ATTACHMENT A

RESPONDENT'S PETITION FOR RECONSIDERATION

ATTACHMENT A

Jackie R Wilson

Received
MAR 25 2014
CalPERS Board Unit

March 24, 2014

Dear Cheree Swednesky,

I am writing this letter to you because I received a letter from the board after my hearing that I attended on 11/12/2013. In this letter it stated that I did not file for retirement until May 24,2011, however, I have enclosed some documents that I had received in August of 2010 and September 2010. As these are dated August 2010,and September 2010, you can see that I originally submitted for my retirement in 2010. I am not sure as to where the date of May 24,2011 came from. I was on a leave of absence until February of 2011 and I originally filed paperwork for my CalPers retirement before I signed the paperwork for my separation from Atascadero State Hospital. I suffered an injury while I was employed there in November of 2002 and had FMLA paperwork on file at the time of my employment. As I informed the judge at the hearing on November 12,2012, I suffered episodes that would cause me to have to leave work and go home. There were many times that these occurrences happened and I, at the time and still do, suffer from memory loss, as a result of injuring my head while at work in November of 2002. I was taking medications for this injury that would cause me to become very drowsy and I did not feel safe at work while on these medications, this again, was also discussed in the hearing in November. I am 46 years old and I am unable to work due to my injuries that I suffered in 2002. I was on disability through the state of California in July of 2010, when I became disabled is when I originally filed for my retirement. I am still under the care of doctors currently due to theses injuries, and have had numerous outpatient surgeries due to the debilitating pain that I suffer as a result.

Sincerely,

Jackie Wilson

Jackie R. Wilson

4/4/2014

To whom it Concerns,

I am enclosing the medical records that I have revived from Med Stop Urgent Care. There are many notes from 2008 and thru 2010. As you can see by the enclosed documents, I was being treated by the doctors there. I did have FMLA paperwork as well. My injuries are related to my injury that occurred 11/2002. I am still under doctor's care and having numerous procedures to date to help with my pain. I find it hard to believe that CAL Pers is trying to keep me from receiving disability retirement when the reason as to why I am in pain is due to the injury that was sustained in November of 2002. I understand that I did return to work; however, I was and still am under doctor's care. I am a 47 year old man who has debilitating back and neck pain that has to use a cane to get around. There are days that I am not even able to walk. I spoke to the judge in November of 2013, informed him of the problems that were going on, as embarrassing as it was to let him know, that I was urinating on myself and having increased groin pain. I think that even having to go this far in trying to obtain my disability retirement is a disgrace.

Thank You,

Jackie Wilson

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ROOM # 2

DATE:	CHECK IN	AVAILABLE	IN ROOM	MA	MD - PA ON DUTY
9-3-07			420	AW	Snyder

PATIENT NAME:	DOB	AGE	DATE OF LAST VISIT
Wilson Jackie		40	—

WORK RELATED	INSURANCE COMPANY	SOCIAL SECURITY #	PRIMARY DOCTOR
YES NO	BX		—

ALLERGIES:	LAST TETANUS	LMP
NKDA	Unknown	N/A

REGULAR / RECENT MEDS: NONE BCP SEE LIST	TIME	TEMP.	PULSE	RESP.	B/P
motrin [illegible]	420	97.3	88	16	140/92
				435	138/80

CHIEF COMPLAINT: LBP R side, fainted X 1° ago

PULSE OX. / RA	VISUAL ACUITY	CORRECTED?	HT.	WT.	STATED
	OD = 20/ OS=20/	OU=20/		LBS.	KG.

REFERRALS FOR TREATMENT & FOLLOW-UP: PR 24°

DIAGNOSTIC IMPRESSIONS: ① Syncopal event ② Low back pain

MEDICAL DECISION MAKING: Dissecting acute cardio pulmonary event doubt PE or AMI. Likely pain response ZT in [illegible] treat (environmental)

DISCUSSED WITH DR. _____ DFR / WSR / PR2 / PR4 / DMV / PHD

DISCHARGE STATUS = SATISFACTORY IMPROVED NO CHANGE

COUNSELED PATIENT / FAMILY RE: DIAG. IMP. - TREAT. PLAN - FOLLOW UP - LAB - RADS

SEP 3 '07 PM 5:48

MEDICATIONS PRESCRIBED: RBA / ICG

RX / DISPENSED / CALL IN

RX / DISPENSED / CALL IN

RX / DISPENSED / CALL IN

PROVIDERS SIGNATURE: [signature] DISCHARGE TIME:

MED+STOP ORDER SHEET

PATIENT NAME: Wilson, Jackie DATE: 9-3-07

LAB IN HOUSE: UA - DIP: AW UA - MICRO: _____ BLOOD GLUCOSE: 113 AW

BHCG: POS. NEG. RAPID STREP: POS. NEG. MONO SPOT: POS. NEG.

