WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

ISMAEL NAVARRO, ***Applicant,*** **vs.** **CITY OF MONTEBELLO, administered by CORVEL CORPORATION,** ***Defendants.***	**Case Nos. ADJ6779197** **ADJ7472140** **ADJ7964720** **(Long Beach District Office)** **OPINION AND DECISION AFTER REMOVAL** **(En Banc)**

We granted removal on February 27, 2014 and issued a notice of intention (NIT) to allow the parties and the Division of Workers' Compensation (DWC) an opportunity to address the issues raised by our proposed holdings as to the Labor Code and Rule 35.5(e). Having considered defendant's response, we now issue our Opinion and Decision After Removal (En Banc).

Defendant sought removal in response to a Findings of Fact issued by a workers' compensation administrative law judge (WCJ) on October 31, 2013. The WCJ found in pertinent part that applicant was entitled to a new panel Qualified Medical Evaluator (QME) for his two new injury claims and that Rule 35.5(e)[1] did not apply.

Defendant contended that all of applicant's three claimed injuries involved the same parties and one of the same body parts, and therefore, Rule 35.5(e) required that applicant be evaluated for his two new claimed injuries by the original panel QME for his original claimed injury.

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[1] Division of Workers' Compensation – Qualified Medical Evaluator Regulations 35.5(e) (Cal. Code Regs,, tit, 8, § 35.5(e)) hereafter, Rule 35.5(e) states that:

> In the event a new injury or illness is claimed involving the same type of body part or body system and the parties are the same, or in the event either party objects to any new medical issue within the evaluator's scope of practice and clinical competence, the parties shall utilize to the extent possible the same evaluator who reported previously.

To secure uniformity of decision in the future, the Chairwoman of the Appeals Board, upon a majority vote of its members, assigned this case to the Appeals Board as a whole for an en banc decision. (Lab. Code, § 115.)[2]

Based upon our review of the relevant statutes and case law, we hold that:

(1) The Labor Code does not require an employee to return to the same panel QME for an evaluation of a subsequent claim of injury.

(2) The requirement in Rule 35.5(e) that an employee return to the same evaluator when a new injury or illness is claimed involving the same parties and the same type of body parts is inconsistent with the Labor Code, and therefore, this requirement is invalid.[3]

As our decision after removal (en banc), we affirm the Findings of Fact and return the matter to the trial level.

BACKGROUND

Applicant is employed as a police officer for defendant and all of his claims of injury were filed during his employment with defendant. All of applicant's claims of injury were filed while he was represented by an attorney.

On February 12, 2009, applicant filed an application for adjudication with a Workers' Compensation Claim Form DWC 1 (claim form) alleging a cumulative injury from February 9, 2008 to February 9, 2009 to his back and ear (ADJ6779197). On September 14, 2009, applicant was evaluated by panel QME J. Yogaratnam, M.D., in that case.

On October 4, 2010, applicant filed applications for adjudication with claim forms alleging a specific injury of June 1, 2010 to his back, lower extremities and legs (ADJ7964720) and a specific

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[2] En banc decisions of the Appeals Board are binding precedent on all Appeals Board panels and WCJs. (Cal. Code Regs., tit. 8, § 10341; *City of Long Beach v. Workers' Comp. Appeals Bd.* (*Garcia*) (2005) 126 Cal.App.4th 298, 313, fn. 5 [70 Cal.Comp.Cases 109]; *Gee v. Workers' Comp. Appeals Bd.* (2002) 96 Cal.App.4th 1418, 1425, fn. 6 [67 Cal.Comp.Cases 236]; see Govt. Code, § 11425.60(b).) In addition to being adopted as a precedent decision in accordance with Labor Code section 115 and Appeals Board Rule 10341, this en banc decision is also being adopted as a precedent decision in accordance with Government Code section 11425.60(b).

[3] Unless otherwise stated, all statutory references are to the Labor Code.

injury of August 31, 2010 to his back and left leg (ADJ7472140).[4]

On November 20, 2012, defendant petitioned to compel an evaluation of applicant's two subsequent claims of injury by original panel QME Dr. Yogaratnam, but it did not seek to have applicant reevaluated regarding his previous claim of cumulative injury. Applicant objected on November 28, 2012. On May 23, 2013, the parties proceeded to trial on the issue of whether applicant must return to original panel QME Dr. Yogaratnam for his subsequent specific injury claims; the issue was ultimately submitted for decision on August 20, 2013.

