THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CLARENDON COUNTY
Court of Common Pleas
R. Ferrell Cothran, Jr., Circuit Court Judge

Case No. 2007-CP-14-00150

Diane C. Dingle, Employee/Claimant.....Appellant,

v.

Federal Mogul Corporation, Employer, and
Travlers Property Casualty Company of America, Carrier.....Respondents.

SUPPLEMENTAL RECORD ON APPEAL

Candace G. Hindersman, SC Bar No. 73710
Willson Jones Carter & Baxley, P.A.
4500 Fort Jackson Boulevard
Columbia, South Carolina 29209
Telephone (803) 227-2888
Facsimile (803) 782-2527
E-mail: cghindersman@wjlaw.net
Attorney for Respondents

Dwight C. Moore, SC Bar No. 63008
Moore Law Firm, L.L.C.
26 North Main Street
Post Office Box 1229
Sumter, South Carolina 29151-1229
Telephone (803) 778-6520
Facsimile (803) 775-6365
E-mail: moorelawfirm@ftc-i.net
Attorney for Appellant

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INDEX

Patients's Name: Diana Dodge | Age: 33

Allergies: Septra

Chief complaint: Continue to c/o HA's. HR's have Δ's. CT of sinuses ~~WNL~~ but done

Medications (including OTC):
Nuvaview/DH tab + q12° PRN
Nuract 25mg + q6° PRN
Trovan 200mg BID

Review of Systems	WNL	NSC	Objective
General Appearance		✓	
HEENT		*	* pressure behind eyes
Neck		✓	
Respiratory		✓	Vertigo when she Δ position
Cardiovascular		✓	
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Neurological			
Endocrine/metabolic			
Hematologic			
Psychiatric			
Nutritional			
Gynecologic			
Lymphatic			

Administered Medications/Treatments:

Assessment: 1) Sinusitis 2) HA

Plans: 1) Promunal + ff q 4-6 hrs

Referrals:

Follow-up: PRN Scheduled

Signature:

332

CLARENDON MEMORIAL HOSPITAL
Manning, SC

Dictated: 5-19-98
Transcribed: 5-19-98

MEDICAL RECORDS
RADIOLOGY PROCEDURE

NAME	NUMBER	SEX	AGE	ADMIT	DISC.	MED.RECORD#	TYPE	ROOM#
DINGLE DIANE	723882	F	33	5/19/98	5/19/98	078876	O/P	

DATE OF BIRTH: 8/18/1964 PHYSICIAN
PHYSICIAN: 5500 KEITH EDWARD C KEITH E C

X-RAY #:89641
DATE:5-19-98
EXAM:CT OF THE SINUSES
HISTORY:SINUSITIS/NASAL CONGESTION/VERTIGO

MULTIPLE 5 MM CORONAL IMAGES THROUGH THE PARANASAL SINUSES WERE OBTAINED USING BONE WINDOWS AND SOFT TISSUE WINDOWS.

NO AIR-FLUID LEVELS OR SIGNIFICANT MUCOSAL THICKENING IDENTIFIED. NO EROSIVE/DESTRUCTIVE CHANGES ARE NOTED. MINIMAL LEFTWARD NASAL SEPTAL DEVIATION IS SEEN.

IMPRESSION: CT DEMONSTRATES NO EVIDENCE FOR SIGNIFICANT MUCOSAL THICKENING OR AIR-FLUID LEVELS WITHIN THE PARANASAL SINUSES.

MICHAEL E. FAULSTICH, MD, PHD/KJM
DIPLOMATE AMERICAN BOARD OF RADIOLOGY

THE INSURED IS RESPONSIBLE FOR ANY EXPENSE INCURRED FOR THE COMPLETION OF THIS FORM.

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PART III – ATTENDING PHYSICIAN'S STATEMENT - To be completed and signed by Attending Physician.

NOTE TO PHYSICIAN

Since this insurance is designed to provide benefits for installment payments, please supply the information required on the form as soon as possible. Your prompt compliance will be greatly appreciated by both your patient and the company.