OTHER: _____

LAB SEND OUTS: CBC / BMP / CMP / TSH / HEPATIC FUNC. / NEEDLE - STICK

OTHER: _____

URINE CULTURE / WOUND CULTURE / CHLAMYDIA / G-C / THROAT CULTURE

OTHER: _____

PATHOLOGY: _____

EKG / MONITOR / +READING:

NML RATE _____ NSR NML INTERVALS NML AXIS NML QRS NML ST / T _____

X-RAY IN - HOUSE: SEE ORDER FORM _____

PRELIMINARY READING: _____

X-RAY OFF SITE: LEFT RIGHT _____ X-RAY MRI / MRA CT

UTZ / DOPPLER CONTRAST REASON FOR STUDY: _____

OTHER ORDERS: PEAK FLOW _____ PRE _____ POST _____ JAMAR RIGHT _____ LEFT _____

TREATMENTS:	TIME	INITIALS	RE-EVALUATION	TIME	INITIALS
O2 138/92	4:40	AW			
O2 134/86	4:42	AW			
O2 136/90	4:44	AW			

PROVIDER'S SIGNATURE 9/3/07 DATE

WORK COMP ASSOCIATED ORDERS:

PHYSICAL THERAPY: _____

CONSULTATION: _____

RADIOLOGY: SEE ABOVE _____

DIAGNOSTIC STUDY: SEE ABOVE _____

MED-STOP URGENT CARE CLINIC
GENERAL ADULT - PROVIDER RECORD

PATIENT NAME: Wilson, Jackie

CHECK ✓ = NORMAL CIRCLE = POS. LINE OUT = NEG.

TIME SEEN _____ DATE 9/3/14 ROOM _____

HISTORIAN: (PATIENT) SPOUSE OTHER _____

REVIEWED: (MA NOTE) (VITAL SIGNS) (ALLERGIES) (MEDS)

CHIEF COMPLAINT: _____

HPI: Sitting outside Chad P Ranch pool began sweats felt light-headed & dizzy; walked into home got H2O came out sat down had me LSP sat back up => faint LOC for moments Disoriented... no other prescriptions factors such as CP/SOB/ Low

PHYSICAL EXAM: (ALERT) ANXIOUS

GEN APPEAR.: NML DISTRESS (NONE) MILD MOD. SEV.

HEENT: SEE DIAGRAM
✓ ENT INSPECTION NML — NASAL D/C
✓ PHARYNX NML — RED EXUDATE

NECK: SEE DIAGRAM
✓ NML INSPECTION — ADENOPATHY R / L

RESPIRATORY: SEE DIAGRAM
✓ BREATH SOUNDS NML — WHEEZE RALES RHONCHI
✓ CHEST NON-TENDER

CVS:
✓ REG RATE, RHYTHM — IRREG EXTRA-SYST TACHY BRADY
✓ NO MURMUR — MURMUR GRADE ____ / 6

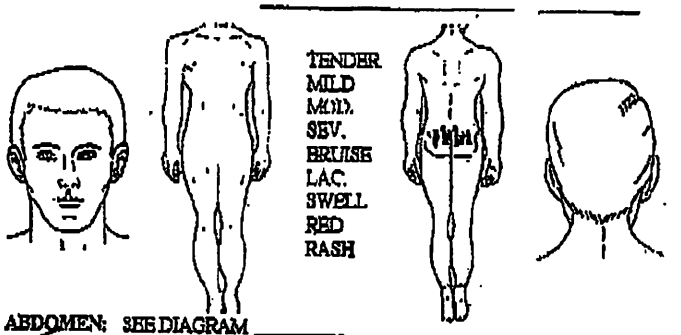
STILL PRESENT WORSE BETTER GONE EPISODIC
Otherwise well
SEVERITY: MILD MOD. SEV. _____

MODIFIERS: NONE _____

SIMILAR SX. PREVIOUSLY: _____

RECENT TX. BY PMD: _____

No bowel or Bladder incontinence. No recent trauma. No recent illness.



ROS:

CONST. FEVER CHILLS _____ GU _____
LMP ____ G ____ P ____ AB ____
DYSURIA FREQ. URG. BLD.