On October 31, 2013, the WCJ found in pertinent part that applicant was entitled to a new panel QME in his specific injury cases and that Rule 35.5(e) did not apply.

Thereafter, defendant timely filed its petition for removal. We received an Answer from applicant. The WCJ prepared a Report and Recommendation (Report) recommending that removal be denied.

In our NIT, the parties and DWC were given twenty days to respond.[5] In pertinent part, our NIT ordered that responses were to be filed at the Office of the Commissioners, and not at a district office, and that misfiled responses would not be accepted or considered. Yet, defendant filed its response on March 21, 2014 at the San Francisco District Office. On March 24, 2014, the last day that a response could be timely filed, defendant's response was brought to our attention. Although defendant misfiled its response, the response was received in the Office of the Commissioners within the time allowed and we accept it and consider it.

In its response to our NIT, defendant contends that Rule 35.5(e) follows the Labor Code. In support of its argument, it cites sections 4062.3(j), 4062.3(k), and 4067, all sections which concern a single claim form and not subsequent claims of injury. It also cites *Frink v. Shasta-Tehama-Trinity Joint Community College* 2012 Cal.Wrk.Comp. P.D. LEXIS 67 and *McDuffie v. Los Angeles County*

[4] The Employer's Section on the lower half of all three of the claim forms is blank. There is no information in the record regarding whether any other claim forms were received by or completed by defendant. Each claim form was served on defendant at the time it was filed at the Workers' Compensation Appeals Board (WCAB).

[5] We did not receive a response from DWC.

Metropolitan Transit Authority (2002) 67 Cal. Comp. Cases 138 (en banc), cases which involve a single cumulative injury.

DISCUSSION

I. The Labor Code does not require an employee to return to the same QME for an evaluation of a subsequent claim of injury.

Defendant contended that Rule 35.5(e) applies and because Rule 35.5(e) applies, applicant must return to original panel QME Dr. Yogaratnam. However, even though the sole basis of defendant's argument is that Rule 35.5(e) applies, we consider the relevant statutory provisions before we consider the application of Rule 35.5(e).

"A fundamental rule of statutory construction is that a court should ascertain the intent of the Legislature so as to effectuate the purpose of the law." (*DuBois v. Workers' Comp. Appeals Bd.* (1993) 5 Cal.4th 382, 387 [58 Cal.Comp.Cases 286] (*DuBois*); *Nickelsberg v. Workers' Comp. Appeals Bd.* (1991) 54 Cal.3d 288, 294 [56 Cal.Comp.Cases 476]; *Moyer v. Workmen's Comp. Appeals Bd.* (1973) 10 Cal.3d 222, 230 [38 Cal. Comp. Cases 652].) "In construing a statute, our first task is to look to the language of the statute itself. (citation) When the language is clear and there is no uncertainty as to the legislative intent, we look no further and simply enforce the statute according to its terms." (*DuBois, supra,* 5 Cal.4th at p. 387; accord, *Atlantic Richfield Co. v. Workers' Comp. Appeals Bd.* (*Arvizu*) (1982) 31 Cal.3d 715, 726 [47 Cal. Comp. Cases 500]; see Code Civ. Proc., §§ 1858, 1859; *Rhiner v. Workers' Comp. Appeals Bd.* (1993) 4 Cal.4th 1213, 1217 [58 Cal.Comp.Cases 172].) Hence, we begin by reviewing the language of the Labor Code sections on medical-legal evaluations by panel QMEs.

Section 4060(a) provides in pertinent part that "this section shall apply to disputes over the compensability of any injury. . ."

Section 4060(c) states that:

> If a medical evaluation is required to determine compensability at any time after the *filing of the claim form*, and the employee is represented by an attorney, a medical evaluation to determine compensability *shall be obtained only by the procedure provided in Section 4062.2*. (Italics added.)

Section 4060(d) states that:

> If a medical evaluation is required to determine compensability at any time after *the claim form is filed*, and the employee is not represented by an attorney, the employer shall provide the employee with notice either that the employer requests a comprehensive medical evaluation to determine compensability or that the employer has not accepted liability and the employee may request a comprehensive medical evaluation to determine compensability. Either party may request a comprehensive medical evaluation to determine compensability. The evaluation *shall be obtained only by the procedure provided in Section 4062.1*. (Italics added.)

