CASE ID: DEU7348315 {450A0A6A-694B-4F9B-AC93-C70895CB990A}

Department of Industrial Relations DIVISION OF WORKERS' COMPENSATION DISABILITY EVALUATION UNIT 605 W Santa Ana Blvd, Bldg 28 Suite 451 Santa Ana, Ca 92701 714/558-4121

STATE OF CALIFORNIA ARNOLD SCHWARZENEGGER, Governor

CONSULTATIVE RATING DETERMINATION

Deion Sanders

WCAB #...: Age at DOI: 32

DEU File No: H78790

Occupation : PROFESSIONAL FOOTBALL PLAYER

EAMS Case No: DEU7348315

Employee Representative:

Employer Representative:

*DR. MARIA LEYNES*QME*08/24/2010*

THIS REPORT RATES 0% FINAL PD.

*DR. MICHAEL WELLS*QME*07/15/2010*

*DR. KENNETH NUDLEMAN*QME*07/08/2010*

*DR. MICHAEL EINBUND*QME*07/08/2010*

11.03.02.00-2-[2]2-590G-3-3 PD (A)

13.01.00.99-1-[6]1-590J-2-2 PD (A)

13.03.00.00-16-[6]21-590J-31-30 PD (A)

13.04.00.00-5-[2]6-590J-11-10 PD (A)

13.06.00.00-5-[8]7-590I-11-10 PD (A)

15.01.01.00-8-[5]10-590J-16-15 PD (A)

15.03.01.00-13-[5]17-590J-26-25 PD (A)

16.02.01.00-1-[7]1-590J-2-2 PD (B)

16.02.01.00-1-[7]1-590J-2-2 PD (C)

16.03.01.00-1-[2]1-590J-2-2 PD (B)

16.03.01.00-1-[2]1-590J-2-2 PD (C)

16.05.04.00-5-[1]6-590I-9-8 PD (B)

16.05.04.00-7-[1]8-590I-12-11 PD (C)

17.03.03.00-3-[5]4-590J-8-7 PD (D)

17.03.03.00-4-[5]5-590J-9-8 PD (E)

1% WP ADD-ON INCLUDED FOR PAIN

17.05.03.00-3-[2]3-590J-6-6 PD (D)

17.05.03.00-4-[2]5-590J-9-8 PD (E)

1% WP ADD-ON INCLUDED FOR PAIN

17.07.03.00-6-[2]7-590J-12-11 PD (D)

17.07.03.00-9-[2]10-590J-16-15 PD (E)

1% WP ADD-ON INCLUDED FOR PAIN

B = 8 C 2 C 2 = 12 PD (A)

C = 11 C 2 C 2 = 15 PD (A)

D = 11 C 7 C 6 = 22 PD (A)

E = 15 C 8 C 8 = 28 PD (A)

A = 30 C 28 C 25 C 22 C 15 C 15 C 12 C 10 C 10 C 3 C 2 = 86 FINAL PD

Cecilia Mejia

November 22, 2010

Disability Evaluator DEU Form 230 (Rev 1-91) K16244 Date

{C887BB4E-238D-484D-BB86-897F4673EAD5}

DOCUMENT SEPARATOR SHEET



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Product Delivery Unit	ADJ		-
- Document Type	LEGAL DOCS		
Document Title APPLICATION FO	OR ADJUDICATION	•	
			
Document Date	05/25/2010	· · · · · · · · · · · · · · · · · · ·	
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Author	NAMANNY, BYRNE & OWENS		
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DWC-CA form 10232.2 Rev. 11/2008 Page 1

{C887BB4E-238D-484D-BB86-897F4673EAD5}

STATE OF CALIFORNIA DIVISION OF WORKERS' COMPENSATION WORKERS' COMPENSATION APPEALS BOARD APPLICATION FOR ADJUDICATION OF CLAIM