ENT _____
SORE THROAT CONGESTION

SKIN / MUSCULOSKELETAL
RASH _____
LEG PAIN _____
FOOT / LEG SWELL _____

CHEST / CVS _____
COUGH SPUTUM _____
SOB _____

NEURO / EYES _____
CONFUSION _____
HEADACHE _____
DIZZY / LOC _____
WEAKNESS _____
DIFF. WALK SPEAK VISION

GI _____
ABD PAIN _____
NAUSEA VOMIT DIARRHEA
BLACK BLOODY STOOLS
ALL OTHER SYSTEMS NEG.

PMH: NEG. INTAKE FORM REVIEWED _____

NEURO: CVA SZ. _____ CARD: CAD CHF HTN

LUNG DIS.: COPD ASTHMA PNEUMO DM: INSULIN TYPE 2

Low back pain [illegible]

SURGERY: _____

FH: NEG. CA CAD DM SH: (SMOKER) DRUGS ETOH

ABDOMEN: SEE DIAGRAM
✓ NON-TENDER — TENDER _____
✓ NML BOWEL SOUNDS — GUARDING REBOUND _____
✓ NO ORGANOMEGALY — HEPATO - SPLENOMEGALY MASS

RECTAL:
___ HEME NEG STOOL — BLACK BLOOD HEME POSITIVE

BACK: SEE DIAGRAM
___ NML INSPECTION — CVA TENDER R / L

SKIN: SEE DIAGRAM
✓ COLOR NML, NO RASH — RASH _____
✓ WARM, DRY — COOL PALLOR SWEATY

EXTREMETIES: SEE DIAGRAM
___ NON-TENDER — TENDER _____
✓ FULL ROM — LIMITED ROM _____
✓ NO EDEMA — EDEMA / CALF TENDER _____
✓ NO LESIONS

NEURO / PSYCH:
✓ ORIENTED X 3 — NOT PERSON PLACE TIME
✓ MOOD / AFFECT NML — DEPRESSED AFFECT _____
✓ CN's 2 – 7 NML — FACE DROOP HEMIPALSY _____
___ NO MOTOR / SENS LOSS — WEAKNESS SENS LOSS _____

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ROOM # 4

DATE: 2.14.08	CHECK IN 10:20	AVAILABLE	IN ROOM	MA AN	MD - PA ON DUTY Dodd
PATIENT NAME: Wilson Jackie			DOB	AGE 41	DATE OF LAST VISIT 9.3.07
WORK RELATED YES NO	INSURANCE COMPANY BS HMO		SOCIAL SECURITY #		PRIMARY DOCTOR Goodman
ALLERGIES: NKDA			LAST TETANUS over 8 yrs		LMP N/A

REGULAR / RECENT MEDS: NONE BCP SEE LIST	TIME	TEMP.	PULSE	RESP.	BP
	10:30	97.6	88	16	144/92
CHIEF COMPLAINT: (2) groin pain X 2 WKS					

PULSE OX. / RA	VISUAL ACUITY	CORRECTED?	HT.	WT.	STATED
	OD = 20/ OS=20/	OU=20/		LBS.	KG.

REFERRALS FOR TREATMENT & FOLLOW-UP:

DIAGNOSTIC IMPRESSIONS: (1) Inguinal strain

MEDICAL DECISION MAKING: Doubt hernia though possible

DISCUSSED WITH DR. _____ DFR / WSR / PR2 / PR4 / DMV / PHD

DISCHARGE STATUS = SATISFACTORY IMPROVED NO CHANGE

COUNSELED PATIENT / FAMILY RE: DIAG. IMP. - TREAT. PLAN - FOLLOW-UP - LAB - RADS

MEDICATIONS PRESCRIBED: RBA / ICG

Naproxen — NAPROXEN 500mg TAB. NDC-52555-0183-40 Qty 1040 Exp: 08/08 Lot: NOMENCLATURE (Naproxen) 00182-0184-03 — RX / DISPENSED / CALL IN

RX / DISPENSED / CALL IN

RX / DISPENSED / CALL IN

PROVIDERS SIGNATURE: [signature] DISCHARGE TIME: 11:25

MED+STOP URGENT CARE CLINIC
MALE G-U PROBLEM PROVIDER RECORD

PATIENT NAME: Wilson, Jackie

CHECK ✓ = NORMAL CIRCLE = POS. LINE OUT = NEG.

