

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NOS. F600824 (1/18/06) & F611412 (10/14/06)

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| ANN BOWMAN, EMPLOYEE | CLAIMANT |
| BOARS HEAD PROVISIONS COMPANY, EMPLOYER | RESPONDENT #1 |
| AMERICAN ZURICH INS. CO., CARRIER | RESPONDENT #1 |
| SECOND INJURY FUND | RESPONDENT #2 |

OPINION FILED JUNE 10, 2008

Hearing before ADMINISTRATIVE LAW JUDGE ANDREW L. BLOOD, on March 14, 2008, at Forrest City, St. Francis County, Arkansas.

Claimant appeared pro se.

Respondents #1 represented by the HONORABLE ERIC NEWKIRK, Attorney at Law, Little Rock, Arkansas.

Respondent #2 represented by the HONORABLE JUDY W. RUDD, Attorney at Law, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was conducted in the above-style claims to determine the claimant's entitlement to additional workers' compensation benefits. On February 12, 2008, a pre-hearing conference was conducted in these claims, from which a Pre-hearing Order of the same date was filed. In light of the issues in dispute, respondent #2 was excused from participating in the hearing. The Pre-hearing Order reflects stipulations entered by the parties, the issues to be addressed during the course of the hearing, and the parties' contentions relative to the afore. The

Pre-hearing Order is herein designated a part of the record as Commission Exhibit #1. Claimant was permitted to amend her contentions to include a claim for benefits pursuant to Ark. Code Ann. §11-9-505 (a).

The testimony of Ann Bowman - the claimant, Annie Randel, Gillette Drone, and Loretta Ratchford, coupled with medical reports and other documents comprise the record in this claim.

DISCUSSION

Ann Bowman, the claimant, with a date of birth of February 10, 1971, is a high school graduate with several years of post-secondary education at East Arkansas Community College, commenced her employment with respondent-employer on July 2, 2001. Claimant's employment with respondent-employer was terminated on June 5, 2007.

The stipulations reflects that the claimant sustained two (2) separate injuries in the employment of respondent-employer which were accepted as compensable medical only claims. Claimant's job title during the pertinent periods of her employment with respondent-employer was that of Quality Assurance Technician. Claimant worked first shift, from 6:00 a.m. to 4:00 p.m. In describing her job duties, the testimony of the claimant reflects:

It was going to the department behind the station monitoring, making sure they were running the right sell by dates, checking the products and making sure, you know, inspecting the product. It consist of doing box weights, doing swabbing and pre-opping other Thermal Processing Department. (T. 27).

Claimant maintains that prior to January 2006, she had never received any disciplinary warnings or complaints as a result of her work at respondent-employer.

In describing the mechanics of the January 18, 2006, injury in the employment of respondent-employer, claimant testified:

On January the 18th, I was performing the micro monitor swabs. We usually do them on Tuesday, but with Monday being a national holiday, it move our swab date to Wednesday. I had completed swabbing the Packaging Department, the Browning Department and the Oil Browning. I entered through the Blast Door One. It was a designated blasting, being that the entrance door, main entrance door was on hold for the repairs. I entered through Blasting One, I walked into the control room, and I spoke to the guys and exited the control room and reentered through Blast Door One to do my swab. I wrote down the swab location on my swab. I opened the swab, and as I walked to the blast pit, I mean, as I walked to the product hole, I slipped and fell. When I slipped and fell I laid on the floor, so I called for Ava Williams because I remember he was out in the main corridor area. (T. 28-29).

The injury was reported to appropriate supervisory personnel of respondent-employer. Claimant received medical treatment from respondent-designated medical provider, Dr. Banaji, the following day of her accident. Claimant estimates that she was seen by Dr. Banaji “about three times”. Claimant noted that after the plant nurse informed Dr. Banaji that her job consisted of walking around, she was released to return to work. Claimant acknowledged that respondent-employer paid for the medication prescribed by Dr. Banaji in connection with her injury.

Claimant’s testimony reflects that she was off work from January 19, 2006, until January 24, 2006. Claimant noted that when she returned to the plant on January 24, 2006, it was for the purpose of talking to the plant nurse and requesting another appointment because she did not feel that Dr. Banaji had performed a thorough examination of her. Claimant explained, regarding the examination:

He just looked at the crook in my neck and just prescribed medication. And so, I came in at 6:25 and the nurse made it in probably about 7:00, so the first thing she came in and I went in there and I talked to her, and I told her that I wanted her to make me another appointment because Dr. Banaji didn’t give me a thorough examination, and so Linda just told me, “Well, you just got to write a letter to the adjuster.” I said,

“Who in the adjuster?” (T. 31).

The testimony of the claimant reflects that in addition to being off work from January 19, 2006 through January 24, 2006, she was also off work January 26, 2006 through February 8, 2006.

Claimant asserts that while she was unable to work due to residuals of her compensable injury, her sick days and vacation days were exhausted:

Yeah, they were using my sick and vacation. Also, I was off like two consecutive days, February 14th, 2006 and February 15th, 2006. I worked half days on February 23rd, 2006 and February 24th, 2006. I worked there like five hours on March the 2nd, and I took off on March the 3rd. On March 8th, I worked 3.82 hours, March 9th, 4.30 hours, March 11th, 2.63 hours, March 16th, 1.62 hours. I was off FMLA on March 20th, 2006. I was on FMLA March the 3rd, 2006 and March the 4th, 2006. I worked 6.95 hours on April the 7th. I worked on March 20th I worked 4.85 hours, then March 27th 5.80 hours, then I was out 5-3-2006, and on the 11-6-2006 I worked like 7.90, 11-8-2006 I worked 5.72 hours, and then I was absent the 11-9-2006, 11-10-2006. (T. 32).

Claimant attributes the afore missed work to her injury. Claimant maintains that spoke to upper management personnel (Gillette Drone, John Campbell, Mike Montella, and Cliff Brode) about her injuries in an attempt to get a personal leave because it was hard for her to work in her physical condition with the pain and medication.

Claimant’s testimony reflects that her treatment was transferred from Dr. Banaji to Dr. Harriman in Memphis by the plant nurse. Claimant acknowledged that she was seen by Dr. Harriman on or about February 7, 2006, for complaints growing out of the January 18, 2006, accident. Claimant’s testimony reflects that her treatment under the care of Dr. Harriman consisted of medication and being furnished a rib brace. Claimant was not directed to remain off work by Dr. Harriman, and, accordingly continued to work while undergoing treatment with

same.

Claimant later petitioned the Commission for a change of treating physician and the same was granted. In accordance with the Change of Physician Order, which was filed on April 11, 2006, Dr. Thomas M. Hart was designated. The testimony of the claimant reflects that Dr. Hart prescribed nerve block injections, however respondents refused to authorize or pay for the treatment. As a consequence of the afore the claimant did not have the nerve block injections. Claimant testified that she was seen by Dr. Hart on three (3) separate occasions. Claimant acknowledged that Dr. Hart did not take her off work.

The testimony of the claimant reflects that an MRI was performed on May 17, 2006, and the same was discussed with Dr. Hart. Claimant testified that she was last seen by Dr. Hart on or about May 22, 2006. Claimant maintains that Dr. Hart did not release her from his care, however respondents refused to pay for further treatment.

Claimant suffered another injury in the employment of respondents on October 4, 2006.

In describing the mechanics of the afore, claimant testified:

Me and a co-worker, we was going to EQ One to pull some AQ hole tags, and I opened the flap door, and the first step I stepped in, after I pushed the flap door over and walked in and I slipped on some ice. (T. 36-37).

Claimant explained that she fell to the floor in the accident. The injury was reported to appropriate supervisory personnel of respondent-employer.

Claimant was seen by Dr. Kumar, the respondent-designated physician, however she was not taken off work. Claimant's injury was treated by Dr. Kumar with steroid injections. In describing the injury from the October 4, 2006, accident, the claimant's testimony reflects:

Yes, sir. My neck, I re-hurt - - my neck was hurt on that day, so he was treating it with those injections, and my chest area was hurting, so he was treating me with those injections. (T. 37).

In addition to Dr. Kumar, claimant was also seen by her family doctor, Dr. Jacobs, on November 15, 2006, following the October 4, 2006, accident. Respondents did not pay for the claimant's treatment by Dr. Jacobs. Claimant maintains that Dr. Kumar refused to provide further medical treatment for her injuries, and, as a consequence, she treated with Dr. Jacobs. Claimant testified that Dr. Kumar took the position that he saw no obvious reasons for her continued pain, and as such effectively released her from his care relative to her knee injury growing out of the October 4, 2006, accident.

Claimant acknowledged that the October 4, 2006, accidental fall resulted in an injury primarily to her knee. Claimant added that her chest area was injured as well in the accident. Claimant testified, relative to the medical treatment she received under the care of Dr. Kumar:

Well, my chest area was hurting in front all the way around, so I was assuming those injections was for that area back here. My chest area was all the way around. (T. 39).

Claimant asserts that she received injections from Dr. Kumar after he released her relative to the knee injury. Claimant testified that she last received treatment under the care of Dr. Kumar in February 2007, at which time she was released to return on an as needed basis. Claimant maintains that Dr. Kumar placed medical restrictions on her employment activities, which were furnished to respondent-employer.

The testimony of the claimant reflects that her treatment under the care of Dr. Jacobs in November 2006, was because Dr. Kumar had released her for the knee complaint. Claimant continued performing her regular employment duties with respondent-employer following her

medical release by Dr. Kumar until her employment was terminated. Claimant's testimony reflects regarding the afore:

Yes, sir, I was doing it, but I was like - - jobs like in the office as far as computer work, and doing all the writing, like writing up like on the QA monitor swabs areas shift, and so after - - you know, I'd spend any time writing down the swabs, you know, everybody's sheets on one sheet. (T. 40-41).

Claimant insist that she performed all of her regular job duties. Claimant asserts that neither her supervisor nor the plant nurse ever discussed with her the medical restrictions, which included no lifting over 10 pounds, put in place by Dr. Kumar on her employment activities. The testimony of the claimant reflects that in performing her regular job duties she did not engage in any employment activities contrary to the restrictions. Claimant maintains that on the day of her release by Dr. Kumar, while she received an injection, she was never told that the restrictions had been lifted.

Claimant continued performing her assigned job duties until the termination of her employment by respondents on June 5, 2007. Claimant maintains that she was continuing to experience residuals of her injury at the time of her employment termination, which included the same pain in her neck area, chest and rib area. The testimony of the claimant reflects that since the June 5, 2007, date she has sought and obtained medical treatment under the care of Dr. Jacobs and Dr. Ashley Park, a Germantown, Tn., orthopedic physician. Claimant asserts that Dr. Park has recommended the same treatment, nerve block injections, as had Dr. Hart. Claimant has been unable to obtain the recommended treatment. Claimant's testimony reflects that she feels that she needs the treatment and desires to have it. The claimant commenced her treatment under the care of Dr. Park while she was still employed by respondent-employer. Claimant

maintains that while Dr. Park provided verbal restrictions on her physical activities, he did not reduce them to a written document. Claimant concedes that she did not provide any documentation from either Dr. Jacobs or Dr. Park to respondents.

Claimant acknowledged that she was told why her employment was terminated by respondent-employer on June 5, 2007. The testimony of the claimant reflects that Gillette Drone, the Human Resource Manager, informed her on June 1, 2007, that she was suspended. Claimant elaborated:

She said she was suspending me for signing my son's application till she did an investigation, until further investigation. (T. 44).

The testimony in the record reflects that respondent-employer accepted bids on seasonal applications for relatives of employees. Claimant has a son who was eighteen (18) years old at the time of the application incident. On June 5, 2007, the claimant's employment was terminated for falsification of records. Claimant applied for employment compensation benefits following the termination of her employment, and received them from July 2007 through December 2007.

Claimant asserts that the termination of her employment was a pretense and the product of work-related injuries. In explaining the afore, claimant testified:

Because I was falsely accused of signing my son's application, one. And then I feel that the many occasions I was trying to get a personal leave, it was okay for me to be working, but the MRI showed I had the bulging disk, but before I even found out what was wrong with my neck, I was repeatedly trying to get personal leave because it was hard for me to function doing my job. (T. 46).

In terms of attempting to get personal leave, claimant testified that she had meetings with Patricia Scott, who handles the FMLA leave, who informed her that she would have to talk with Gillette Drone, the Human Resource Manager. Claimant asserts that she spoke with Ms. Drone and her

request was denied. Claimant testified that Ms. Drone informed her that she could not give her personal leave for the work injury. Regarding her request for FMLA, claimant testified:

I requested a FMLA with Patricia, and so Patricia - - somehow Bill Williams called Patricia and they had a conference call with me, and so Bill told her to deny that. (T. 47).