Patient's Name: Diane Dingle Date of Birth: 8, 18, 64

DIAGNOSIS:
(a) Primary: Vertigo, Sinusitis, Headaches
(b) Contributory causes of disability: N/A
(c) Complications: N/A
(d) Did patient have surgery? ☐ Yes ☑ No
If "YES," describe: Date performed / /
(e) If hospitalized, name & address of hospital N/A

HISTORY:
(a) When did symptoms first appear or accident happen? 4, 28, 98 INJURY ☐ Yes ☑ No ILLNESS ☑ Yes ☐ No
(b) Date patient ceased work because of disability? 5, 7, 98
(c) Has patient ever had same or similar condition? ☐ Yes ☑ No
If "YES," state when and describe:

TREATMENT:
(a) Initial date of treatment 5, 5, 98 (b) Last date of treatment 5, 18, 98
(c) Frequency of visits ☑ Weekly ☐ Monthly ☐ Other

EXTENT OF DISABILITY:
(a) Give exact dates of Total Disability (unable to work) From 5, 7, 98 To 5, 20, 98
☑ His/Her Occupation ☑ Any Occupation
(b) Give exact dates of Partial Disability From N/A To / /
☐ His/Her Occupation ☐ Any Occupation

PROGNOSIS:
(a) Has patient progressed? ☑ Yes ☐ No (b) Progress ☑ Improved ☐ Recovered ☐ No change ☐ Retrogressed
(c) Estimate the date the patient can return to work 5, 20, 98
(d) Is patient still under your care for this condition? ☐ Yes ☑ No If "NO," Patient was released 5, 18, 98
(e) Any limitations? ☐ Yes ☑ No

NAMES, ADDRESSES, AND PHONE NUMBER OF REFERRING PHYSICIAN, IF ANY: N/A

I hereby certify that the above-described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."

NAME OF ATTENDING PHYSICIAN Edward C. Keith MD (Please Print)

Edward C Keith MD (Signature of Attending Physician)

Telephone (803) 435-2529

Street Address 15 East Hospital St

City, State MANNING SC Zip 29102 Tax ID No. 57-0876438 Date 7 27 98

PART IV - STATEMENT OF EMPLOYER - To be completed and signed by employer (If self-employed, so state)

Employee by name of

Was away from work beginning / / ☐ AM ☐ PM through / / ☐ AM ☐ PM

Original date of employment / / 4. If terminated, give date / /

If disability is due to sickness, was employee previously afflicted with this illness? Yes No

Is disability due to employment? ☐ Yes ☐ No If "YES," date of injury? / /

Description of duties

Do you describe these duties as light, medium, or heavy work?

Do you have any light duty work available? ☐ Yes ☐ No If "YES," as of what date? / /

(Name of Company) By: (Signature and Title)

Phone No. ( ) Date / /

Patient's Name: Diane Dingle Chart #:

Date: 8-24-98	Age: 33
Subjective:	Cold, sinus
	Robomine tab ÷ q8h -
	force fluids Dx-E.C. Keith III
	8-27-98 Bronchial Tor" q4-6h #30 Dx-E.C. Keith III
Objective:	
Assessment:	
Plans:	
Follow-up:	
Date:	Age:
Subjective:	
bjective:	
ssessment:	
ans:	
ow-up:	

EXHIBIT C

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

P. White

CERTIFICATION OF PHYSICIAN OR PRACTITIONER
(Family and Medical Leave Act of 1993)

Diane Jayce Dingle

1. Employee's Name: ~~Jayce~~ Dingle

2. Patient's Name (If other than employee): Same

3. Diagnosis: Blocked eustachian tube, sinusitis, allergic rhinitis

4. Date condition commenced: 8-24-98 approx 5. Probable duration of condition: 9-11-98

6. Regimen of treatment to be prescribed (Indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.):

a. By Physician or Practitioner: Steroids, Antibiotics, antihistimine test and fluids

b. By another provider of health services, if referred by Physician or Practitioner:

N/A

IF THIS CERTIFICATION RELATES TO CARE FOR THE EMPLOYEE'S SERIOUSLY-ILL FAMILY MEMBER, SKIP ITEMS 7, 8 AND 9 AND PROCEED TO ITEMS 10 THRU 14 ON REVERSE SIDE. OTHERWISE, CONTINUE BELOW.

Check Yes or No in the boxes below, as appropriate.