REVIEWED: MA NOTE VITAL SIGNS ALLERGIES MEDS

TIME SEEN _____ DATE 2/14/08 ROOM _____

HISTORIAN: PATIENT PARENT OTHER _____

CHIEF COMPLAINT: DYSURIA URG. FREQ. BLOOD DISCHARGE TESTICULAR PAIN URINARY RETENTION

HPI: Pain (L) inguinal area x 2 wks. Pain pt to bend over, stoop, etc. Does lots of heavy lifting. Climbing into truck, etc

WORSE BETTER GONE ON / OFF flexing hip

PAIN WITH URINATE BURN URG. FREQ. BLOOD IN URINE

PAIN: ABD. SUPERPUBIC FLANK BACK L / R

CONTEXT: LIFT BEND TRAUMA RECENT SURGERY _____

INGUINAL MASS / LUMP _____

DISCHARGE FROM PENIS. YELLOW CLEAR THICK THIN

PAIN / SWELLING IN TESTICLE L / R _____

SEXUALLY: ACTIVE INACTIVE _____

EXPOSURE / PROTECTION: CONDOM _____

PENILE: PAIN LESION HESITANTCY NOCTURIA IMPOTENCE

SIMILAR SX. PREVIOUSLY: _____

RECENT TX. BY MD: _____

ROS: _____

CONST. FEVER _____ CHILLS

GI _____
NAUSEA VOMIT _____
DIARRHEA _____
ABD. PAIN _____
BLOOD / STOOL _____

SKIN / LYMPH _____
RASH SWELL _____

MUSCULOSKELETAL
BACK PAIN _____
ARTHRALGIA _____
LEG PAIN SWELL _____

NEURO _____
WEAKNESS _____
DIZZY / LOC _____
HEADACHE _____

ALL OTHER SYSTEMS NEG.

PMH: NEG. INTAKE FORM REVIEWED _____

UTI PYELO. PROSTATITIS URETHRITIS EPIDIDYMITIS

HERPES CHLAMYDIA GC STONES RENAL FAIL. EPH

CAD: _____ HTN DM: INSULIN ORAL DIET

SURGERY: _____

FH: NEG. RENAL FAIL. DM SH: SMOKER DRUGS ETOH

PHYSICAL EXAM: ALERT ANXIOUS _____

GEN APPEAR.: NML DISTRESS = NONE MILD MOD. SEV.

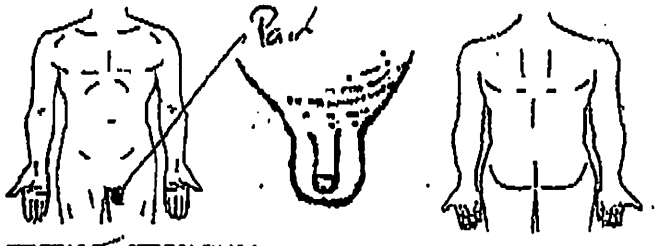
HEENT:
__ HEENT INSPECTION NML — NASAL D/C _____
__ PHARYNX NML — RED _____

NECK:
__ NML. INSPECTION — ADENOPATHY _____

RESPIRATORY:
__ NO RESP DISTRESS
__ BREATH SOUNDS NML — RALES RHONCHI WHEEZE

CVS:
__ REG RATE, RHYTHM — IRREG RHYTHM _____
__ NO MURMUR — MURMUR GRADE _____ / 6 _____

ABDOMEN: SEE DIAGRAM _____
__ NON-TENDER — TENDER _____
__ NML BOWEL SOUNDS — GUARD _____ REBOUND _____
__ NO ORGANOMEGALY — HEPATO - SPLENOMEGALY MASS



GENITALS: SEE DIAGRAM _____
__ RT GENT. EXAM NML — LESIONS _____
URETHRAL D / C _____
__ NML TESTICLE PALP. — TESTICULAR TENDER _____
EPIDIDYMUS TENDER _____
SCROTAL SWELL / MASS _____
INGUINAL NODES ? tenderness (L)
__ NO HERNIA / LAXITY — HERNIA MASS _____
STANDING EXAM no compaint
HYDROCELE / VARICOCELE _____
__ NML PROSTATE — TENDER / NODULE _____
__ NML STOOL HEME NEG — HEME POSITIVE _____

BACK: SEE DIAGRAM _____
__ NML INSPECTION — CVA TENDER R / L _____

SKIN:
__ COLOR NML, NO RASH — RASH _____

EXTREMETIES:
__ NON-TENDER — TENDER EDEMA _____

NEURO / PSYCH:
__ MOOD / AFFECT NML — DEPRESSED AFFECT _____
__ NO MOTOR / SENS LOSS — WEAKNESS SENS LOSS _____