The claimant offered that Mr. Williams is the supervisor of the plant nurse. Claimant's testimony reflects that she made numerous request to supervisory personnel for personal leave or FMLA leave because of her inability to continue performing her job due residuals of her injury, which were all denied. (T. 48).

Claimant acknowledged that she was aware that falsification of any documentation or application would result in the termination of employment. Claimant's testimony reflects:

Yes, sir, I had over 10 years QA, you know. QA, Quality Assurance, is - - that's one of the main things we're monitoring for out there on the lines is, you know, make sure they're not falsifying documents or anything, so I was very aware of the policy as far as falsification. (T. 50).

Claimant has not worked any place since her employment was terminated on June 5, 2007, although she has sought same. Claimant testified that she has been looking for work that would be compatible with her restrictions. With respects to whether she disclosed any physical restrictions in her employment search efforts, claimant testified:

I filled it out on the computer, but I'm not sure what the questions were. Me and another, me and one of my friend girls, she was helping me fill it out because she knew how to do it and she was helping me fill it out, so she did answer some of the questions for me. (T. 51).

The testimony of the claimant reflects that she last received medical treatment in connection with her injuries on March 13, 2008, the date prior to the hearing, at the emergency

room in Wynne, Cross Ridge Community Hospital. Claimant explained that while she lives in Forrest City she went to the emergency room in Wynne because it is closer to her family doctor, Dr. Jacobs, who is in Wynne. Claimant asserts that her treatment during the recent emergency room visit consisted of medication.

During cross-examination, claimant testified that her principle injuries, for which she seeks additional medical treatment, are her neck, chest and rib areas, with occasional complaints associated with the knee injury. Claimant acknowledged having problems with her chest area prior to January 2006, which she attributed to asthma. Claimant testified that her symptoms, chest pain and shortness of breath, resulted in her going to the doctor three to four time in a five year period.

Claimant asserts that her neck complaint/pain, growing out of the January 18, 2006, accident, has never subsided, but has in fact gotten worse. Claimant asserts that she has so informed her doctors. Claimant maintains that the only neck problems that she had prior to the January 18, 2006, accident was her thyroid, which caused soreness in the front of her throat. Claimant denies any prior problems with the back of her neck. Claimant concedes that Dr. Jacob treated her for a lymph node behind her right ear on August 21, 2002.

Claimant denies telling Dr. Harriman that her neck complaints had subsided at the time of the February 2, 2006, visit. Claimant was kept on full duty by Dr. Harriman, who ordered a whole body scan. Claimant acknowledged going to the emergency room in Cross Ridge Community Hospital, in Wynne on February 13, 2006, with complaints of pain in her ribs and chest wall before her return visit to Dr. Harriman. Claimant was again seen by Dr. Harriman on February 28, 2006. Claimant acknowledged that the whole body bone scan disclosed only some

osteoarthritis in her ankles.

The medical reflects that when the claimant return to Dr. Harriman on March 7, 2006, she complained of chest pain and discomfort. Claimant maintains she also complained of neck pain during her visits to Dr. Harriman. Claimant was released from the care on Dr. Harriman, at which time she submitted a March 7, 2006, handwritten request for a change of physician. Claimant acknowledged that she did not list neck pain as one of her complaints in her change of physician request.

Claimant notes that another one of her present complaints is upper back pain in addition to her neck pain. Claimant denies having back pain prior to her January 18, 2006, accident. Claimant concedes that a June 7, 2005, office note of her family physician reflects complaints of lower back pain. Regarding the afore, claimant asserts that the pain was “hurting like down in” her thigh area and she was uncertain if that was considered lower back. (T. 63-64).

Pursuant to her request, claimant obtained a change of physician to Dr. Thomas Hart, who ordered an MRI scan. Claimant conceded that she was directed by Dr. Hart to another physician to address the finding regarding her thyroid. Claimant was seen by Dr. Sells for her thyroid, which resulted in a June 27, 2006, report. After she was seen by Dr. Hart, respondents made arrangement for the claimant to be seen by Dr. Steve Cathey.

The claimant was initially seen by Dr. Cathey, a North Little Rock neurosurgeon, at the request of respondents on October 5, 2006. Claimant sustained her second work-related accident on October 4, 2006, for which she was seen by Dr. Kumar. The testimony of the claimant reflects that she was aware of the recommendations of Dr. Cathey, which included his disagreement with the treatment recommendations of Dr. Hart. Regarding her contact with Dr.

Cathey, the claimant testified:

But when I first saw Dr. Cathey for the first time, you know, he was talking about how swollen and everything my neck area was, and he was telling me - - he was asking me did I, you know, sit down a lot because of the area that's affected. (T. 70).

Claimant acknowledged that the only doctor that took her off work was Dr. Banaji, which was the one day following the January 18, 2006, accident. Claimant was seen by Dr. Banaji on January 26, 2006, and directed to remain off work the following day and to return to work on January 30, 2006. Claimant attributes her sanctioned continuing working by her treating physicians to the contact with the plant nurse and information relayed by same regarding her job duties/work activities. Claimant emphasized that she used her accrued sick days during the period following the January 18, 2006, accident:

Yes, because I was hurting and couldn't come to work, whereas Dr. Banaji did - - no, Dr. Harriman did mention the bending of the neck. I couldn't come to work with those pains. My neck was bent, the crook in it. (T. 73).

Claimant again attributed all of her missed days from work recited above to residuals of the January 18, 2006, work-related injury.

Claimant acknowledged that she was never told that her continued employment with respondent-employer was in jeopardy because of her request for leave, FMLA or her work injuries. Claimant explained:

No. Just I was just having a lot of - - I went to Gillette and complained about how the nurse and the supervisors treated me, and then a short time after that, I got written up. I was actually going to be terminated on the day I got on paperwork for my days missed, but so happened Patricia Scott had some FMLA paperwork, and that's the only reason they didn't terminate me on that day, but I was being mistreated. I was treated and I was about to be - - they were trying to

terminate me, my boss and everyone. (T. 74-75).

Claimant acknowledged that in her employment position she was aware that “application falsification” would be grounds for dismissal.

Claimant denies that supervisory personnel went over in great details with her the employment application and concerns they had:

No, sir. The only thing they told me is, “You’re being suspended for further investigation for signing your son’s application.” That’s all they - - (T. 75).

However, the claimant concedes that she was shown the application in question and allowed to examine it. Claimant acknowledged that a document in the evidence reflects that her son confirmed that the signature on it was not his signature.

Claimant acknowledged that in receiving unemployment compensation benefits from July 2007 through December 2007, she held herself out as being able and willing to work. Claimant anticipated again applying for unemployment compensation benefits in April 2008. Further, the claimant has applied for social security disability benefits in August 2007, two months following the termination of her employment by respondent-employer. The claimant has been turned down during the initial ruling in her social security disability claim, and is now in process of seeking a hearing.

Claimant denies any outstanding issues regarding child support arrearage. Claimant has three (3) children, one of which has been adopted by her mother. Regarding the afore, claimant testified:

Yes, sir. That’s something I just found out about. That’s something I just found out about around the time of his birthday, I just found out about that. My mon had been telling me all the time

that he was just - - she was his legal guardian as far as just like my other nephew. (T. 77-78).

Claimant acknowledged that several garnishment proceedings had been filed against her by a couple of different medical providers trying to get medical bills paid over the last couple of years, however they had been resolved. The testimony of the claimant reflects that during the entire time of her employment by respondent-employer through June 2007, she had group health insurance coverage.

Claimant acknowledged that respondents furnished medical treatment regarding the injury she suffered in the October 2006, fall at work, to include an MRI of her left knee. Further, the claimant concedes that Dr. Kumar released her to return to work on November 10, 2006, while noting that there was no etiology for her pain complaints. Claimant disputes the findings of Dr. Kumar, and offer instead the November 15, 2006, findings of Dr. Jacobs in that regard.

Claimant denies that she stopped or terminated the prescribed physical therapy on her own. Claimant maintains that she was instructed by Dr. Cathey to stop going to the physical therapy because she was being provide the wrong type of therapy. Claimant added that she discussed the afore with Dr. Kumar, the plant nurse, and her supervisor.

On re-direct, claimant offered the following explanation surrounding the termination of her employment and the falsified employment application dispute:

Okay. On May the 29th I got a - - the board said (Boars Head) was taking seasonal job applications, and I got a job application from another employee because I had went to talk to Kay the Human Resources receptionist, and she said it was a limited amount of applications the day I was gone. So I talked to - - I mean, I got an application from another employee. I took an application home that night, and I filled the application out and Kellon signed it and put his social security number on it, and I brought that application back to Boars Head the next morning and gave

it to Kay. So the next day on the 30th, I called Loretta Ratchford concerning my son's application. At that time Loretta told me that it was the wrong application, and she didn't have any more of the seasonal applications. Then I told her that - - said she had a seasonal application, and would it be okay if I got it for my son. And so Loretta said yes if I could bring it back the same day. So I brought the application back and Ms. Annie Randle left to go give me an application. When she came back, filled the application out. I gave the application to Ms. Annie Randle to take it to my mother's house for Kellon to sign it and put his social security number on there and tell him I'll be back to pick it up. So about - - Ms. Annie left at 1:00, so it was after 1:00 I remember Willie Stone was outside and so it had to be between 2:00 or 2:30, sometime in there. And so my mother called and told me that the application was ready. I told my supervisor, I asked her could I leave to go and get Kellon's application from my mother's house. At that time my supervisor told me I could, and Torcia asked to go with me. So me and Torica went to my mom's house to get the application. It was in a manila folder. I called mom and told her I was on my way to pick up the application, and so when we got there my mom handed me the application, you know, she gave me the application at the door. It was in the folder. So me and Torcia left and went back to work. So I took the application - - when we got back in - - when we came in I saw Willie Stone so I knew it had to be between 2:00 and 2:30, around that time. So, we walked into the building and I stopped at HR and gave them the - - took it to Loretta and gave the application to Loretta. So then the next day, the next morning, Gillette Drone called me and said - - she and my supervisor, my supervisor called me and told me Gillette wanted to see me in her office. And I sent down to Human Resource office and Gillette and Loretta was in the office. Gillett, she pointed at the signature and said, "Ann, did you sign your son's application, did you sign it?" I said, "No, Gillette, I didn't sign his application." She said, "Well, look here, did you sign his application?" And I said, "No, Gillette, I didn't sign his application." And then she told me that if I had anything I wanted to go get out of my desk and I told her yes and purse. So Gillette escorted me to the QA office, and Gillette walked in and tells my manager what was going on. So Torcial was in there with me, and I said, "Torcia, Gillette trying to fire me for the application we went and picked up at Mama's house." And Gillette, "Shut up, shut up, come on, come on." So I just grabbed my purse and Gillette escorted me out. On the way down the walkway Gillette said, "Ann, it don't look like you're hearing right (hand-writing). Who signed it?" I said, "Gillette, I don't know who signed it. I picked the application up from my mama's house." And I walked on out the gate. I mean, I walked and left. (T.81-84).

Claimant added that it was her belief that her injuries led up to her being falsely accused regarding the employment application.

Ms. Annie Randle, a eight year employee of respondent-employer, testified that she worked first shift in the Quality Assurance department with the claimant, whom she has known for 15 to 20 years. Ms. Randle was at work at the time of the claimant's June 2007, termination.

Ms. Randle testified regarding her involvement in the employment application dispute:

I went to my house and got an application because we wasn't sure that the application that we had was the application that should have filled out, and after that I carried the application back and after that then the application got filled out and the day the application got filled out and I carried it back because it got off, I went in that time, I went in at 2:00 - - I believe I went in at 4:00 o'clock, and I took the application back to her mom because I got off at 1:00 o'clock. (T. 88).

Ms. Randle's testimony corroborate that of the claimant's regarding the claimant complaining about her condition attributed to the January 18, 2006, accident to supervisory personnel as well as her efforts to get some type of leave from work. Ms. Randle testified:

She called - - first we're where we can email different people that work in management, people that work in the plant with us. So when she emailed Mike Montella and Bill Williams and she spoke to Gillette.

She called her, and I wasn't present when she went in the office with her. What I did was, she went in the office and talked to her and I sat up front. I wasn't in the office with her. (T. 89).

Ms. Randle's testimony reflects efforts/actions she took on behalf to the claimant following the claimant's work-related injuries:

One time she (claimant) came to work with - - on some crutches, she had hurt her leg, and I talked to Gillette about her getting off them. (T. 90).