	Yes	No	
7.	☐	☑	Is inpatient hospitalization of the employee required?
8.	☐	☑	Is employee able to perform work of any kind? (If "No", skip Item 9.) Medications cause drowsiness
9.	☐	☑	Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.)

15. Signature of Physician or Practitioner: P. L. Kelly

16. Date: 9-4-98

17. Type of Practice (Field of Specialization, if any): Family Practice

OPTIONAL Form WH-380
June 1993

FEDERAL-MOGUL HEALTH CARE SYSTEM

FMHCS
P.O. BOX 1989
DETROIT, MI 48235
Telephone (800) 522-0041
Fax (810) 354-7553

ACCIDENT AND SICKNESS (A&S) FORM
(Short-Term Disability)

EMPLOYEE STATEMENT

mployee – please complete the "Employee Statement", sign and date below. Take this form to your treating physician to complete nd then return it to your Human Resources Representative.

ast Name	First Name	M.I.	Date of Birth

reet Address	City	State	Zip Code

ocial Security Number	Home Phone Number

ur Doctor's Name: _____ Telephone Number: _____

te of Disability: _____ Date you were first treated for this disability: _____

pe of Disability: ☐ Sickness ☐ Injury ☐ Pregnancy

Accident: ☐ Automobile ☐ Work Related

Date of Accident: _____

EMPLOYEE AUTHORIZATION

derstand and agree that if any benefits should not have been paid to me under the terms or conditions of the Plan, or should have been paid a er amount, any and all such payments may be recovered. I additionally agree that if I should receive a settlement or payments from any other ce (i.e., Workers' Compensation, Automobile Policy or other source), I will reimburse Federal-Mogul for any payments made on my behalf. I ori deral-Mogul, my medical provider, or any other organization to release or to obtain information required to establish the validity of this l by apply for Medical Leave of Absence and/or Accident & Sickness Benefits.

loyee Signature: _____ Date: _____

PHYSICIAN STATEMENT

ician – please complete the "Physician Statement" in full and return to the above employee.

nosis: Blocked Eustachian tube, Sinusitis, Allergic rhinitis EDC: N/A

of most recent office visit: 8-31-98 Date first treated for this diagnosis: 8-24-98

complaints: Pain behind eyes, blurry vision, left occipital pain radiating into left ear

ostic testing: _____

nent plan (include specialist referrals): Steroids, Antibiotics, Antihistamine

al Procedure: N/A Date of procedure: _____

of hospitalization: N/A to _____ Name of facility: _____

sability began: _____ Same or similar condition before? ☑ Yes ☐ No

lease describe and indicate date of previous occurrence: 5-98 Sinusitis allergic rhinitis, headaches

ember able to return to work? ☐ Yes – Date returned to work: _____

☑ No – Date of next office visit: _____

Anticipated return to work date: 9-11-98

ame: Edward C. Kerth MD Specialty: Family Practice Phone No.: 803-435-2529

's Address: 15 East Hospital St Manning SC 29102 Fax No: 803-435-4196

's Signature: E.C. Kerth MD Date: 9-4-98

CERTIFICATE OF COUNSEL

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

Candace G. Hindersman, SC Bar No. 73710
Willson Jones Carter & Baxley, P.A.
4500 Fort Jackson Boulevard
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Attorney for Respondents

March 15, 2013
Columbia, South Carolina

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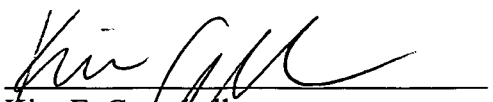
PROOF OF SERVICE

I certify that I have served the Supplemental Record on Appeal on Diane Dingle by depositing a copy of the Supplemental Record in the United State Mail, postage prepaid, on March 15, 2013, addressed to her attorney of record, Dwight C. Moore, Esquire, Moore Law Firm, L.L.C., 26 North Main Street, Post Office Box 1229, Sumter, South Carolina 29151-1229.

WILLSON JONES CARTER & BAXLEY, P.A.



Kira E. Campbell
Legal Assistant to Candace G. Hindersman, Esquire
Attorney for Respondents
4500 Fort Jackson Boulevard
Columbia, SC 29209

Date: March 15, 2013