu, Albert <cfdaowusu@columbiasc.net>

Mon 12/30/2013 2:08 PM

To: Capone, Terry <tcapone@liberty.edu>

Chief Capone,

Please see the email response below to your email dated December 6<sup>th</sup>. My response to you was sent to your City Of Columbia email address which I am now aware you do not have access to. My apologies for the delay.



**Albert K. Owusu**, Health and Safety Officer  
Fire Department

1800 Laurel Street, Columbia, SC 29201

Phone: 803-545-0223

Mobile: 803-315-3717

Fax: 803-545-4063

ColumbiaSC.net

**From:** Owusu, Albert

**Sent:** Friday, December 20, 2013 1:19 PM

**To:** Capone, Terry

**Cc:** Edmonds, Michael

**Subject:** RE: 2014 Annual Fire Brigade Physicals TCapone 12/6 Ortho Status

**Sensitivity:** Personal

Chief Capone,

With regards to the completion of your fire brigade physical and your request for restricted duty, you are out due to multiple physical and psychological conditions you have brought to the forefront. The Fire department will need clearances from licensed medical professionals that address each and every one of the issues you have brought to light. Each will need to be evaluated separately and clearances will be required for each of the conditions before we can integrate you back into any fire department function, including the fire brigade physical process and/or being considered for restricted duty.

I wish you a speedy recovery.



**Albert K. Owusu**, Health and Safety Officer  
Fire Department

1800 Laurel Street, Columbia, SC 29201

Phone: 803-545-0223

Mobile: 803-315-3717

Fax: 803-545-4063

ColumbiaSC.net

# EXHIBIT

#13

**#2 Claim#64949 TCApone Return to work status Oct 29 2013**

Capone, Terry <tcapone@liberty.edu>

Tue 3/4/2014 10:28 PM

To: Mary\_Ann\_Pany@glic.com <Mary\_Ann\_Pany@glic.com>

Ms. Mary Ann,

This was the email letting me know Light duty was not available to me and I would have to use my sick leave to get paid.

Terry Capone

---

From: Owusu, Albert

Sent: Tue 10/29/2013 4:41 PM

To: Capone, Terry

Cc: Roach, Wilfred; Wright, Mark

Subject: RE: TCApone Return to work status Oct 29 2013

Chief Capone,

I have reviewed your return to work status note from Carolina Occupational Healthcare LLC. The note clears you for light duty. Unfortunately, there is no light duty available. Therefore you will have to use your accrued permissive leave until such time as the doctor clears you for "Full Firefighting Duties".

I would like to meet with you personally and discuss your injury in an effort to make sure that all your needs are met. Per our phone conversation today, I will expect you at 12:00 PM. While you are here, I would like you to meet with Chief Roach so he can go over the use of your permissive leave time.

Thank you.

[Description: Description: Description: Description: Description: Description:

EmailSignatureLogo.eps]Albert K. Owusu, Health and Safety Officer

Fire Department

1800 Laurel Street, Columbia, SC 29201

Phone: 803-545-0223

Mobile: 803-315-3717

Fax: 803-545-4063

ColumbiaSC.net

From: Capone, Terry

Sent: Tuesday, October 29, 2013 12:12 PM

3/11/2020

Mail - Capone, Terry - Outlook

To: Wright, Mark  
Cc: Owusu, Albert; Roach, Wilfred  
Subject: TCApone Return to work status Oct 29 2013  
Importance: High

Greetings DivChief Wright and Chief Owusu & Roach,

Please see the attached return to work status and advise me what you want me to do, I am due back on shift tomorrow.

Terry Capone

# EXHIBIT

#14

Capone, Terry H. (HM)

Calendar

10 / 2013						
SUN	MON	TUE	WED	THU	FRI	SAT
Sep 29	30	Oct 01	02	03	04	05
ST			ST		\$	
06	07	08	09	10	11	12
ST		ST				
13	14	15	16	17	18	19
		Hol			\$	
20	21	22	23	24	25	26
SL			SL			
27	28	29	30	31	Nov 01	02
SL		SLinj			\$	SLinj
03	04	05	06	07	08	09
		SLinj			SLinj	

11 / 2013						
SUN	MON	TUE	WED	THU	FRI	SAT
Oct 27	28	29	30	31	Nov 01	02
SL		SLinj			\$	SLinj
03	04	05	06	07	08	09
	SLinj			SLinj		
10	11	12	13	14	15	16
SLinj			SLinj		\$	
17	18	19	20	21	22	23
SLinj		SLinj				SLinj
24	25	26	27	28	29	30
	SLinj			\$	\$	
Dec 01	02	03	04	05	06	07
SLinj			SLinj			