Ms. Randle's testimony further reflects that based on her conversation with the claimant during

the period following January 18, 2006, accident, claimant felt as though she was being mistreated management personnel and they were trying to terminate her employment. In furtherance of the afore, Ms. Randle testified:

Well, I heard her one day when she went to our manager and told our manager that - -

Oh, it wasn't our - - let me retract that. It was our supervisor that she thought that - -

Mattie Brandon was picking on her, and I'm thinking she went to Gillette. You know what, it's hard for me to think. I'm not going to lie, I'm not going to lie. It's hard for me to think, but I know she did. I'm thinking she went to Gillette and told Gillette that she felt like that Linda Long, that's our nurse, and somebody was picking on her. (T. 91).

The testimony of Ms. Randle reflects that while both she and the claimant worked in Quality Assurance and had the same supervisor, they had different job duties. Ms. Randle testified that she is aware of the claimant's work-related accidents on January 18, 2006, and October 4, 2006. Ms. Randle's testimony reflects that prior to the January 18, 2006, date she did not observe the claimant having difficulties, physical or otherwise, performing her job duties. Additionally, Ms. Randle testified that prior to January 18, 2006, she never heard the claimant voice or register complaints of pain about her neck, back, or shoulder. Following January 2006, Ms. Randle testified the claimant complained of pain, which she attributed to the January 2006, work-related accident.

Ms. Randle further testified regarding her observation of a change in the relationship between the claimant and her supervisors following the January 18, 2006, accident:

The supervisors and nurse was always talking and it made her think that they were talking about her, and the supervisors and the nurse did actually treat her different. They treated her different from what they had

treated her before. (T. 95-96).

Ms. Randle testified that the supervisors and the nurse did not have a “friendly attitude” toward the claimant as before the January 18, 2006, accident.

Ms. Gillette Drone, Human Resources Manager, has held the position since December 2004. Ms. Drone testified regarding the circumstances surrounding the termination of the claimant’s employment in June 2007:

In the morning, Ms. Ratchford brought me the application. The application was for summer help. We were hiring summer help of relatives that we employed, but the application is a separate application. Now, she mentioned it’s a seasonal, has seasonal on there that we use when we hire those type of employees. Ms. Bowman had handed in an application prior to that one, but it was the wrong application. So, she had to get another application, but this particular morning Ms. Ratchford was getting ready to hire those employees, and she was going over the interview process. They had to interview those employees, and when she matched the signatures on Mr. Bowman, Mr. Kellon Bowman, with the signature that was on the application, they did not match. But Ms. Bowman was the one who brought us the application to the plant, so Ms. Ratchford brought the application in to me and told me that she didn’t think that those applications - - that the signatures were the same, and so since Ms. Bowman was the one who brought those applications , I did call her to my office and Ms. Ratchford was in there as well, and I asked her about the application. Did she fill out the application because the writing on the application looked like Ms. Bowman’s writing, and she told me, no, she did not fill out the application. I asked her did she sign the application and she told me, no, she did not sign the application. Because I had showed it to her and she said - - I said, “Ann, this looks like your handwriting,” and she said, “Let me see the application,” and she said, “No, I didn’t sign it. That’s not my handwriting. I didn’t fill out the application, nor did I sign the application,” and then she asked Loretta if she could see the other application. So Loretta went to get the other application and she looked at it, and I said, “Ann, that looks like your handwriting,” and she said, “Well, let me look at this,” and she kept looking at it, and she kept looking at, and I said, “Ann, the handwriting looks like yours.” I said, “If you filled out the application, it’s okay, if you filled the application out,” but Ann kept telling me she didn’t fill out the application, and then when I asked about the signature, she said she didn’t

sign it, and I said, "Well, who signed it?" She said she didn't know who signed it. So at that point, I told Ann that I would have to suspend her until I could investigate it further. I asked her if she had anything in her locker or anything she needed to get, and she said she had her purse in her desk, so I escorted her to her purse. As we were walking out, she again told me that she didn't fill out the application and she didn't sign the application, even though she had told me in the office eventually that she did, that she was the one who filled out the application, but she didn't sign it. (T. 98-100).

In summary, Ms. Drone testified that the claimant conceded that while she did complete/fill out the employment application of her son, she did not sign it. Ms. Drone's testimony reflects that she verified from the claimant's son that it was not his signature on the application. (T. 100).

Ms. Drone testified that it is the policy of respondent-employer to terminate the employment of employees for falsifying documentation and/or statements. In explaining the basis for the policy, Ms. Drone testified:

It's to protect our brand. I mean, Ann is also in a very - - she was in a very sensitive position as our Quality Assurance tech, and as she testified earlier, it's very important in that position that honesty is - - that we can maintain honesty with the type of sensitive information that she works with. (T. 100-101).

Ms. Drone denies that the termination of the claimant's employment was the product of a conspiracy due to the work related injuries. Ms. Drone maintains that the claimant's work-related injuries were not a consideration in the termination of her employment.

Ms. Drone asserts that the claimant's contention at the hearing regarding the termination of her employment being linked to her injuries was the first that she had heard of it:

That was the first I had heard of that because as far as I know, Ann was a good employee, you know, as far as I know. She had come and complained to me about her injuries, and I tried to help her as much as I could. It was out of my scope, and I would give her the people she - - I would tell her the people she needed to talk with. (T. 101).

With respect to the claimant's leave request, Ms. Drone testified:

She came to my office wanting a personal leave, but the reason she wanted a personal leave was for medical reasons, and so I explained to Ann if her reason for leave was for medical reasons, she should get an FMLA leave. (T. 101).

Ms. Drone concedes that the FMLA leave would require supporting documents from the doctor.

Ms. Drone added:

Yes, and when she said that we did not offer her FMLA leave, I did offer FMLA leave, and it's up to her to take those papers. She did not take them. (T. 102).

Ms. Drone testified that while she had access to samples of the claimant's handwriting from her personnel file and obtained documents with the claimant's handwriting on them from Ms. Mattie Brandon, the claimant's supervisor, she never received a statement saying the writing on the application was that of the claimant. In explaining the claimant's employment status, Ms. Drone testified:

It can be, Ann. The statement - - mostly the reason what happened to you is that your statement was inconsistent. You told me - - gave me two different stories at the same time, and most of my discussion was based upon your testimony of what you had given me and also based upon the fact that I had writing specimens to back up that you had filled out the application, even though you had first told me you didn't fill it out, and you even told me that you didn't sign it, but you couldn't tell me who did sign it. (T. 104).

Ms. Drone described the substance of her investigation, regarding the questioned employment application:

Your handwriting specimens that I had on file as well as your testimony of what you had told me during - - when we were talking with you as well as the fact that your son told me he did not sign the application, and the fact that you could not tell me who signed the application, even though you were the one who filled out the application and were the one

who turned in the application. (T. 104).

Ms. Dorne acknowledged that the claimant talked to the concerning the manner in which was being treated following the January 2006, compensable injury:

Yes, you did, and at that time I asked you to notify Bill Williams who was over the workers' compensation. You said you felt that you were being treated that way because of your injury. Each time that you came to talk to me, Ann, I tried to help you and point you in the right direction. If I couldn't help you, I tried to point you to the people who could. (T. 105).

Ms. Drone testified that respondent-employer did respond when the claimant applied for unemployment compensation benefits following the termination of her employment, however the benefits were award over their objection. Respondent-employer did not appeal the award. Ms. Drone testified that Ms. Ratchford was present at the time the claimant acknowledged completing the employment application.

Regarding the complaints that the claimant registered with her about the manner in which she felt she was being treated following the January 2006, injury, Ms. Drone's testimony reflects:

One time she came to me about she had an appointment with a workers' comp appointment, and she said that they didn't give her enough time to go to her appointment because she wanted to go home and change before, and I got that straight for her so she could be able to go home and freshen up or whatever before she went to her doctor's appointment. Other times she would come and she would say that she felt like her supervisor was picking on her, but she couldn't tell me how she was picking on her. She would just say, "Well, she's picking on me," and I would ask her, "Well, what do you mean?" She couldn't tell me what she was doing, and she says, she would talk about because of her workers' comp injury. I said, "Well, then, you need to speak with Bill. Bill is the person that is over he workers' comp." I would refer her to him for her to speak because he was the one that was over Linda - - she would talk about Linda, that was the reason she talked about Linda not letting her go on her appointments early enough, and I referred her to Bill at that time, and I also talked with Bill about that and we got that straightened out so she would be able to go. (T. 107-108).

Ms. Drone acknowledged having a conversation with Ms. Randle about the claimant:

Ms. Randle came to my office after Ms. Bowman was terminated and asked - - she was more or less pleading for her job, that she not be terminated because she said that was her only help she had out there and she needed her help, and she did come to me one time about the fact that Ann was on crutches and they were going to make her go out into the plant with the crutches or something, and I got that fixed where she wouldn't go out in the plant with the crutches. She had to work in the office. (T. 108-109).

Ms. Drone testified that she did not recall if Ms. Randle conveyed her perception of the claimant being mistreated by her supervisor or the plant nurse.

Ms. Loretta Ratchford, who has been the Human Resources Coordinator for respondent-employer for ten (10) years, testified that she was familiar with the circumstances surround the termination of the claimant's employment and prepared a statement in connection with same.

Ms. Ratchford testified that to her knowledge there were no factors attributable to the claimant's work injuries involved in the employment termination. Ms. Ratchford maintains that respondent-employer had work available for the claimant, which she was expected to continuing performing, but for the termination of the employment for falsifying the application.

During cross-examination Ms. Ratchford testified regarding the dispute surrounding the employment application which resulted the termination of the claimant's employment:

Your son, his name is Kellon Bowman, came in and put in the application - - well, he came in to be interviewed for a job. We had an application on file for him, from him, and also you had given me an application from him for employment there. And when he came in, he filled out the interview sheet, and he signed the interview sheet, and when I saw the application, I noticed it was not the same, and at that time I wen in and I told the HR Manager, which is Gillette Drone, that those two signatures did not look the same the same signature, and at that time she called in - - she asked you, Ann Bowman, to come to her office, and she asked Ann if this was her signature, did she fill the

application out. Then you asked Gillette to let you see the application, and you looked at it and you said, “No, I didn’t fill it out or sign the application.” We mentioned that there was another application and you wanted to see both applications and your looked at it again, and you said, no, and then you said, “Well, this one I filled out, but I didn’t sign it.” (T. 112).

Ms. Ratchford testified that in examining the applications, she looked at an application of the claimant’s son that was already on file, however regarding the similarity of the signatures on the applications to the claimant’s signature, responded:

I don’t know. I didn’t really know how your handwriting looked. I just called to Gillette’s attention that those applications, the signatures were different on them. (T. 113).

Ms. Ratchford acknowledged that respondent-employer had in its possession two (2) different employment applications for the claimant’s son, Kellon Bowman. Ms. Ratchford concedes, with respect to the writing on the applications:

No, it didn’t appear to be the same. As I recall, it didn’t appear to be the same. Of the signatures that I was looking at was the one on the interview sheet that he had just signed and the last application that had been brought in to me. Those two signatures did not match. (T. 114).

Ms. Ratchford’s testimony reflects that the writing on the two (2) employment applications, one for a permanent position and one for as seasonal/temporary position, appeared to be different. Claimant acknowledged completing the seasonal application for her son, however, denied signing his signature on it.

Ms. Ratchford testified that her duties as Human Resources Coordinator include interviewing, hiring, terminating, and disciplinary actions for associates. The testimony of Ms. Ratchford reflects that sometimes her duties extent to FMLA issues.

On February 22, 2008, respondents obtained the deposition of the claim. After describing

the mechanics of the January 18, 2006, accident, claimant testified regarding the onset of her complaints/symptoms attributable to accident:

And so I told Demetrius, I said, Demetrius, I can't get up. And so Demetrius Johnson helped me up to the control room. So I sat down and I called Linda Long, the nurse, and told her that I had just slipped down and fell in blast cell one and the I was going to be down there as soon as I caught my breath. I felt like I couldn't catch my breath. And so I sat down, Demetrius helped me sit down. Another employee, Thomas Williford left out of there, left out of the control to go get me a dry frock. And so as I was sitting there my neck went to throbbing, it was just pounding like and it started swelling. And so I started crying because it was so much pain and then I was scared altogether.

And so D. J. and Demetrius saw the swelling in my neck, saw my neck swelling. And so Tim John said, no, Ann, you're fixing to go now to the nurses station. And so by that time Thomas came in with me a dry frock. And Tim John helped me down to the nurses station. As we got down to the blast cell one he was showing me the skidmarks. He said, that's where you fell at. I said, Tim, I don't want to see it, just help me to the nurses station.

And when I got to the nurses station Linda, she was in there seeing another patient, Fanny Houston, so she told me to have a seat. And I took a seat, I told her that I was hurting so bad that I was going to lay down on the little bench table. By that time my supervisor and some co-workers entered and I told them what had happened. And my supervisor was mentioning an incident on the floor where it involved bleach. And I stated to her, I said, man, you've got bleach all over your shirt. And they was looking at me like I was crazy or something. So they told me that she didn't have any bleach on her shirt, to lay back down. So I laid back down on The little bench table.