	Amended Applica	tion RECEIV
Case No.		I I I
		MAY 2 7 2010
SSN (Numbers Only)		MAI 27 2010
Venue choice is based upon (Completion of this section is required)	; F	DWC/WCAB SANTA ANA
County of residence of employee (Labor Code section 5501.5(a)(1) o	or (d).)	Andrews of the second s
County where injury occurred (Labor Code section 5501.5(a)(2) or (d)).)	the time is a first to the second of the sec
County of principal place of business of employee's attorney (Labor C	Code section 5501.5(a)(3)	or (d).)
ANA Select 3 - Letter Office Code For Place/Venue of Hearing (From the Document Code)	ment Cover Sheet\	
Injured Worker (Completion of this section is required)	THERE COVER CREEK	
DEION	-	
First Name	MI .	
SANDERS		
Last Name		
Street Address/PO Box (Please leave blank spaces between numbers, no	ames or words)	
		•
Street Address2/PO Box (Please leave blank spaces between numbers,	names or words)	• .
International Address (Please leave blank spaces between numbers, nan	mes or words)	
PROSPER	TV	
City	TXState	Zip Code
Applicant (If other than Injured Worker)		
Insurance Carrier Employer	Lien Claimant	ŧ
		
N== (Ol		·
Name (Please leave blank spaces between numbers, names or words)		(
Charle Address IDO Bay (Diens In the black and as between numbers of	Company of Words	
Street Address/PO Box (Please leave blank spaces between numbers, n	ames or words)	
Cteach Addison Class Co. / Diagrams to the blood of the boundary of the bounda		
Street Address2/PO Box (Please leave blank spaces between numbers.	names or words)	
XII.	State	Zip Code ,
City DWC/WCAB Form 1A (11/2008) - (Page 1)	State	WCAB1
ייייייייייייייייייייייייייייייייייייי		***/****

Employer Information (Completion of this section is required)		
✓ Insured Self-Insured Legally Uninsured	Unins	ured
DALLAS COWBOYS Employer Name (Please leave blank spaces between numbers, names or words)		
compleyer Name (Freese leave blattic spaces between minibers, (laines of words)		
ONE COWBOY PARKWAY		·
mployer Street Address/PO Box (Please leave blank spaces between numbers,	names or words)	
IRVING	TX	75063
City	State	Zip Code
TRAVELERS / GULF	· .	
surance Carrier Information (If known and If applicable - include even if car		
INAVECERS / OULF Insurance Carrier Name (Please leave blank spaces between numbers, names or words)		
PO BOX 660281		
PO BOX 660281 Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, i	names or words)	
	names or words)	
nsurance Carrier Street Address/PO Box (Please leave blank spaces between numbers,) DALLAS	TX	75266
nsurance Camer Street Address/PO Box (Please leave blank spaces between numbers, i DALLAS City		75266 Zip Code
nsurance Camer Street Address/PO Box (Please leave blank spaces between numbers, i DALLAS City	TX	
nsurance Camer Street Address/PO Box (Please leave blank spaces between numbers,) DALLAS City	TX	
nsurance Camer Street Address/PO Box (Please leave blank spaces between numbers,) DALLAS City Stalms Administrator Information (If known and If applicable)	TX	
nsurance Camer Street Address/PO Box (Please leave blank spaces between numbers,) DALLAS City Stalms Administrator Information (If known and If applicable)	TX	
	TX	
DALLAS City Please leave blank spaces between numbers, 1 Please leave blank spaces between numbers, 1 Please leave blank spaces between numbers, names or words)	TX	
DALLAS City Please leave blank spaces between numbers, 1 Please leave blank spaces between numbers, 1 Please leave blank spaces between numbers, names or words)	TX	
nsurance Camer Street Address/PO Box (Please leave blank spaces between numbers,) DALLAS City Claims Administrator Information (If known and If applicable)	TX	

Suffered a .