Section 4062.2(a) states that:

> Whenever a comprehensive medical evaluation is required to resolve any dispute arising out of *an injury* or *a claimed injury* occurring on or after January 1, 2005, and the employee is represented by an attorney, the evaluation *shall be obtained only as provided in this section.* (Italics added.)

Preliminarily then, section 4060(a), (c) and (d) and section 4062.2(a)[6] all refer to a ***single*** *claim form*, *injury* or *claimed injury* and require that any medical-legal evaluations to determine compensability of that injury or claimed injury occur under the procedures provided in sections 4062.1 or 4062.2.

Section 4062.3(j) states that:

> Upon completing a determination of the disputed medical issue, the medical evaluator shall summarize the medical findings on a form prescribed by the administrative director and shall serve the formal medical evaluation and the summary form on the employee and the employer. The medical evaluation shall address all contested *medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator.* (Italics and underscoring added.)

Section 4064(a) states that:

> The employer shall be liable for the cost of each reasonable and necessary comprehensive medical-legal evaluation obtained by the employee pursuant to Sections 4060, 4061, and 4062. *Each comprehensive medical-legal evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms*, except medical treatment recommendations, which are subject to utilization review as provided by Section 4610, and objections to utilization review determinations, which

[6] Unlike section 4062.2, section 4062.1 does not contain a subdivision like section 4062.2(a) for unrepresented employees, but sections 4060(a) and (d) and section 4061(i) all specify that section 4062.1 applies to unrepresented employees.

> are subject to independent medical review as provided by Section 4610.5. (Italics and underscoring added.)

Considering section 4062.3(j) and section 4064(a) together, both sections state that a medical evaluation shall address "all medical issues arising from all injuries reported on one or more claim forms."[7] Both sections refer to an injury reported on a claim form as the operative act, and not to a date of injury, a report of injury other than on a claim form[8], or the filing of an application with the WCAB. Under section 5401, an employer must provide a claim form and an injured worker must *file a claim form* ***with*** *an employer*.[9] Hence, the *reported date* under sections 4062.3(j) and 4064(a) must be the *filing date* as defined by section 5401 because only section 5401 refers to filing a claim form. Because the date the claim form is filed with employer is the operative act, the date of filing of the claim form determines which evaluator must consider which injury claim(s). This is significant in that the date a claim of injury is *reported* is often not the same as the date that an injury is claimed to have occurred. Consequently, it is foreseeable that a claim might be reported *after* an original evaluation, but be for a claim of injury on a date *before* the original evaluation, and even in those circumstances, the result would be that the date the claim is reported is still the operative date.

Next, section 4062.3(k) states that:

> If, after a medical evaluation is prepared, the employer or the employee subsequently objects to any *new medical issue*, the parties, *to the extent possible*, shall utilize the same medical evaluator who prepared the *previous* evaluation to resolve the medical dispute. (Italics added.)

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[7] Although section 4064(a) does not include the phrase "before the appointment takes place," since section 4064(a) provides that these claims of injury had to have been "reported," those claims had to have been made before the evaluation.

[8] Section 5400 concerns notice of injury with no reference to a claim form. Section 5402 concerns notice and knowledge of injury and section 5402(b) provides for a ninety day period after "the date the claim form is filed under [s]ection 5401."

[9] Section 5401(a) requires that an employer must provide a claim form "[w]ithin one working day of receiving notice or knowledge of injury under [s]ection 5400 or 5402." Section 5401(c) states that:

> "The completed claim form shall be filed with the employer by the injured employee, or, in the case of death, by a dependent of the injured employee, or by an agent of the employee or dependent. . . .[A] claim form is deemed filed when it is personally delivered to the employer or received by the employer by first-class or certified mail. A dated copy of the completed form shall be provided by the employer to the employer's insurer and to the employee, dependent, or agent who filed the claim form."

As discussed above, sections 4062.3(j) and 4064(a) provide that a medical evaluation shall address "all medical issues arising from all injuries reported on one or more claim forms," and in keeping with that statutory language, section 4062.3(k) directs an employee to return to the same evaluator who conducted the previous evaluation when a new medical issue arises relating to the previously reported injury claim(s). As a matter of construction, a prior evaluation of that previously reported injury claim(s) must have already occurred at the time the medical issue arises, and consequently, the employee must then return to the same evaluator for the same reported injury claim(s).[10] In contrast, there is no reference in section 4062.3(k) to subsequent claims of injury.