And so Linda Long, she gave me two packs, two cold packs and told me to put them on where I was hurting. And so while she was still seeing after Fanny a little while later she gave me two hot packs to put on the area that was hurting. So I put them on my neck and down on my side. So when Linda finished with Fanny Houston she get up the paperwork and gave me the urine test sample, so I took that. And when I finished the test I sat down and Linda got some kind of cream gel out of the cabinet and went to massaging where it was swollen on my neck down here in my shoulder area. She went to massaging it for about like 30 seconds. And so she told me, now you can go back to work.

So I went over, I left out of her office and went to my desk to, you know, to sit down. And I was hurting so bad. I told my supervisor

that I was leaving for the day, that I was going to go home and lay down and see if I could, see if it will fell better the next day. And so I left and went home that day.

* * *

The next morning I woke up, I had a crick in my neck, I couldn't turn my neck. And so I called and told my supervisor that I wasn't going to come in that day because my, I was going to try to see a doctor. And so she told me to call Linda Long. So when I called Linda and I told Linda that I had a crick in my neck and I was hurting so bad down my left side. So Linda Long told me to come in, that she was going to make me an appointment. So when I wen in, sent into her office she had a list of about three or four doctors names and she told me to pick a doctor. And since I wasn't familiar with any of the doctors and she stated that Dr. Banaji was her family physician, that he was good. So that's, so then she made me, I told her, well, I'll see Dr. Banaji and she made me an appointment to see Dr. Banaji. (RX. #3, pp. 47-50).

During the February 22, 2008, deposition claimant described the site of her continuing symptoms from the January 18, 2006, accident as the present of a knot in the area between the base of her neck down into her shoulder. (RX. #3, p. 51). Regarding the observation of her treating physician of the knot, claimant's testimony reflects:

Yes, when I, Dr. Kumar, when he, when I fell, when I hurt my knee that time and he went in and so he started giving me the injections in those areas where the knots was, he started giving me like some injections, some kind of pain medication and injected it, you know, into this area up here, one was here and one was like right down here. He was giving me some injections helping the pain. (RX. #3, p. 51).

The evidence reflects that in May 2005, Dr. Kumar obtained a judgement for unpaid medical bills which resulted in garnishment proceedings. Claimant had no recollection of having been seen or treated by Dr. Kumar prior to her October 2006, work-related left knee injury. The claimant was provided crutches in connection with the knee injury by Dr. Kumar. (RX. #3, p. 57).

Regarding her lateness in attending an appointment for therapy, claimant testified:

When I was late, when I was late Linda Long made my doctor appointment as soon as I got off from work, which I had to go, you know, make sure my kids and everything was all right. She was making my appointment like as soon as I get off from work. (RX. #3, pp. 58-59).

Claimant asserts that Dr. Kumar ordered the therapy in October 2006. Claimant saw Dr. Cathey on two (2) occasions in October 2006 (10/05/06 and 10/25/06).

Claimant testified that she exhausted nine (9) vacation days and five (5) sick days following her January 18, 2006, work-related accident. Further, the claimant asserts that after her employment was terminated in June 2007, she did not receive her bonus check, which covered the 2006 work-year. (RX. #3, pp. 77-80).

During her February 22, 2008, deposition, claimant testified that she had gone to the emergency room in Wynne due to complaints of severe muscle spasms in her neck. As a consequence of the visit she was prescribed medication by the attending emergency room physician, which included Tylenol, Flexeril and Ultram. (RX. #3, p. 83-84). Claimant's testimony reflects, with respect to the history relayed to the attending emergency room physician:

I just told him I was hurting, I had a tingling it was like a tingling in my neck. And it was a sharp, it was a sharp tingling feeling like it was just going up my neck like. And it scared me and I went to the emergency room and I was just told him that I had a tingling feeling. (RX. #3, p. 84-85).

Claimant denies that she told the attending emergency physician that she having spasms:

I just got that off the medication where it says that it was for spasms, but I told him I'm having a tingling feeling in my neck, that's what I stated to him.

I just said tingling, but he gave me a prescription. He did do some kind of little feeling back here, he did feel back there.

I said that I had tingling in my neck and the did feel back there and he wanted me to move my neck. (RX. #3, p. 85).

The testimony of the claimant reflects that the medical bill associated with the emergency room visit is an outstanding unpaid bill. The claimant's testimony reflects that since her employment with respondent-employer was terminated in June 2007, she has sought medical treatment at the emergency room in Wynne, Forrest City Medical Clinic and the clinic in Marianna, all related to the neck injury sustained in the employment. Prior to the termination of her employment claimant had group health insurance through her employment.

Claimant also disclosed during the February 22, 2008, deposition that she had been seen by Dr. Ashley Park in Germantown, Tennessee for her neck complaint in addition to Dr. James Jacobs, the Cross Ridge Community Hospital emergency room in Wynne, the Forrest City Medical Clinic and the clinic in Marianna. The testimony of the claimant reflects that she took the Ultram, for pain, between 9:00 -9:15 a.m. on the February 22, 2008, and Flexeril just prior to sitting down for the deposition.

While acknowledging that she was released to full duty following her January 18, 2006, accident, claimant explained regarding the performance of her job duties prior to the October 4, 2006, subsequent accident:

I didn't do, I didn't do the box weights on my own. I wasn't doing the box weights. And I did a lot of, on that medication stuff I did a lot of laying around because I had a lot of free time on that job, so I spent a lot of time sitting in the, sitting in the bathroom, you know, resting or laying down, laying my head down in the smokehouse, just, I was hurting so bad I did a lot of sitting around. (RX. #3, p. 97).

The claimant's regular family physician is Dr. James Jacobs. A review of Dr. Jacobs' medical records relative to the claimant does not reflect the presence of complaints relative to the

claimant's neck or shoulders prior to the January 18, 2006, accident. (CX. #1, p. 1-2). Prior to the January 18, 2006, work-related accident, the claimant had last been seen by Dr. Jacobs on July 11, 2003, relative to her blood pressure. (CX. #1, p. 2). The claimant was at the Webber Medical Complex in Forrest City for her thyroid complaint in April 2005. Claimant was also seen for complaints of back pain on June 7, 2005, at the Webber Medical Complex. (RX. #1, p. 5). There is no documented medical evidence in the record of the claimant either having complained of neck and shoulder pain or received treatment for same prior to January 18, 2006.

The earliest medical in the record following the claimant's January 18, 2006, work-related accidental fall is a January 19, 2006, clinic note of Dr. Sudesh Banaji of Internal Medicine of Forrest City. The clinic note reflects, in pertinent part:

The patient is a 34-year-old black female here with complaints of pain in the left side of the neck after she fell on ice yesterday. Apparently, she blacked out for just a brief moment. She is Worker's Comp from Boar's Head. She has no numbness or tingling. She is concerned about returning back to work, where she may have to pull and push some items tomorrow.

NECK: Neck movements are limited past 5 or 10 degrees to the left. Tenderness of a moderate degree is in the paraspinal neck muscle area.

Neck strain.

I am giving her Naprosyn 500 mg b.i.d. with food and Skelaxin 800 mg t.i.d. Apply heating pad. From what I gather, she has a job where she has to do only walking around and I think that should be possible without any restrictions tomorrow. She will let me know if her symptoms persist into next week. (RX. #1, p. 6).

The assertion of the claimant that she was returned to regular duties by the treating physician following her injury pursuant to the communications of the plant nurse, Ms. Linda Long, with the

physician appears to be borne out in Dr. Banaji's assessment of the claimant's job responsibilities.

The claimant was seen at the emergency room of Cross Ridge Community Hospital in Wynne on January 22, 2006, for complaints of left shoulder pain growing out of the January 18, 2006, work-related accidental fall. The emergency room records reflect a history of the claimant work-related fall. The physical findings disclosed tender lateral left shoulder and trapezus. X-rays were obtained of the claimant's left shoulder during the visit. The claimant's complaint was diagnosed as "sprain left shoulder", for which she was provided medication, Vicodin. The emergency room report further provided, in terms of after care instructions, that the claimant follow-up with her own doctor in 1 week, will need a MRI if not better, a prescription for Vicodin and over-the-counter ibuprofen. (RX. #1, p. 7-8).

Following the January 22, 2006, emergency room visit to Cross Ridge Community Hospital, claimant was next seen in connection with complaints growing out of the January 18, 2006, work-related accident on January 26, 2006, by Dr. Banaji. The January 26, 2006, clinic note reflects, in pertinent part:

The patient is here with persistent pain in the left side of her neck. Also hurts in her upper back above the left shoulder blade area and in her ribcage. She apparently took some personal sick days off since she could not work for the last three days or so. She continues to have persistent symptoms despite being on Naprosyn and Skelaxin.

MUSCULOSKELETAL: She is tender in the left sternoclavicular joint and in the neck muscles. She does have good lumbar flexion, both AP and lateral shoulder movements are normal.

Sternoclavicular sprain, rib sprain, and neck myalgia.

I am going to send her for an x-ray of the C-spine, T-spine, and chest PA and lateral. Gave her Vicoprofen one three times a day as needed, #30 tablets. Continue to use Naprosyn and I have given her excuse from work tomorrow. She will return to work on 30th. If her symptoms persist beyond another week, I may have to send her for a referral. (RX. #1, p. 9).

The claimant was seen in follow-up by Dr. Banaji on February 1, 2006. After reciting a history of the claimant's injury and complaints, Dr. Banaji recorded that claimant had not return to work and had used her sick days because she relayed that she was unable to work with her present complaints. The February 1, 2006, clinic note further reflects, in pertinent part:

MUSCULOSKELETAL: She has mild tenderness in the lower paraspinal region of the neck. Neck movements are only minimally limited. She had bending of her neck previously, which seems to be resolved at this time. She has some tenderness, which is of a mild-to-moderate nature in the left lower ribs and upper quadrant. I did not see nay obvious bruise or swelling. Shoulder movements are within normal limits.

Myalgia of the neck and ribcage pain from sprain.

I do not think it is severe enough to restrict her from work, which consists mainly of walking and standing. I am going to let her return to work at this time and continue Naprosyn. I do not think we will need any Vicoprofen at this time. The patient seems to have a lot of difficulty agreeing with my assessment and I have discussed this with the plant nurse and we have decided to refer her for a second opinion through an orthopedic doctor. She is seeing him tomorrow. (RX. #1, p. 11).

In accordance with the above, the claimant was seen on February 2, 2006, by Dr. Mark S. Harriman, a Memphis orthopedic surgeon. The February 2, 2006, office note of Dr. Harriman relative to his evaluation of the claimant reflects, in pertinent part:

PI: Ms. Long of Boars Head has asked me to take a look at Ms. Bowman who is 34 years old and is a lab tech at Boars Head in Forrest City. She denies previous injuries and had a fall on January 18th when she slipped on some ice. Apparently she found herself on her back and was able gt up walk. She initially had complaints of neck and back pain, but says these are minimal problems now and her chief complaint is pain in the left ribs.

I have reviewed records from her treatment which is by an internal medicine specialist in Forrest City and I have also seen some x-ray reports which indicated negative thoracic spine, negative chest and negative C spine.

PE: Just to be thorough, I did a good exam on her neck and back and she has excellent motion in those areas, no pain or complaints. Her reflexes and strength are normal in the upper and lower extremities. The left ribs are tender, but I don't feel crepittance. The tenderness is basically anterolateral. There is slight prominence of the left ribs which is most likely congenital and not traumatic.

* * *

IMPRESSION: She may have had a neck and back strain initially, but has no residuals from this. Otherwise, she has had a rib strain which really doesn't require treatment and I believe the symptoms that she is having will resolve rather rapidly.

PLAN: We have given her a rib belt. She can work full duty and I will see her in two weeks on if she is having trouble. (RX. #1, p. 13).

On February 13, 2006, the claimant was again seen at the emergency room of Cross Ridge Community Hospital with chief complaints of pain in left ribs and right upper chest. The emergency room records reflects and assessment of rib pain for which after care treatment of warm moist compress to the affected areas was recommended and ibuprofen and Flexeril provided. (RX. #1, p. 14-15).

The medical reflects that the claimant was again seen by Dr. Harriman on February 28, 2006. The clinic note relative to the afore visit reflects, in pertinent part:

Ms. Bowman is hurting in a new location. Now she has pain in the sternal area superiorly. She no longer has the pain down in the lower left ribs. She states that she has been working. Evaluation reveals no swelling over the manubrium. There is slight tenderness across the manubrial sternal junction. I did not re-xray her.

IMPRESSION: I don't see much here, but she is complaining. We will

give her a little Darvocet with precautions. She should not take this while working or driving. I think at this point, given her continued complaints, a bone scan should be done to rule out some type of occult injury to the chest wall area. She is full duty and I will see her after the bone scan. (RX. #1, p.16).

