

ATTACHMENT A

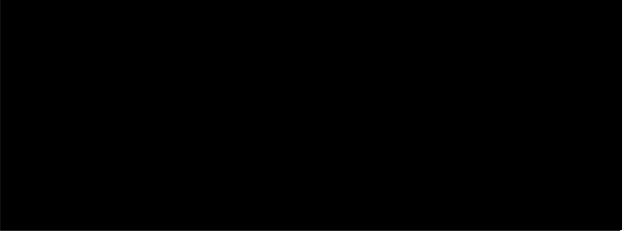
RESPONDENT'S PETITION FOR RECONSIDERATION

~~FBX~~



ATTACHMENT A

01-21-2020



"Petition for Reconsideration"

I submit that the decision be reversed on the issue below.

Please reconsider, there seems to be different filing dates.

Thanks
Ailie Dampier

SE NO.
2019-0634

H. 2019080683

Put your name and Social Security number or CalPERS ID at the top of every page

Little B. Sample
Your Name



Section 3

Please complete all the questions. If you need additional space, attach separate sheets and be sure to include your name and Social Security number or CalPERS ID on all sheets.

Disability Information

What is your specific disability? Back Doctor said no more work after MRI

When did the disability occur? (mm/dd/yyyy) 06-02-17

How did the disability occur? Lifting boxes at work. Taking out trash.

What are your limitations/preclusions due to your injury or illness? See medical records

How has your injury or illness affected your ability to perform your job? can't perform no lifting, pulling, pushing, bending - ect.

Are you currently working in any capacity? No Yes

If yes, what is your employment status? Full time Part time

Job duties: empty trash, vacuum and shampoo carpets. Sweep, mop, dust, wipe walls, clean restrooms

Other information you would like to provide: _____

If you indicated a third-party liability, CalPERS will require additional information.

Did a third party cause your injury? No Yes (If yes, CalPERS has a potential "right of subrogation.")

Section 4

Treating Physician Detail

What is the complete name and address of your treating physician(s)?

Elber Gaspar
First Name Last Name



975 Serena Dr.
Address

Vallejo CA 94589-2441 USA
City State ZIP Country

Specialty Secondary Specialty Phone Number 707 451 1000



Employer Information for Disability Retirement

888 CalPERS (or 888-225-7377) • TTY: (877) 249-7442 • Fax: (916) 795-1280

COPY

NOV 20 PM 2:30

Section 1

Member Information

To Member:
Complete this form, sign, date and forward to your employer.

Lillie B Sample
Name of Member (First Name, Middle Initial, Last Name)

[Redacted Social Security Number]

Custodian
Position/Occupational Title

Vallejo City Unified School
Name of Employer/Agency

I have submitted an application for disability retirement with the California Public Employees' Retirement System (CalPERS). I am submitting this letter to you (my employer) on behalf of CalPERS. CalPERS is seeking information to substantiate my disability.

To Employer:
Use this form as a cover sheet for the employee's job description and other documents you submit to CalPERS.

As soon as possible, please send CalPERS the job duty statement/job description for the position I held. Please include a copy of all accident reports, medical reports, and personnel actions filed within the past five years. These documents must be identified with my name and Social Security number. If you have additional comments, please submit them.

CalPERS requires the physical requirements of my position/occupational title. I will be contacting you so we can complete the Physical Requirements of Position/Occupational Title form for my position. At that time, a copy of my job duty statement/job description that you send to CalPERS must be provided to me. Both the job duty statement/job description and the Physical Requirements of Position/Occupational Title form will be presented to my physician/medical specialist to assist in the evaluation of my disability retirement.

When the CalPERS determination of disability is completed, they will inform you. When you are notified of their determination, you will have the right to appeal the approval/denial of the application for disability retirement for the medical condition stated, in accordance with Section 555.3, Title II, California Code of Regulations by filing a written request with CalPERS within 30 days of the mailing of the determination letter. An appeal, if filed, should set forth the factual basis and legal authorities for such appeal.

Under the law, if a person (other than my employer) caused an injury that results in certain CalPERS benefits being paid, CalPERS has the right to recover from the responsible party up to one-half of the total retirement benefit costs payable. This right is known as a "right of subrogation" (Government Code Section 20250, et seq.).

Please advise CalPERS if you are aware of any claim (other than a workers' compensation claim) against any person or entity for the same injuries that also entitle me to a disability retirement from CalPERS.

Section 2

Authorization to Release Information

Mail signed authorization to your employer, not CalPERS.

The purpose of this authorization is to assist CalPERS in determining my right to retirement or reinstatement under the Retirement Law, pursuant to Government Code Section 20128, and for no other purpose. This authorization will be valid for four years from the date shown below. A photocopy of this authorization shall be as valid as the original.