| Commutative injury | Commutative in

{C887BB4E-238D-484D-BB86-897F4673EAD5}

		(State whi	ich parts of t	the body were inj	ured)			
Body Part 1:	100 HEAD	<u>,</u>						
Body Part 2:	200 NECK	***						
Body Part 3:	398 UPPER EX	<u> </u>						
Body Part 4:	519 LEG	***				· · · · · · · · · · · · · · · · · · ·		
Other Body Parts:	700 MULTIPLE						- M	
(EXPLAIN W		WAS DOING AT TH		NJURY AND HOV	VTHE IN.	JURY OCC	URED)	
SUSTAINE	D INJURIES WH	LE PLAYING FO	OTBALL					
							•	
3. Actual earn	ings at the time of	injury:	A	, v (r———————————————————————————————————		•	· · · · · · · · · · · · · · · · · ·	,,,,,,,,
Rate of Pay \$	MAK [ralue of tips, rages, regula	meals, lodging, or rly received	other \$_	<u> </u>	Monthly Weekly Hourly	
Number of ho	urs worked per wee	k <u>MAX</u>				· · · · · · · · · · · · · · · · · · ·		
4. The injury o	aused disability a	s follows:	-					
Last day off w	ork due to injury;	01/09/2000 MM/DD/YYYY						
First Period of	Disability:	Start Date	TBD	'YY 		End Date	TBD MM/DD/YYYY	
Second Period	of Disability:	Start Date	TBD MM/DD/Y			End Date	TBD MM/DD/YYYY	
5. Compensat	ion:		••••					
Compensation	was paid:	Yes 📝 No						٠.
Total paid:	HONE							
Weekly rate(s)): <u> </u>		,			•		
Date of last pa	ayment: NONE MM/DD/Y	YYY					,	
6. Has the wordisability ben	rker received any efits (state disabil	unemployment insu ty) since the date o	# * 4 ~ -	fits and/or any un ✓ Yes	employn	ent compe	ensation	

(C887BB4E-2:	38D-484D-BB86-89	/F46/3EAD5}		
7. Medical treatment:				
Medical treatment was received:		✓ Yes	☐ No	
All treatment was furnished by the Employer or Ins	urance Carrier.	Yes	✓ No	
Date of last treatment: UNKNOWN				
Other treatment was provided/paid by: UNKKNO		CENCY PROVIDIN	OR PAYING FOR MEDICAL CA	DEI
ų,	PAINE OF FERSON OR P	OCIACI FROVIDIA	O ON PAINING FOR MEDICAL CA	
Did Medi-Cal pay for any health care related to	this claim?	Yes	No	
Names and addresses of doctor(s)/hospital(s)/o provided or paid for by the employer or insurar	clinic(s) that treated nce carrier:	t or examined f	or this injury, but that wer	e not
Name of Darker II In the 1905 and 1914 and 1914				
Name of Doctor/Hospital/Clinic 1 (Please leave bla	ank spaces between	numbers, name	s or words)	
				•
				
Name of Doctor/Hospital/Clinic 2 (Please leave bla	•		s or words)	
Other cases have been filed for industrial injustrial	uries by this worke	r as follows:		
			•	
Case Number 1	Case Num	ber 3		•
Case Number 2	Case Num	hor A		
9. This application is filed because of a disagre	ement regarding il:	ability for:		
Temporary disability indemnity	✓ Perma	nent disability in	demnity	
Reimbursement for medical expense	✓ Rehab	ilitation	e.	•
Medical treatment	✓ Supple	mental Job Disp	lacement/Return to Work	*
Compensation at proper rate	☑ Other /	Specify) BEN	EFIT LABOR CODE	

837 437 4818 16.3r

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	مغالا وبرغوان ويستكنف والمساول فيناكر في ويسيدون
Is the Applicant Represented? Yes No If "No", applicant is to sign and date	below.
If "Yes", applicant's representative is to complete the following and is to sign and date b	elow.
Law Firm/Attorney	
NAMANNY BYRNE OWENS Law Firm of Company Name (If Applicable)	<u> </u>
Esta Film of Company restrict (if Applicable)	
Law Firm Number (if Applicable)	
MEL Attomey/Representative First Name	T MI
OWENS Attorney/Representative Last Name	
24411 RIDGE ROUTE DRIVE SUITE 135	
Street Address/PO Box (Please leave blank spaces between numbers, names or words)	n (r)
City Allews Sta	
Applicant Attorney/Representative Signature Applicant Sign	nature
Dated at LAGUNA HTUS City	California
Date 3/24/co	