Claimant underwent the whole body bone scan on March 2, 2006, which disclosed mild osteoarthritis most notable in the ankles but otherwise negative. (RX #1, p. 17). Thereafter, the claimant was seen by Dr. Harriman on March 7, 2006, and discharged from the care of same.

The March 7, 2006, clinic note reflects, in pertinent part:

. . . Says she is having a lot of chest pain. I have explained to her that her bone scan was normal, as far as her chest wall is concerned. Her bone scan did show some degenerative changes in the knees and ankles, but she has no symptoms there. I have advised her today that I don not find any evidence Of any significant ongoing problems from her on the job injury. I have advised her to see her regular physician to make sure htat her chest pain is not being cause by some type of medical problem, specifically her heart. Otherwise, she is released to full duty at maximum medical improvement, no restrictions, no impairment. (RX. #1, p. 18).

The record reflects a March 7, 2006, handwritten request from the claimant to the Clerk of the Arkansas Workers' Compensation Commission, requesting a change of physician in connection with her January 18, 2006, compensable accidental injury. In the correspondence claimant identified the physicians that had rendered medical treatment to date for the injury.

Prior to the April 11, 2006, entry of the Change of Physician Order claimant was seen by the family physician, Dr. Jacobs on March 8, 2006. The clinic note of Dr. Jacobs relative to the afore reflects a history of the claimant's January 18, 2006, accidental work-related fall and physical complaints attributable to same. The records of Dr. Jacobs also reflects contact with the claimant on March 9, 2006, wherein claimant requested additional test due to her persistent. The physical examination of the claimant during the March 9, 2006, visit was unchanged. Dr. Jacobs

directed that the claimant undergo a CT of the chest wall and return following the test. (CX. #1, p. 3).

On March 20, 2006, claimant had the CT of chest performed at Cross Ridge Community Hospital pursuant to the above recommendation of Dr. Jacobs. The CT scan disclosed a small area of scarring in the right upper lobe posteriorly, however no other obvious nodules, effusions, or masses were detected. (RX. #1, p20-22).

On April 11, 2006, a Change of Physician Order was entered by the Medical Cost Containment Department of the Arkansas Workers' Compensation Commission pursuant to the claimant's request. The Change of Physician Order designated Dr. Thomas Hart, a Little Rock pain management specialist, as the claimant's authorized treating physician relative to the January 18, 2006, compensable injury. (RX. #1, p. 23-24).

The claimant was seen by Dr. Hart on May 12, 2006. The May 12, 2006, report of Dr. Hart relative to the claimant reflects that the chief complaint of neck pain to the shoulder and rib pain since the January 2006, slip and fall. The May 12, 2006, report further reflects, in pertinent part:

. . . According to her history she did not have any previous neck, anterior chest or thoracic complaints until this injury. She has not required any type of surgical intervention. She has had some imaging studies which did not show any ominous type pathology, i.e., fracture. She has not had an MRI of the cervical or thoracic spine according to her history today. She has not had any type of interventional spine procedures. She has basically had conservative management which has not done well. She describes the pain as sometimes sharp shooting. On her pain diagram she shows pain from the left paracervical muscles into the left shoulder, left upper intrascapula area, also the same pain radiates to the anterior chest in what appears to be a C5-6 distribution from the cervical spine. Also she drew some areas of the anterior, as well as posterior thoracic chest wall. The main complaint is her left neck. She

denies any marked weakness in the upper or lower extremity. She denies any color changes or temperature changes. She denies any unexplained rashes. She denies any visual or auditory changes. She denies any blood in the urine or stool. On a VAS score with 0 being no pain and 10 the worst pain you can possibly image, she rates it as a 5. What time of the day your pain is worst? Mornings, getting up. What do you do when you hurt badly? Take pain medication. How does the pain affect your activities of daily living? Cause shortness of breath. . . . Her pain is also affected by physical activities, pressure, movement, sleep, lying down, sneezing, coughing. She still continues to work. There is no disability.

* * *

MEDICATIONS: Occasionally an anti-inflammatory and some other medications. Apparently some type of muscle relaxant.

* * *

NECK: She does have some limited range of motion with horizontal rotation with pain increased to the far right on the left side. More pain on extension than flexion. There are no apparent sympathetic changes in the face or upper extremity. No palpable masses. No lymphadenopathy. She does have some diffuse anterior cervical disc tenderness, but most of the pain appears to be in the posterior mid to lower cervical facet joints and she does have some diffuse, very small myofascial taut bands. Compression signs were negative.

* * *

EXTREMITIES: Deep tendon reflexes are 2+ C5, C6, C &, 2 patellar, 2 Achilles. Toes are down going. No clubbing, cyanosis or edema. Intact ulnar, radial, dorsalis pedis, posterior tibial pulses.

* * *

PLAN: At this point I had a long discussion with Ms. Bowman about her main complaints, i.e., her left neck. I discussed with her and showed her in the textbooks one of the most common causes of neck pain, which can refer pain to the shoulder, intrascapula area, and even to the chest are the cervical facets. There are several articles discussing referred versus radicular pain, which can also overlap with a cervical disc, the number one and number two causes of neck pain complaints. Since her pain has been on going, it is beyond a simple sprain or strain which usually lasts a few weeks

to a few months, I think that it would be appropriate and medically necessary to get an MRI of the cervical spine, as well as the upper thoracic spine to see whether or not she may have possible cervical disc protrusion or bulging disc and have baseline study. But as I indicated to Ms. Bowman there is an article in the December 1996 New England of Medicine that one can have a perfectly normal MRI, one could have a normal neurological evaluation, which she has and also one could have normal EMG and nerve conduction studies and that does not mean that one does not hurt. This would require diagnostic facet injections, very simple out patient nonsurgical procedure in blocking the medial branch of the posterior primary rami to the cervical facets. If that reduces her neck pain complaints, then, again, that may indicate that she has a cervical spondylosis without myelopathy. I would be extremely reluctant at this point to proceed toward cervical discography with her neurologically intact. If we found an abnormal disc it basically boils down to what will you do about it? Our first plan is to get an MRI of the cervical upper thoracic spine and have her return with the original, as well as the radiologist report so that we can review that and plan what needs to be performed. She was receptive to the current plan. (RX. #1, p.25 -27).

On May 12, 2006, the claimant under went the MRI of the cervical spine at Westside Open MRI pursuant to the direction of Dr. Hart. (RX. #1, p. 28-32). The claimant was seen in follow-up by Dr. Hart on May 22, 2006. After noting the results of the MRI of the cervical spine, the May 22, 2006, report concluded:

PLAN: At this point I discussed with Ms. Bowman. First and foremost as to her neck pain complaints, i.e., the main reason she is seeing me, I think that she would be an appropriate candidate to proceed with diagnostic left cervical facet injections per medial branch approach performed properly under fluoroscopic visualization and see if we can not only delineate but reduce her neck pain complaints. I would be extremely reluctant for a cervical discography since she overall appears to be neurologically intact. The third issue is that the thyroidmegaly reported will need an endocrinologist. I would like to refer her to Dr. Timothy Boehm for further evaluation. After this was discussed extensively she was receptive to the current plan. (RX. #1, p. 33).

In a May 31, 2006, correspondence to Dr. Hart, respondent-carrier inquired if the requested cervical facet injections were for the osteoarthritic condition and his medical opinion

whether the claimant's condition and complaints were the direct result of her employment. (CX. #1,p. 19). Dr. Hart responded to the afore in a June 5, 2006, correspondence:

I was informed by my office personnel today that I needed to dictate a letter to you even though I have called and left you a telephone message several days ago concerning Ms. Bowman. You made mention that you had received the MRI results dated May 22, 2006 and you did not see any bulging disc. The radiologist did mention that the C4-5, "Shallow noncompressive posterior disc displacement with a low grade facet hypertrophy. At C5-6 shallow central ligamentous disc displacement resulting in mild thecal sac effacement in the midline. Low grade facet hypertrophy bilaterally. C6-7 shallow noncompressive disc displacement and low grade disc hypertrophy." In other words those are bulging disc. They also mention that she had thyroidmegaly, which yes according to your letter, is an unrelated health issue.

But in my initial report of 5/12/06, I clearly indicated that the proposed procedure would be diagnostic facet injections according to the medical literature since that is the most common cause of neck pain complaints and this was also made mention in her MRI. Even if you look at the New England Journal of Medicine December 1996, one could have a perfectly normal MRI, normal neurological evaluation, normal EMG's and nerve conductions and it does not mean that one does not hurt. That requires diagnosis facet injections. That is basic standard care, which I discussed with Ms. Bowman. If the facet injections performed properly under fluoroscopic visualization and documented do indicate a reduction in her neck pain complaints, then I think that she would be a candidate possibly, due to the chronicity of her neck pain complaints, for consideration of radiofrequency. This too is standard of care for chronic neck pain complaints from these types of injuries.

As to the cervical disc, they too can be a source of pain, but I don't think it would be appropriate at this time to put her through a very painful procedure, i.e., cervical discography since she is neurologically intact. It may indicate that she has a discogenic component, but it boils down to what do you do about it. I wouldn't recommend a multilevel cervical fusion since statistically it is prone to failure.

So as to my request, which is medically necessary and appropriate for cervical facet injections, I think this is basic standard of care and in my 15 years as a physician doing and being board certified as a pain medicine

and interventionalist I think it the most appropriate diagnostic procedure. (CX. #1, p. 20-21).

The medical reflects that the claimant was seen by her family physician, Dr. Jacobs, on June 23, 2006. While complaining of pain in the neck which she attributed to the January 18, 2006, work-related accidental fall, the June 23, 2006, clinic note recited that the claimant has been seen by Dr. Hart and the finding regarding her thyroid gland. (CX. #1, p. 4). A June 27, 2006, Progress Note of Dr. J. Hugh Sales regarding the claimant reflects, in pertinent part:

Ann Bowman is a very pleasant thirty-five year old female who comes in for evaluation of an enlarged right thyroid gland. This was picked up on MRI scan back when she was having neck evaluated from trauma back in January. She reports the front of her neck has hurt intermittently. It gets kind of sore around the thyroid gland at times. It has done this off and on for years. She denies any dysphagia, odynophagia, or hoarseness. She is generally healthy. She has no family history of thyroid cancer and no history of head or neck radiation therapy. She has not taken any thyroid hormone. (RX. #1, p. 34).

The medical in the record reflects that the claimant was again seen by her family physician, Dr. Jacobs, on August 2, 2006, for complaints of pain in her neck. The office note reflects that the claimant was provided Flexeril and Ultram as well as directions to exercise. (CX. #1, p. 5).

On October 4, 2006, the claimant was seen by Dr. Kumar, respondents' designated medical provider, relative to injuries sustained on that date growing out of an accidental fall at work. Handwritten entries on the October 4, 2006, clinic note of Dr. Kumar, reflects a history of the claimant having fallen at work that morning injuring her neck, upper and lower back. The clinic note further reflects, in pertinent part:

S: The patient came in complaining of left neck pain, left shoulder pain, going on since January, she fell in January on ice, and again

she fell today, hurting more, seen Dr. Thomas Hart in Little Rock, pain clinic, was told she might require surgery, complain of pain in The left side of the chest and left knee since she fell today, no LOC.

O: On exam, vitals are stable. Afebrile. Pupils are normal and reactive. C-spine flexion is normal. Good range of movement is present. A lot of spasm felt in the left suprascapular and left intrascapular muscles. Shoulder, good range of movement is present. Bicipital tendon test is negative. T-spine and LS-spine are normal. Hip, knee, and ankle are normal. Chest wall is mildly tender at fifth and sixth ribs, anterior axillary line on the left side. CNS, cranial nerves are intact. No neurological deficits. . . .

A: Left neck sprain, left knee pain, left chest pain, secondary to fall. Medically stable at this time.

P: MRI done of the patient at Little Rock was reviewed. Vicoprofen q.12h. p.r.n., #30. Soma q. 12h., #20. Scheduled physical therapy at the hospital three times a week for at least three weeks. Return to work next Monday. Follow up here in a week. (CX. #1, p. 22).

The medical further reflects that the claimant was physical therapy by Dr. Kumar, three time per week for four week. A October 4, 2006, Therapy Initial Evaluation, reflects a history of the claimant's January 18, 2006, work-related accidental fall and complaints of continued cervical pain and headaches as well as occasional radicular pain in left upper extremity. The form further reflects the duration of the claimant's physical therapy, October 5, 2006 through November 4, 2006. (CX. #1, p. 23). The record also reflects documentation of the claimant's physical therapy sessions. (CX. #1, p. 24-29).