Finally, section 4067 states that:

> If the jurisdiction of the appeals board is invoked pursuant to Section 5803 upon the grounds that *the effects of the injury* have recurred, increased, diminished, or terminated, a formal medical evaluation shall be obtained pursuant to this article.
>
> "When an agreed medical evaluator or a qualified medical evaluator selected by an unrepresented employee from a three-member panel has *previously made a formal medical evaluation of the same or similar issues, the subsequent or additional formal medical evaluation shall be conducted by the same agreed medical evaluator or qualified medical evaluator*, *unless* the workers' compensation judge has made a finding that he or she did not rely on the prior evaluator's formal medical evaluation, any party contested the original medical evaluation by filing an application for adjudication, the unrepresented employee hired an attorney and selected a qualified medical evaluator to conduct another evaluation pursuant to subdivision (b) of Section 4064, or the prior evaluator is no longer qualified or readily available to prepare a formal medical evaluation, *in which case Sections 4061 or 4062, as the case may be, shall apply as if there had been no prior formal medical evaluation*. (Italics added.)

Section 4067 sets forth specific procedures governing the reopening of a claim, and like section 4062.3(k), requires that an employee return to the same evaluator for new medical issues arising out of a particular injury claim. Section 4067 also provides that under certain circumstances an employee does not have to return to the same evaluator even when it is for an evaluation of the same claim of injury, and

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[10] Similarly, section 4062(a) provides in pertinent part that when a party objects to a medical issue not covered by sections 4060 or 4061 and not subject to section 4610, a medical evaluation must be obtained under the procedures in sections 4061.1 and 4062.2. And, section 4062(a) only refers to medical issues and not to subsequent claims of injury or body parts. In addition, section 4061(i) also requires that evaluations of permanent impairment be obtained in accordance with sections 4061.1 and 4062.2.

when that occurs, sections 4061 and 4062 apply "as if there had been no prior formal medical evaluation." Like section 4062.3(k), there is no reference in section 4067 to subsequent claims of injury.

Accordingly, after review of the pertinent statutes, we conclude that the Labor Code requires that all medical-legal evaluations be obtained as set forth under sections 4062.1or 4062.2 and that the Labor Code requires that an evaluator discuss all medical issues arising from all reported claims of injury at the time of an evaluation. Further, we conclude that the Labor Code generally requires that an employee return to the original evaluator when a new medical issue arises in the same claim of injury and when an employee reopens the same claim. But, we see no provision in the Labor Code that requires an employee to return to the same evaluator for a subsequent claim of injury. And, we see no provision that distinguishes between procedures for evaluation of claims of injury based on the same or different body parts. Thus, we conclude that the Labor Code does not require an employee to return to the same evaluator for a subsequent claim of injury.

II. The requirement in Rule 35.5(e) that an employee return to the same evaluator when a new injury or illness is claimed involving the same parties and the same type of body parts is inconsistent with the Labor Code, and therefore, this requirement is invalid.

We now consider Rule 35.5(e) in light of our conclusion that the Labor Code does not require an employee to return to the same evaluator for a subsequent claim of injury. As discussed above, we conclude that the Labor Code provisions concerning medical-legal evaluations only require the employee to return to the same evaluator when a new medical issue arises out of a previously evaluated injury. In contrast, Rule 35.5(e) imposes an *additional requirement* that an employee return to the same evaluator when a *new* injury or illness is claimed that involves the *same body parts* and the *same parties*.

The WCAB has exclusive original jurisdiction to determine the validity of regulations adopted by the Administrative Director (AD). (Lab. Code, § 5300(f); see *Mendoza v. Huntington Hospital Workers' Comp. Appeals Bd.* (2010) 75 Cal.Comp.Cases 634, 640 (Appeals Board en banc) [discussing the WCAB's jurisdiction to determine the validity of Rule 30(d)(3)].)

In considering the validity of a regulation, "our task is to inquire into the legality of the . . . regulation, not its wisdom." (*Moore v. Cal. State Bd. of Accountancy* (1992) 2 Cal.4th 999, 1014; accord, *State Farm Mutual Automobile Ins. Co. v. Garamendi* (2004) 32 Cal.4th 1029, 1040 (*State Farm*).)