Lillie Sample
Signature of Member

11-19-18
Date (mm/dd/yyyy)

Mail to: CalPERS Benefit Services Division • P.O. Box 2796, Sacramento, California 95812-2796



Physical Requirements of Position/Occupational Title

888 CalPERS (or 888-225-7377) • TTY: (877) 249-7442 • Fax: (916) 795-1280

COPY

Section 1

This form must be completed by the member and their employer to supplement the physical requirements listed on the member's job duty statement/job description.

Member Information

Lillie B Sample
Name of Member (First Name, Middle Initial, Last Name)

Custodian
Position/Occupational Title

Vallejo City Unified School Dist.
Name of Employer

Pennycook Elementary
Worksite Street Address

Vallejo CA 94590
City State ZIP

Section 2

Indicate with a check mark (✓) the frequency required for each activity listed at the right.

Physical Requirements Information

Activity	Never	Occasionally Up to 3 hours	Frequently 3-6 hours	Constantly Over 6 hours	Distance/ Height
Sitting		X			
Standing				X	
Running	X				
Walking				X	
Crawling	X				
Kneeling		X			
Climbing			X		
Squatting			X		
Bending (neck)				X	
Bending (waist)				X	
Twisting (neck)			X		
Twisting (waist)			X		
Reaching (above shoulder)			X		
Reaching (below shoulder)				X	
Pushing & Pulling				X	
Fine Manipulation					
Power Grasping	X				
Simple Grasping	X				
Repetitive use of hand(s)			X		
Keyboard Use	X				
Mouse Use	X				
Lifting/Carrying					
0 - 10 lbs.				X	
11 - 25 lbs.				X	
26 - 50 lbs.				X	
51 - 75 lbs.	X				
76 - 100 lbs.	X				
100 + lbs.	X				

Continued on page 2.

Put your name and Social Security number of CalPERS ID at the top of every page.

Willie B Sample
Your Name

Section 2 (continued)

Indicate with a check mark (✓) the frequency required for each activity listed at the right.

If there is not enough space to enter all your additional requirements or comments, attach a separate sheet. Be sure to use a label, or clearly write your name and Social Security number on each attachment.

Physical Requirements, continued

Activity	Never	Occasionally Up to 3 hours	Frequently 3-6 hours	Constantly Over 6 hours	Distance/ Height
Walking on uneven ground	X				
Driving	X				
Working with heavy equipment	X				
Exposure to excessive noise	✓				
Exposure to extreme temperature, humidity, wetness	✓				
Exposure to dust, gas, fumes, or chemicals	✓				
Working at heights	✓				
Operation of foot controls or repetitive movement	✓				
Use of special visual or auditory protective equipment	✓				
Working with bio-hazards (e.g., blood-borne pathogens, sewage, hospital waste, etc.)	✓				

Section 3

This form must be completed and signed by you and your employer and sent to a medical specialist along with other documentation.

The medical specialist must be the treating physician specializing in your disabling condition.

Signature of Employer and Member

If you are a Disability Retirement Election applicant, your employer must provide you a copy of this completed form. Your employer must send the signed original to CalPERS.

Also, you must attach your current job duty statement/job description and a copy of the *Physical Requirements of Position/Occupational Title* form to the *Physician's Report on Disability* form prior to sending them to a medical specialist. Complete document submittal requirements are described in *A Guide to Completing Your CalPERS Disability Retirement Election Application*.

If you are a Request to Work While Receiving Disability/Industrial Disability Benefits applicant or a Reinstatement from Disability/Industrial Disability Retirement applicant, you must attach the job duty statement/job description of the prospective job to a copy of the completed *Physical Requirements of Position/Occupational Title* form prior to sending them to a medical specialist. You must submit the resulting medical report and other required documents to CalPERS. The *Physician's Report on Disability* form is not required.


 Signature of Employer Representative
 Assistant Chief HR Officer
 Title
 12-21-2018
 Date (mm/dd/yyyy)
 (707) 556-8921
 Phone Number
 Willie Sample
 Signature of Member
 707 641-3809
 Phone Number
 11-19-18
 Date (mm/dd/yyyy)

Mail to:

CalPERS Benefit Services Division • P.O. Box 2796, Sacramento, California 95812-2796



One Stop Printing Place

2125-2123 Sonoma Blvd ,Vallejo, Ca 94590
Phone: 707-554-2679, Fax: 707-554-6653

Fax Cover Sheet

ATTN.: Cheree Swedensky

FAX TO: 916-795-3972

FROM: Lillie Sample

Number of Pages: ~~6~~ 7
(Include the Cover Page)

Contact me:



Note:

JAN 22 2020

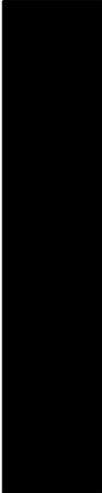
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TO: _____

FROM:

DIGITAL COPY _____

FAX: 7075546653

TEL: 

COMMENT: CONFIDENTIAL

JAN 29 2020
CALPERS LEGAL OFFICE

RECEIVED
JAN 22 2020
CALPERS Legal Office

GA