On October 5, 2006, the claimant was evaluated by Dr. Steven L. Cathey, a North Little Rock neurosurgeon, at the request of respondents. The clinic note relative to the October 5, 2006, visit of the claimant reflects, in pertinent part:

Ms. Bowman is a very pleasant 35-year-old black female who works as a quality technician for Boarshead Brand, a meat processing facility in

Forrest City. She is here today for a neurosurgical evaluation to address her current diagnosis and how this relates to diagnostic facet blocks proposed by Dr. Tom Hart, her pain management specialist.

Ms. Bowman presents with chronic neck and upper back pain on the left side that she relates to an occupational injury sustained on January 18, 2006. According to the patient, she slipped and fell at work. She fell backwards striking her head and upper back. She has had pain there ever since. She was seen by her primary care physician in Forrest City, and subsequently referred to Dr. Mark Harrison, a Memphis orthopedic surgeon. He diagnosed the patient with neck and back "strain" and did not recommend any additional treatment. When her pain continued, she was referred to Dr. Thomas Hart. Dr. Hart reviewed an MRI scan of her cervical spine and suggested that diagnostic facet blocks were indicated to help establish a diagnosis and also to better outline treatment options. It was at this point that the neurosurgical consultation was advised.

The patient denies any previous history of neck pain or injury. She has continued to work full time since the occupational injury of January 18, 2006. She takes some occasional pain medication, but has not had any physical therapy. She is not experiencing radicular arm pain, paresthesias, upper or lower extremity weakness, etc.

PHYSICAL EXAMINATION: On examination, the patient has palpable thyromegaly. Her neurological examination is otherwise negative. She specifically has no sign of cervical myeloradiculopathy. While there is point tenderness in the neck and upper back on the left, no paraspinal muscle spasm or restriction of movement was noted.

The patient had a MRI scan of her cervical spine on May 17, 2006, that apparently showed no "high grade disc protrusions, critical canal stenosis or neural effacement involving the cervical or thoracic levels." There is mention of some "facet hypertrophy" at a couple of levels. Unfortunately, The patient did not bring the films with her so I have not had an opportunity to review them first hand.

ASSESSMENT/PLAN: In my opinion, Ms. Bowman has suffered a musculoskeletal injury. I agree with Dr. Harrison that this problem should go on and resolve without specific treatment. Any facet hypertrophy (facet arthropathy) would not be in any way related to the occupational injury of January 18, 2006. I therefore do not really see an indication for facet blocks, diagnostic or otherwise.

Although I was going to go ahead and obtain an MRI scan here in the office today for expediency's sake, her workers compensation carrier has requested that we reschedule her on a day that the MRI scan can be captured and reviewed here in the office. I will therefore defer all final opinions until I have had a chance to look at the MRI scan firsthand. (RX. #1, p. 38-39).

As noted above, the claimant sustained another work-related injury on October 4, 2006, the day prior to her October 5, 2006, evaluation with Dr. Cathey. On October 6, 2006, the claimant was again seen by her primary care physician, Dr. Jacobs, in Wynne with complaints of neck pain attributable to the "old injury" at respondent-employer. (CX. #1, p. 5).

On October 18, 2006, the claimant was seen in follow-up to her October 4, 2006, work-related accidental fall by Dr. Kumar. The clinic note relative to the afore visit reflects, in pertinent part:

S: The patient came in for followup of her neck pain, knee pain, knee pain is resolved, neck pain is still bothering her, complain of left-sided chest pain since she has been injured at work on and off, taking Vicoprofen p.r.n. and Soma p.r.n., getting physical therapy at the hospital, this is the third week. Left neck pain is slightly better, but it is significantly restricting her to work according to her.

O: on exam, a lot of spasm felt in the left suprascapular and intrascapular areas. Shoulder is normal. C-spine, good range of movement is present. Neurologically intact.

P: Injected trigger point injection in to the left suprascapular area, two areas with Depo-Medrol 40 mg 0.5 cc and 3 cc of 0.5% Marcaine total, tolerated the procedure well. Advised heating pad. Continued PT and her medicines as before. Re-evaluate in two weeks. (CX. #1, p. 30).

It is noteworthy that when examined by respondents' designated medical provider, Dr. Kumar, on October 4, 2006, muscle spasms were documented in the claimant's cervical and shoulder regions, however, Dr. Cathey failed to observe any. As noted above, upon the claimant's follow-up visit of October 18, 2006, Dr. Kumar again documented muscle spasms.

The medical in the record reflects that on October 30, 2006, claimant underwent an MRI of the cervical spine at Imaging Solutions of Arkansas in accordance with the recommendation of Dr. Cathey. Among the findings/impression in the October 30, 2006, was minimal posterior disc bulge and osteophyte complex at C5-6 causing flattening of the ventral aspect of the thecal sac, and no evidence of herniated disc or spinal canal stenosis. (RX. #1, p. 40). The claimant was last seen by Dr. Cathey on October 30, 2006. The clinic note relative to the visit reflects, in pertinent part:

Ms. Bowman returns today for follow-up. She is still experiencing chronic neck and upper back pain that she relates to an occupational injury suffered in January of this year. Her symptoms have not changed significantly since her initial visit here on October 5, 2006.

PHYSICAL EXAMINATION: Her neurological examination remains negative. There is specifically no sign of cervical myeloradiculopathy.

The patient and I reviewed an MRI scan of her cervical spine obtained earlier today. For what ever reason, she has still been unable to capture the original studies from May of 2006.

Today's study is entirely negative. She specifically does not have any evidence of cervical disc herniation, spinal stenosis, nerve root entrapment, compression fracture, etc.

ASSESSMENT/PLAN: It is still my opinion that Ms. Bowman has suffered a musculoskeletal injury that should go on and resolve without specific treatment. I therefore do not see an indication to proceed with diagnostic facet blocks, facet rhizotomy, etc.

The patient was satisfied with this and will otherwise be seen here on a p.r.n. basis. (RX. #1, p. 42).

On November 1, 2006, two day following her October 30, 2006, final visit to Dr. Cathey, the claimant was again seen by Dr. Kumar. The clinic note relative to the November 1, 2006, visit reflects, in pertinent part:

S: The patient with continued left-sided neck pain, not on any medicine, on physical therapy for three weeks so far, claims pain is better, but still hurts, chronic ongoing, on a scale of 1 to 10, she claims it around 3 to 4.

O: On exam, vitals are stable. Afebrile. Multiple tender points in left suprascapular area. C-spine and T-spine are nontender, normal. Both shoulders, elbows, and wrists are normal. Neurologically intact.

A: left neck pain, muscle spasm.

P: Ultram 50 mg b.i.d. given with one refill, #30. Advised not to lift more than 10 pounds. Recheck back in four weeks. (CX. #1, p. 33).

On November 6, 2006, claimant was seen at Forrest City Medical Center for complaints of pain in her left upper leg which she attributed to the fall at work on October 4, 2006. The medical records regarding the November 6, 2006, visit reflects that the claimant relayed a history of having hurt her left leg in a fall a month earlier, the pain got better, and then was worse on the date of the visit. (RX. #1, p. 43-49).

On November 7, 2006, the claimant was seen by Dr. Sudhir Kumar, respondents' designated medical provider, relative to her left leg complaint. The clinic note relative to the afore visit reflects, in pertinent part:

S: The patient came in complaining of left knee pain, started yesterday when she woke up in the morning, at work her knee gave away and she had to be wheeled out at work, hardly able to walk, using crutches, claims this pain started in the past when she fell, when she hurt her neck and right shoulder, in the meantime it got better, now it worse again.

O: On exam, vitals are stable. Both hips are normal. Right knee is normal. Left knee, no effusion. No warmth. Full range of movement is present. Mild tenderness according to the patient in the medial aspect of the knee. Neurologically intact. Deep tendon reflexes are normal. X-ray of the left knee is done. No effusion. No deformity. Normal x-ray of the left knee.

A: Left knee pain, etiology unknown.

P: Medrol Dosepak, use as directed. Return to work in the morning. Follow up her in a week. If symptoms are not better, we will do an MRI (RX. #1, p. 50).

The record reflects the presence of a November 8, 2006, prescription of Dr. Kumar directing an MRI of the claimant's left knee. (RX. #1, p. 52). On November 9, 2006, the MRI of the claimant's left knee was accomplished. at Cross Ridge Community Hospital. (RX. #1, p. 51).

The radiology report regarding the afore reflects:

CONCLUSION: No evidence for cruciate or collateral ligament injury. The menisci appears to be unremarkable. No significant effusion in noted though very small amount of fluid is noted on the lateral aspect of the knee. (RX. #1, p. 53).

The claimant returned to Dr. Kumar on November 10, 2006, with continued complaints of left knee pain and reporting that the steroid Dosepak did not make an difference in her symptoms.

The clinic note of the visit further reflects:

O: On exam, left knee good range movement is present. No effusion. No deformity. No warmth. No evidence of any acute inflammation. Right knee is normal. Both hips and ankles are normal. MCP and IP joints, C-spine, T-spine, and LS-spine arr normal. MRI reviewed with the patient, normal.

A: Left knee pain, etiology unknown. There is no evidence of any pathology causing her knee pain so far.

P: Advised Alive p.r.n. b.i.d. Return back to work. (RX. #1, p. 54).

The record also reflect the presence of respondents's Medical Treatment & Work Form relative to the claimant's October 4, 2006, follow-up treatment of November 10, 2006. (RX. #1, p. 55).

A December 12, 2006, correspondence from Eastern Arkansas Physical Therapy in Forrest City, reflects that the claimant received services at that facility through November 1, 2006. (RX. #1, p.

56).

The medical in the record reflects that the claimant was seen on November 15, 2006, by her primary care physician, Dr. Jacobs, for complaints relative to her left knee. The clinic note does reflect on physical exam findings of tenderness and swelling. (CX. #1, p.6).

On January 10, 2007, claimant was seen by Dr. Ashley L. Park, Memphis orthopedic physician with Campbell Clinic in Germantown. The January 10, 2007, clinic note regarding the afore reflects, in pertinent part:

Ms. Bowman is a 35 year old African-American female who reports injuring herself in the work place on 1/18/06 manifesting while performing usual and customary job duties for Boars Head. She comes to Campbell Clinic today for evaluation.

Ms. Bowman states that on the above mentioned date of injury, she slipped on ice inside a freezer at the Boars Head Meat Processing Plant. Sine this incident, she has had pain in the left side of her neck. She does not feel that her condition is getting any better. Since her injury, she has had some physical therapy which primarily included modalities. She has also been on pain medication as well as a Medrol Dosepak which did not seem to help.

PAST MEDICAL HISTORY: Ms. Bowman denies having previous problems with her neck prior to her work injury of 1/18/06.

* * *

PHYSICAL EXAM: In general, we had a cooperative, well developed, well nourished female in no acute distress. The patient was alert and oriented x3. She had a normal affect. . . .

Examination of the upper and lower extremities revealed no gross musculoskeletal deformities. Range of motion about the upper and lower extremities was within functional limits. . . .

On further examination of the upper extremities, . . . On segmental examination of the cervical spine, there was left-sided more prominent than right-sided facet tenderness on palpation. Range of motion about

the cervical spine was within functional limits. On observing the patient, she demonstrated normal coordination and gait.

RADIOGRAPHIC REVIEW: On 5/17/06, a MRI of the cervical spine was performed. There was moderate facet hypertrophy at C3-C4, shallow noncompressive posterior disc displacement with low grade facet hypertrophy at C4-5, shallow central subligamentous disc displacement at C5-6 with mild thecal sac effacement in the midline with low grade facet hypertrophy bilaterally and shallow noncompressive disc displacement at C6-7 with low grade facet hypertrophy.

MUSCULOSKELETAL IMPRESSION:

1. Shallow posterior disc displacement at C4-5 and C5-6 as well as C6-7 without disc protrusion, critical canal stenosis or neural effacement by MRI of 5/17/06.
2. Ongoing complaints of left-sided neck pain since work injury on 1/18/06 manifesting while performing usual and customary job duties as a QC tech for Boars head Meat Processing Plant. Physical examination was notable for left more so than right-sided facet tenderness. It would appear that Ms. Bowman's persistent pain complaints are emanating for the Z joints.

MEDIAL DIAGNOSES:

1. Reactive airway disease.
2. History of goiter.

TREATMENT RECOMMENDATIONS:

1. I am recommending the Ms. Bowman undergo reversible branch blocks at the cervical facet joints which will serve both as diagnostic tool and hopefully therapeutically will lessen the patient's pain. Side effects/potential complications were reviewed with the patient.
2. The patient should avoid repetitive pulling, pushing, reaching as well as activities sustained at or above chest height.
3. Follow-up in 8 weeks. (CX. #1, p.35-37).