Thus, we are "limited to determining whether the regulation (1) is within the scope of the authority conferred (Gov. Code, § 11373) and (2) is reasonably necessary to effectuate the purpose of the statute." (*State Farm*, 32 Cal.4th at p. 1040 [quoting from *Agric. Labor Relations Bd. v. Superior Court* (1976) 16 Cal.3d 392, 411 (*Agric. Labor Relations Bd.*) (internal citations and quotation marks omitted)].) "Although in determining whether . . . regulations are reasonably necessary to effectuate the statutory purpose we will not intervene in the absence of an arbitrary or capricious decision, 'we need not make such a determination *if the regulations transgress statutory power*.'" (*Cal. Assn. of Psychology Providers v. Rank* (1990) 51 Cal.3d 1, 11–12 (*Cal. Assn. of Psychology Providers* [quoting from *Morris v. Williams* (1967) 67 Cal.2d 733, 749 (*Morris*) (italics added)].)

With regard to this latter point, we are guided by two of the central provisions of the administrative rule-making provisions of the Administrative Procedures Act [APA] (Gov. Code, § 11340 et seq.), to which the AD is subject.[11] Government Code section 11342.2 provides that "no regulation adopted is valid or effective unless consistent and not in conflict with the statute." Hence, it has been said that "[w]hen a statute confers upon a state agency the authority to adopt regulations . . . , the agency's regulations must be consistent, not in conflict with the statute" (*Mooney v. Pickett* (1971) 4 Cal.3d 669, 679) and that "[a] regulation that is inconsistent with the statute it seeks to implement is invalid." (*Esberg v. Union Oil Co*. (2002) 28 Cal.4th 262, 269.) "No matter how altruistic its motives, an administrative agency has no discretion to promulgate a regulation that is inconsistent with the governing statutes." (*Mendoza, supra,* 75 Cal.Comp.Cases at p. 640; see *Agric. Labor Relations Bd., supra,* 16 Cal.3d at p. 419.) Government Code section 11342.1 provides that "[e]ach regulation adopted, to be effective, shall be within the scope of authority conferred." Thus, it has been said that "administrative regulations which exceed the scope of the enabling statute are invalid and have no force or life" (*Woods v. Superior Court* (1981) 28 Cal.3d 668, 680) and that "[a]dministrative regulations that . . . enlarge [a statute's] scope are void and courts not only may, but it is their obligation to strike down such

[11] The APA makes every regulation subject to its rulemaking provisions unless expressly exempted by statute. (Gov. Code, § 11346.) By statute, DWC is exempted only from the APA's provision regarding Superior Court review of agency regulations. (Gov. Code, § 11351(c).)

regulations." (*Cal. Assn. of Psychology Providers, supra,* 51 Cal.3d at p. 11 [quoting from *Morris, supra,* 67 Cal.2d at p. 748].) "[T]he Legislature possesses the plenary constitutional authority to create and enforce a workers' compensation system" and accordingly, a regulation promulgated by the AD which contradicts the Workers' Compensation Act is invalid. (*Boehm & Associates v. Workers' Comp. Appeals Bd. (Lopez)* (1999) 76 Cal.App.4th 513, 519 [64 Cal.Comp.Cases 1350].)

As set forth in our discussion above, we conclude that the Labor Code requires that all medical-legal evaluations be obtained as set forth under sections 4062.1 or 4062.2 and requires that an evaluator discuss all medical issues arising from all reported claims of injury at the time of an evaluation. We also conclude that the Labor Code generally requires that an employee return to the original evaluator when a new medical issue arises in the same claim of injury and when an employee reopens the same claim. But, the Labor Code makes no reference to same or different body parts. Therefore, unlike Rule 35.5(e), *the Labor Code does not require an employee to return to the original evaluator when another claim of injury is filed even when the subsequent claim of injury involves the same body parts and the same parties*. The language of the statutes is mandatory, and thereby controls.

Rule 35.5(e) imposes an unwarranted limitation on the Labor Code, particularly sections 4060(a), (c), and (d), 4062.1, 4062.2, 4062.2(a), 4062.3(j), 4062.3(k), 4064(a), and 4067. Thus, Rule 35.5(e) is invalid to the extent that it imposes the additional requirement that an employee return to the same evaluator when a new injury or illness is claimed that involves the same body parts and the same parties. While parties are not precluded from agreeing to return to the same evaluator for subsequent claims of injury, based on the foregoing, we conclude that an employee may be evaluated by a new evaluator for each injury or injuries reported on a claim form after an evaluation has taken place. Thus, regardless of whether a subsequent claim of injury is filed with the same employer or a different employer and regardless of whether injury is claimed to the same body parts or to different body parts, when a subsequent claim of injury is filed, the Labor Code allows the employee and/or the employer to request a new evaluator. In keeping with the limitations set forth in sections 4062.3(j) and 4064(a), at the time of an evaluation the evaluator shall consider all issues arising out of any claims that were reported before

the evaluation, and if several subsequent claims of injury are filed before the evaluation by the new evaluator takes place, that *one* new evaluator shall consider all of those claims of injury.