02 / 2014

SUN	MON	TUE	WED	THU	FRI	SAT
Jan 26	27	28	29	30	31	Feb 01
		WcWop			WcWop	
02	03	04	05	06	07	08
	WcWop		WcWop		\$	
09	10	11	12	13	14	15
WcWop		WcWop				WcWop
16	17	18	19	20	21	22
	WcWop				\$	
23	24	25	26	27	28	Mar 01
	WcWop		WcWop			
02	03	04	05	06	07	08
WcWop		WcWop			\$	WcWop

Capone, Terry H. (HM)

Calendar

03 / 2014						
SUN	MON	TUE	WED	THU	FRI	SAT
Feb 23	24	25	26	27	28	Mar 01
	WcWop			WcWop		
02	03	04	05	06	07	08
WcWop		WcWop			\$	WcWop
09	10	11	12	13	14	15
	WcWop			WcWop		
16	17	18	19	20	21	22
WcWop			WcWop		\$	
23	24	25	26	27	28	29
WcWop		WcWop				WcWop
30	31	Apr 01	02	03	\$ 04	05
	WcWop			WcWop		



THE STATE OF SOUTH CAROLINA  
In The Court Of Appeals

APPEAL FROM THE SOUTH CAROLINA  
WORKERS COMPENSATION COMMISSION  
★ VOLUNTARY REMANDED ★  
BY THE APPELLATE PANEL

**RECEIVED**

**Jul 22 2020**

**SC Court of Appeals**

W.C.C. File Nos. 1322451, 1319203, 1420487  
Appellate Case No.: 2018-000369 associated with 2018-001364

PROOF OF SERVICE

Terry H Capone, Claimant,

Appellant,

v.

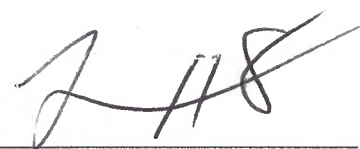
City of Columbia, Employer, and  
Companion Third Party Administrator, LLC, Carrier, ..... Respondents.

Terry H Capone, of Richland County, Pro Se Appellant.

I certify this 22<sup>nd</sup> day of July 2020 that I have served a copy of the Appellants' Notice of Motion to Stay Proceedings and Motion To Remand to Lower Tribunal Due to Fraud On The Court and Other violations of Law a copy in the United States Mail, first class postage pre-paid, or by personal service addressed to the following:

Cynthia C. Dooley, Esquire  
Carmelo Barone Sammataro, Esquire Attorneys for Respondents  
TURNER PADGET GRAHAM & LANEY P.A.  
P.O. Box 1473  
Columbia, SC 29202

South Carolina WCC Judicial  
VIA EMAIL [judicial@wcc.sc.gov](mailto:judicial@wcc.sc.gov)  
July 22, 2020

By:   
Mr. Terry H Capone  
130 Summerlea Drive  
Columbia, SC 29203  
(803) 622-6578  
Email: [tcapone@liberty.edu](mailto:tcapone@liberty.edu)  
APPELLANT, PRO PER



**RECEIVED**

**Jul 22 2020**

**SC Court of Appeals**

July 22, 2020

VIA EMAIL COVID- 19 PROTOCOLS

The Honorable Jenny Abbott Kitchings, Clerk  
South Carolina Court of Appeals  
1220 Senate Street  
Columbia, SC 29201

Re: Motion to Stay Preceding to Lower Tribunal Terry Capone, Appellant, v. City of Columbia, Employer, and Companion Third Party Administrator, LLC, Carrier, Respondent Case No. 2019-000369

The Honorable Jenny Abbott Kitching, Clerk:

Please see attached Motion to Stay proceedings and Remand Void Decision and Order to lower tribunal, and to take judicial notice of form 15's and Motion to Reconsider based on Fraud On The Court mailed to South Carolina Workers' Compensation Commission and Attorneys for Defendants/Respondents.

I am not an attorney. Thank you for your assistance with this matter, please contact me if you have any questions. Thank you for your consideration.

With Regards,

Enclosure: As staed

Mr. Terry H. Capone  
Fire Battalion Chief-Retired  
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Columbia, SC 29203  
(803) 622-6578  
Email: [tcapone@liberty.edu](mailto:tcapone@liberty.edu)