The claimant was seen by Dr. Kumar on February 7, 2007. The clinic note relative to the afore visit reflects, in pertinent part:

S: The patient with continued chronic left side neck pain, left suprascapular pain, history of hyperthyroidism, supposed to be on Tapazole and Tenormin, not sure if she is taking it.

O: On exam, heart rate is up today. Multiple tender points in the left

suprascapular and intrascapular areas.

P: Injected the left suprascapular area two areas with Depo-Medrol 40 mg 0.5 cc and 4 cc of 0.5% Marcaine, half of each dose given in two areas, tolerated well. Put Lidoderm patch on it. Re-evaluate p.r.n. Return to work tomorrow. (CX. #1, p. 38).

Claimant was again seen by Dr. Jacobs on February 23, 2007. The clinic note relative February 23, 2007, visit reflects complaints of neck pain and pain in the left knee. (CX. #1, p. 6).

The medical in the record reflects that the claimant was seen at the emergency room of Cross Ridge Community Hospital on March 2, 2007, relative to her neck complaint. The emergency room record reflects that the claimant arrived at 10:45 p.m. The emergency room records reflect the following entry:

Pt presents ambulatory to ER c/o neck pain - woke up like this, this AM - can't hardly turn head - pt injured neck approx 1yr ago. (CX. #1, p. 39).

The emergency room report reflects that the claimant was provided Flexeril, and was discharged at 12:20 a.m. (CX. #1, p. 39). The claimant was again seen by Dr. Jacobs on May 11, 2007, regarding her complaint of neck pain. (CX. #1, p. 7).

The medical in the record reflects that the claimant was seen at the emergency room of Cross Ridge Community Hospital on February 8, 2008, relative to her neck pain. The attending emergency room physician during the claimant's February 8, 2008, visit was Dr. Carlton Cash. The emergency room records reflect entries of "cervical/SCM spasm-chronic neck pain exacerbation". (CX. #1, p. 42). The evidence also reflects that during the February 8, 2008, emergency room visit, she was provide a document containing the following:

PAIN MANAGEMENT - GENERAL INFORMATION, ENGLISH

Special Instructions:

1. FLEXERIL 10MG 3 X A DAY

2. TYLENOL 1000MG EVERY 6 HRS
3. ULTRAM 50MG 1 OR 2 EVERY 6 HOURS
4. INDOCIN 25MG EVERY 8 HRS
5. FOLLOW UP MD
6. MOTRIN AND IBUPROFEN SAME, DO NOT TAKE IF ALLEGRIC TO MOTRIN. (CX. #1, p. 41).

The testimony of the claimant reflects that she received unemployment compensation benefits following the termination of her employment by respondent-employer. Ms. Gillette Drone testified that the respondent-employer contested the claimant's unemployment compensation claim; however acknowledged that the benefits were awarded. Records of the Arkansas Department of Workforce Services reflect that the claimant was discharged from her employment on May 30, 2007, for allegedly turning in falsified company documents. Claimant filed her unemployment compensation claim on June 6, 2007. In a notice mailed June 26, 2007, the agency determined that the employer had provided insufficient evidence to substantiate the allegation that the claimant turned in falsified company document. As a consequence of the afore, the claimant was not disqualified from receiving unemployment compensation benefits. (CX. #1, p. 43).

The record reflects the presence of a June Memorandum to the claimant from Human Resources regarding the company performance bonus. Based on the claimant's eligible earnings of \$26,532.00, with a 5% eligible company performance is \$1,326.60, and the company's earned performance of 6.551%, is \$1739.00, represent the claimant's 2006 bonus which was payable in 2007. Claimant did not receive her earned 2006, which was payable in 2007. (CX. #1, p. 44).

The claimant also provided documentary evidence supportive of, and corroborative of her testimony regarding her inability to discharge her employment duties following the January 18,

2006, compensable accidental injury. (CX. #1, p. 45-62). Finally, the record reflects the presence of an Employee Warning Notice which was issued to the claimant on September 12, 2006, by respondent-employer. The afore is the only evidence of the claimant having been issued such a warning throughout her employment with respondents, which commenced on July 2, 2001, and as such is corroborative of the claimant's assertions of the impact of the January 18, 2006, on her ability to perform her assigned job duties. Specifically, the September 12, 2006, Employee Warning Notice for unsatisfactory work reflects, in pertinent part:

During June, July, and August, you have averaged just over one (1) days per month being absent from your work assignment. The four (4) days were June 26 and August 2, 17, & 18. This is an unacceptable trend that is occurring. Other members of the QA team is having to carry your work assignment due to you not being available to complete your assignments.

Attendance is a vital part of your job performance. Please see that the trend is reversed. (CX. #1, p. 63).

The claimant's employment with respondent-employer was terminated effective June 5, 2007. The basis for the termination as reflected on the notice was "Falsifying Company Document". (RX. #2, p. 5). The record also reflects the presence of the witness statement of Ms. Loretta Ratchford, HR Coordinator, summarizing her contact with the claimant and the events of June 1, 2007, which ultimately resulted in the termination of the claimant's employment. (RX. #2, p. 6). Finally the record reflects the presence of the wage verification report of respondent-employer regarding the claimant's gross earnings for the period January 2, 2005 through June 3, 2007. (RX. #2, p. 1-4).

After a thorough consideration of all of the evidence in this record, to include the testimony of the witnesses, review of the medical reports and other documentary evidence,

application of the appropriated statutory provisions and applicable case law, I make the following:

FINDINGS

1. The Arkansas Workers' Compensation Commission has jurisdiction of these claims.
2. At all times pertinent, to include January 18, 2006, and October 4, 2006, the employee-employer-carrier relationship existed among the parties.
3. At all times pertinent the claimant earned an average weekly wage of \$635.00, which generates compensation benefit rates of \$424.00/\$318.00, for temporary total/permanent partial disability.
4. On January 18, 2006, the claimant sustained an injuries to her neck and left ribcage arising out of and in the course of her employment.
5. The claimant was temporarily totally disabled for the periods January 19, 2006 through January 24, 2006; January 26, 2006 through February 8, 2006; February 14, 2006, and February 15, 2006; June 26, 2006; August 2, 2006; and August 17 and August 18, 2006.
6. The claimant remains within her healing period relative to the compensable January 18, 2006, cervical injury.
7. Pursuant to an April 11, 2006, Change of Physician Order entered by the Medical Cost Containment Department of the Arkansas Workers' Compensation Commission, Dr. Thomas M. Hart, is the claimant's authorized treating physician relative to her compensable cervical injury of January 18, 2006. Medical treatment rendered and recommended to the claimant by Dr. Hart is reasonably necessary in connection with the claimant's compensable

injury.

8. Medical treatment rendered to the claimant under the care of Dr. Ashley L. Park, as well as emergency medical treatment rendered to the claimant at Cross Ridge Community Hospital on March 2, 2007, and February 8, 2008, was reasonably necessary in connection with the claimant's compensable injury.

9. On October 4, 2006, the claimant sustained injuries to her neck and left lower extremity arising out of and in the course of her employment.

10. The respondents shall pay all reasonable hospital and medical expenses arising out of and in connection with the compensable injuries of January 18, 2006, and October 4, 2006.

11. The claimant has proved by the greater weight of the credible evidence that she is entitled to benefits pursuant to Ark. Code Ann. §11-9-505 (a). Specifically, the evidence preponderates that respondent-employer refused without reasonable cause to return her to employment that was suitable and available subsequent to June 5, 2007. The refusal of respondent-employer to return the claimant to suitable employment was not based upon reasonable cause.

12. The respondents have controverted the payment of temporary total disability benefits to the claimant; the claimant's entitlement to medical treatment as recommended by her treating physician, Dr. Hart; as well as claimant's entitlement to medical benefits subsequent to November 10, 2006.

CONCLUSIONS

Claimant commenced her employment with respondent-employer on July 2, 2001, and continued in the employment of same until it was suspended on June 1, 2007, and terminated

effective June 5, 2007. The claimant sustained compensable accidental falls on January 18, 2006, and October 4, 2006, resulting in injuries to her neck, left ribcage, and left lower extremity. In addition to the contentions as set forth in the February 12, 2008, Pre-hearing Order, claimant also asserts entitlement to additional benefits pursuant to Ark. Code Ann. §11-9-505 (a). Respondents contend that the claimant did sustain injuries in the January 18, 2006, and October 4, 2006, work-related incidents all appropriate workers' compensation benefits have been paid.

The present claims are governed by the provisions of Act 796 of 1993, in that the claimant asserts entitlement to workers' compensation benefits as a result of injuries having been sustained subsequent to the effective date of the afore provision. In their February 27, 2008, supplemental pre-hearing filing, respondents contest the compensability of both the January 18, 2006, and October 4, 2006, work-related incidents of the claimant.

It is undisputed that the claimant successfully discharged her employment duties in the employment of respondent-employer from her July 2, 2001, hire date until January 18, 2006. There is no credible evidence in the record to reflect that the claimant sought or required medical treatment relative to her neck, shoulder, back, ribs, or left lower extremity prior to January 18, 2006. Further, there is no evidence in the record to reflect that the claimant experience physical limitations or restrictions in the discharge of her employment duties prior to January 18, 2006.

The claimant performed the duties of a quality assurance technician in her employment with respondent-employer during the pertinent time periods. Claimant present credible undisputed testimony surrounding the occurrence of the January 18, 2006, accidental fall at work while performing employment duties.

Compensable Injury

The present claims grow out of specific incident injuries asserted by the claimant. In order to prove a compensable injury as a result of a specific incident which is identifiable by time and place of occurrence, the claimant must establish by a preponderance of the evidence: an injury arising out of and in the course of employment; that the injury caused internal or external harm to the body which required medical services or resulted in disability or death; medical evidence supported by objective findings, as defined in Ark. Code Ann. §11-9-102 (16), establishing the injury; and that the injury was caused by a specific incident and identifiable by time and place of occurrence. Ark. Code Ann. §11-9-102 (4)(A) (i). Should the claimant fail to establish by a preponderance of the evidence any of the requirements for establishing the compensability of the claim, compensation must be denied. *Mikel v. Engineered Specialty Plastics*, 56 Ark. App. 126, 938 S.W.2d 876 (1997).

The claimant credibly described the mechanics of the January 18, 2006, slip and fall while within the course and scope of her employment. The accident results in complaints of pain in the left side of the neck. Upon receiving medical treatment for her complaints under the care of Dr. Sudesh Banaji, respondents' designated medical provider, on January 19, 2006, the physical examination disclosed restriction in the claimant's neck movement, as well as moderate tenderness in the paraspinal neck muscle area. Claimant was provided Naprosyn and Skelaxin and diagnosed with a neck sprain. The claimant was seen at the emergency room of Cross Ridge Community Hospital on January 22, 2006, complaints of left shoulder pain growing out of the January 18, 2006, work-related accident. The physical examination disclosed tender lateral left shoulder and trapezius. In addition to x-rays, claimant was provided Vicodin during the emergency visit. An MRI was recommended if the symptoms persisted.

Continued complaints attributable to the January 18, 2006, accident and a subsequent visit to respondents' designated medical provider resulted in assessments of sternoclavicular sprain, rib sprain, and neck myalgia. The clinic notes regarding the claimant observed "mild tenderness in the lower paraspinal region of the neck", "tenderness, which is of a mild-to-moderate nature in the left lower ribs". On May 17, 2006, the claimant underwent an MRI of the cervical spine which disclosed objective findings. The evidence preponderates that the claimant sustained a compensable injury on January 18, 2006.

On October 4, 2006, the claimant sustained another slip and fall within the course and scope of her employment. Again, the claimant presents credible undisputed testimony regarding the mechanics of the October 4, 2006, fall. The claimant was seen by respondents' designated medical provider, Dr. Sudhir Kumar, in connection with her injuries growing out of the October 4, 2006, accidental fall. During his physical examination of the claimant on October 4, 2006, Dr. Kumar noted, "a lot of spasm felt in the left suprascapular and left intrascapular muscles". The claimant injuries were assessed as left neck sprain, left knee pain, left chest pain, secondary to the fall. The claimant was prescribed Vicoprofen, Soma and physical therapy. The evidence preponderates that the claimant sustained a compensable injury on October 4, 2006.

Respondents have controverted the compensability of both the January 18, 2006, injury and the October 4, 2006, injury of the claimant.

Temporary Total Disability Benefits

Temporary total disability is that period within the healing period in which a claimant suffers a total incapacity to earn wages. *Georgia-Pacific Corporation v. Carter*, 62 Ark. App. 162, 969 S.W. 2d 677 (1998). The evidence preponderates that the claimant sustained

compensable injuries on January 18, 2006, and on October 4, 2006. The credible evidence in the record reflects that following the January 18, 2006, compensable injury the claimant was physically unable to discharge her employment duties for the periods January 19, 2006, through January 24, 2006; January 26, 2006, through February 8, 2006; February 14-15, 2006; June 26, 2006; August 2, 2006, and August 17-18, 2006. The afore periods are documented in the medical records of the claimant and disciplinary warning issued by respondent-employer.