We are aware that in a particular case it may be beneficial to one side to seek a new evaluator and that unfortunately, a subsequent claim of injury could be filed by an employee or an employer with the goal of "doctor-shopping," potentially leading to increased medical-legal costs and delays. However, since these provisions of the Labor Code apply equally to both employees and employers, we do not see that either side gains an overall advantage. We also remind all participants that it is constitutionally required that workers' compensation proceedings be expeditious. (Cal. Const., art. XIV, § 4.)

Here, while we agree with the WCJ's decision that applicant is entitled to a new panel QME, we do not believe that the result turns on the application of Rule 35.5(e). Applicant attended a medical-legal evaluation by Dr. Yogaratnam for his claimed cumulative injury and because applicant was represented that evaluation necessarily would have been pursuant to section 4062.2.[12] Subsequently, applicant reported two specific injury claims.[13] Even where, as here, an applicant's three claimed injuries involve some of the same body parts and the same parties, the statutes make no distinction between claims or injuries to same or different body parts and same or different parties. Applicant's two claims of specific injury were reported after the original evaluation but before a subsequent evaluation by a new evaluator. Thus, under sections 4062.3(j) and section 4064(a), applicant is entitled to be evaluated by one new evaluator for his two subsequent claims of injury. Therefore, we conclude that applicant is not required to return to Dr. Yogaratnam for an evaluation of his two subsequent claims of injury and may be evaluated by a new panel QME.

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[12] Although the case of an unrepresented applicant is not before us, it appears that the difference between an unrepresented and a represented applicant is whether section 4062.1 or 4062.2 applies. Accordingly, we do not believe that whether applicant was represented or unrepresented would change the outcome of this decision.

[13] Here, there is nothing in the record to indicate whether applicant filed claim forms for his subsequent claims of injury with his employer before he filed claim forms at the WCAB on October 4, 2010. However, the original evaluation occurred on September 14, 2009, almost a year before the dates of the two subsequent claimed injuries. Although the issue does not arise in the case before us, we point out that in other cases where multiple claim forms were filed for the same date of injury, the date that the first of those multiple claim forms was filed could be significant in determining which panel QME conducts an evaluation.

Accordingly, based upon our review of the relevant statutes and case law, we hold that:

(1) The Labor Code does not require an employee to return to the same panel QME for an evaluation of a subsequent claim of injury.

(2) The requirement in Rule 35.5(e) that an employee return to the same evaluator when a new injury or illness is claimed involving the same parties and the same type of body parts is inconsistent with the Labor Code, and therefore, this requirement is invalid.

We also affirm the Findings of Fact and return the matter to the trial level.

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For the foregoing reasons,

IT IS HEREBY ORDERED as the Decision After Removal of the Workers' Compensation Appeals Board (En Banc) that the Findings of Fact issued on October 31, 2013 is **AFFIRMED** and the matter is **RETURNED** to the trial level.

WORKERS' COMPENSATION APPEALS BOARD (EN BANC)

/s/ Ronnie G. Caplane
RONNIE G. CAPLANE, Chairwoman

/s/ Frank M. Brass
FRANK M. BRASS, Commissioner

/s/ Deidra E. Lowe
DEIDRA E. LOWE, Commissioner

/s/ Marguerite Sweeney
MARGUERITE SWEENEY, Commissioner

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

4/2/2014

SERVICE MADE ON THE ABOVE DATE ON THE PERSONS LISTED BELOW AT THEIR ADDRESSES SHOWN ON THE CURRENT OFFICIAL ADDRESS RECORD.

ISMAEL NAVARRO
ACTING ADMINISTRATIVE DIRECTOR OVERPECK
HITZKE & ASSOCIATES, ATTN: JEANNETTE Y. OROZCO
LISTER, MARTIN & THOMPSON, LLP, ATTN: JONATHAN D. OGDEN

AS/jp/abs