Prior to the entry of the April 11, 2006, Change of Physician Order, the claimant's medical treatment relative to her January 18, 2006, compensable injury was had at the directions of respondents' designated medical providers. The evidence preponderates that the afore physicians were provided information regarding the claimant's regular duties by the plant nurse which persuaded them to conclude that the claimant could physically perform her regular duties while within her healing period and receiving active medical treatment. The clinic notes and medical reports document evidence of contact with the plant nurse, Ms. Linda Long. Additionally, claimant provided credible testimony regarding the afore. Respondents did not put forth evidence regarding the substance of the testimony of the plant nurse with respondents' designated medical providers. In *Barnes v. Greenhead Farming*, ___ Ark. App. ___, ___ S.W.3d __ (January 9, 2008), the court noted "the absence of testimony from these witnesses, who were within the control of Greenhead Farms, raises the presumption that their testimony would have been unfavorable to Greenhead Farms".

While the claimant was not provided an off-work slip by the treating physicians to remain off-work, the credible evidence reflects that the claimant was not physically capable of performing her assigned job duties during the periods specified above, as a result of the

compensable injury. Claimant was forced to utilize her accrued sick days and vacation days during the absences. Ultimately, the claimant's absences resulted in the disciplinary warning once she had exhausted the sick days and vacation day, however was still unable to physical work due to residuals of her compensable injury.

In the instant claim, the evidence preponderates that the claimant was within her healing period and totally incapacitated from engaging in gainful employment as a result of her January 18, 2006, compensable injury during the periods cited in the above findings. According, the claimant is entitled to the payment of temporary total disability benefits at the appropriate compensation benefits rate for those periods. While the claimant received payment for sick days and her vacation during the periods of her total incapacitation, respondents may not claim credit for same pursuant to Ark. Code Ann. §11-9-411. When payment not pursuant to a group insurance plan is made by the respondents, Ark. Code Ann. §11-9-411 would be inapplicable. *Socha v. Northwest Airlines*, 2006 AWCC 65, Claim No. F500085 (Full Commission Opinion filed April 7, 2006); *Norman v. North Hills Service, Inc.*, 2005 AWCC 323, Claim No. F408828 (Full Commission Opinion filed November 21, 2005.). Respondents have controverted the claimant's entitlement to temporary total disability benefits.

Additional Medical Benefits

Ark. Code Ann. §11-9-508 (a) mandates that respondent-employer provide medical services that are reasonably necessary in connection with the injury received by the employee. The employee has the burden of proving by a preponderance of the evidence that medical treatment is reasonable and necessary. *Wal-Mart Stores, Inc. v. Brown*, 82 Ark. App. 600, 120 S.W.3d 153 (2003). What constitute reasonably necessary treatment under the statute is a

question of fact for the Commission. *Hamilton v. Gregory Trucking*, 90 Ark. App. 248, 205 S.W.3d 181 (2005). The Commission has note that medical services required to be provided by the employer may include that necessary to accurately diagnose the nature and extent of the compensable injury; to reduce or alleviate symptoms resulting from the compensable injury; to maintain the level of healing achieved or to prevent further deterioration of the damage caused by the compensable injury. *Jordan v. Tyson Foods, Inc.*, 51 Ark. App. 100, 911 S.W.2d 593 (1995); *Artex Hydroponics, Inc., v Pippin*, 8 Ark. App. 200, 649 S.W.2d 845 (1983). A claimant may be entitled to ongoing medical treatment if the treatment is geared toward management of the claimant's compensable injury. *Patchell v. Wal-Mart Stores, Inc.*, 86 Ark. App. 230, 184 S.W.3d 31 (2004). Finally, the claimant does not have to prove objective medical evidence of his continued need for medial treatment. *Castleberry v. Elite Lamp Co.*, 69 Ark. App. 359, 13 S.W.3d 211 (2000).

The evidence preponderates that the claimant sustained compensable injuries in the employment of respondents on January 18, 2006, and October 4, 2006. On April 11, 2006, a Change of Physician Order was entered by the Medical Cost Containment Department of the Arkansas Workers' Compensation Commission with respect to the January 18, 2006, compensable injury. Specifically, Dr. Thomas M. Hart, a Little Rock, pain medicine specialist, was designated the claimant's authorized treating physician. In accordance with the April 11, 2006, Change of Physician Order, the claimant was seen by Dr. Hart on May 12, 2006. The claimant was seen by Dr. Hart on two (2) separate occasion, during which time an MRI of the cervical spine was obtained, and a specific recommendation was made for "diagnostic left cervical facet injections per medial branch approach".

Respondents refused to authorize the recommended diagnostic procedure. Pursuant to an inquiry by respondent-carrier, the evidence discloses that Dr. Hart went through extraordinary measures to explain the purpose for the recommended procedure. Rather than authorize the procedure, respondents instead scheduled an evaluation of the claimant with Dr. Steven L. Cathey, a North Little Rock neurosurgeon. The claimant was seen by Dr. Cathey on two (2) occasions. The claimant was initially seen by Dr. Cathey on October 5, 2006, pursuant to the directions of respondents. While Dr. Cathey reported that he did not observe muscle spasms in the claimant neck region, the evidence preponderates that she sustained another work-related slip and fall on October 4, 2006, for which she was seen by respondents' designated medical provider, Dr. Kumar, who documented "lot of muscle spasms". Further, when seen by Dr. Kumar on October 18, 2006, muscle spasms were documented.

The October 30, 2006, clinic note of Dr. Cathey purports to dismiss the claimant and "will otherwise be seen here on a p.r.n. basis". While the respondents may direct, and the claimant may acquiesce in an evaluation by a physician of their choosing, the same does not render the physician the sanctioned authorized treating physician pursuant to Ark. Code Ann. §11-9-514.

Dr. Hart remains the claimant's authorized treating physician relative to the January 18, 2006, compensable injury pursuant to the April 11, 2006, Change of Physician Order. Respondents refused to authorize the claimant's treatment under the care of Dr. Hart subsequent to May 22, 2006. It is noteworthy that when the claimant was seen by Dr. Ashley Park, a Memphis orthopedic physician, for complaints relative to her neck on January 10, 2007, in addition to placing medical restriction of the claimant's employment activities, he also

recommended “reversible branch blocks at the cervical facet joints” which would serve both as a diagnostic tool and “hopefully therapeutically”. In *Gansky v. Hi-Tech Engineering*, 325 Ark.

163, 169, 924 S.W.2d 790, 794 (1994) the Arkansas Supreme Court held:

Under these circumstances when the treating neurosurgeon has prescribed a functional capacity assessment and that was not done because Hi-Tech would not pay for it, we cannot agree with the Commission that additional medical treatment was not reasonably necessary or that the healing period had ended. We conclude that fair-minded persons, viewing the same evidence, could not decide otherwise.

Respondents refused to provide further medical treatment to the claimant subsequent to October 30, 2006, in connection with either the January 18, 2006, compensable injury. The claimant last receive treatment in connection to the October 4, 2006, compensable injury, under the care of Dr. Kumar on February 7, 2007; however any treatment regarding the left knee complaint ceased on November 10, 2006.

The evidence preponderates that the medical treatment recommended by Dr. Hart, and later by Dr. Park, is reasonably necessary in connection with the claimant’s compensable injury of January 18, 2006, as well as the October 4, 2006, injury. The claimant’s neck symptoms have been continuous since the January 18, 2006, work-related accidental fall. Respondents have controverted the compensability of both the January 18, 2006, injury and the October 4, 2006, injury. Medical treatment rendered to the claimant in connection with the compensable injuries has been reasonably necessary in connection with same, to included that treatment rendered under the care of Dr. James Jacobs, Cross Ridge Community Hospital, Dr. Thomas M. Hart and Dr. Ashley Park.

505 (a) Benefits

Ark. Code Ann. §11-9-505(a) provides:

(1) Any employer who without reasonable cause refuses to return an employee who is injured in the course of employment to work, where suitable employment is available within the employee's physical and mental limitations, upon order of the Workers' Compensation Commission, and in addition to other benefits, shall be liable to pay to the employee the difference between benefits received and the average weekly wages lost during the period of the refusal, for a period not exceeding one (1) year.

(2) In determining the availability of employment, the continuance in business of the employer shall be considered, and any written rules promulgated by the employer with respect to seniority or provisions of any collective bargaining agreement with respect to seniority shall control.

In order to prove entitlement to benefits pursuant to Ark. Code Ann. §11-9-505 (a) (1), the employee must establish (1) that she sustained a compensable injury; (2) that suitable employment within her physical and mental limitations was available with the employer; (3) that the employer refused to return the employee to work; and (4) that the employer's refusal to return the employee to work was without reasonable cause. *Torrey v. City of Fort Smith*, 55 Ark. App. 226, 934 S.W.2d 237 (1996).

In the instant claims, the evidence preponderates that the claimant sustained compensable injuries to her neck, left shoulder, left ribcage, and left lower extremity on January 18, 2006, and October 4, 2006. The claimant was returned to work by her treating physicians, and, while the injuries resulted in loss time from work, she continued in the employment of respondent-employer through June 1, 2007.

The claimant had been employed by respondent-employer since July 2, 2001. There is no evidence in the record to reflect that the claimant received either disciplinary warnings or write-ups regarding her job performance or attendance prior to the January 18, 2006, compensable

injury. The credible evidence in the record reflects that subsequent to the January 18, 2006, compensable injury, as the claimant continued to complain of residuals of same and request further medical treatment and leave from work attributable to the injury, she was treated differently by supervisory personnel. The claimant was not allowed to take medical leave; medical appointments were scheduled in inopportune times; and she was ultimately written up because of attendance. The credible testimony of Ms. Annie Randle, a co-worker of the claimant, is corroborative of that of the claimant with respect to the afore. Indeed, the situation became so grave the Ms. Randle intervened to the Human Resource Manager on behalf of the claimant.

The evidence preponderates that the suspension of the claimant's employment on June 1, 2007, and subsequent termination on June 6, 2007, for falsifying company document, was nothing more than a pretext to refuse to return her to work without reasonable cause. Respondent-employer asserts that the claimant's employment was terminated because she signed an employment application of her son. The allegation was found wanting and insufficient to disqualify the claimant from receiving unemployment compensation benefits. The claimant's pursuit of workers' compensation benefits in connection with her January 18, 2006, and October 4, 2006, accidental injuries subjected her to be "picked out to be picked on" by supervisory personnel of respondent-employer. I find the casual observation of the purported differences in the writing on the summer employment application of the claimant's son out of the total number of employment applications submitted to respondent-employer to be incredible. Even more so since the "observation" served as the basis for the termination of the employment of a long time employee who had never experienced document discipline prior to the compensable January 18,

2006, injury.

Until the June 1, 2007, suspension and later termination of the employment of the claimant, claimant performed her assigned job duties, even with the January 10, 2007, medical restrictions that had been imposed by Dr. Park. The evidence preponderates that respondent-employer refused to return the claimant to work which was available and within her physical limitations on June 1, 2007, and that said refusal was without reasonable cause. Accordingly, the claimant is entitled to the payment of benefits at her average weekly wage of \$635.00, for the period commencing June 1, 2007, and continuing through June 1, 2008, less the \$210.00 per week, the claimant received in weekly unemployment compensation benefits during the period she received same.

AWARD

Respondents are herein ordered and directed to pay to the claimant temporary total disability benefits at the weekly compensation benefit rate of \$424.00, for the periods beginning January 19, 2006, through January 24, 2006; January 26, 2006, through February 8, 2006; February 14, and 15, 2006; June 26, 2006; August 2, 2006; and August 17 and 18, 2006, as a result of the January 18, 2006, compensable injury. Said sums accrued shall be paid in lump without discount.

Respondents are further ordered and directed to pay to the claimant additional compensation pursuant to Ark. Code Ann. §11-9-505 (a)(1), at the claimant's average weekly wage rate of \$635.00, for the period June 1, 2007, through June 1, 2008, less the \$210.00, in weekly unemployment compensation benefits the claimant received during the afore period. Said sums accrued shall be paid in lump with discount.

Respondents are further ordered and directed to pay all reasonably necessary medical, nursing, hospital, and other apparatus expenses growing out of the claimant's compensable injuries of January 18, 2006, and October 4, 2006, to include medical related milage.

This award shall bear interest at the legal rate pursuant to Ark. Code Ann. §11-9-809, until paid.

Matters not addressed herein are expressly reserved.

IT IS SO ORDERED.

Andrew L. Blood, ADMINISTRATIVE LAW JUDGE