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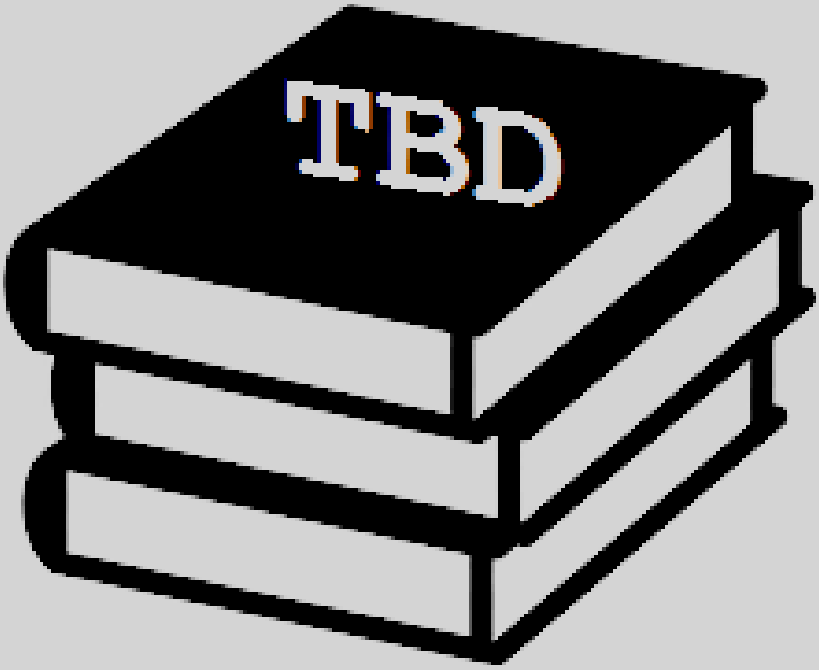

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(help others get the justice that they deserve)

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IN THE DISTRICT COURT OF APPEAL OF THE STATE OF FLORIDA
FIFTH DISTRICT

CARLOS F. VILLAVERDE,

Appellant,

v. CASE NO. 5D18-3842

CITY OF ORLANDO,

Appellee.
_____/

APPENDIX TO APPELLANT'S INITIAL BRIEF

Dated: April 03, 2019

KEITH L. HAMMOND, P.A.
Hammond Law Center
250 N. Orange Avenue, Suite 1200
Orlando, Florida 32801
Telephone: (407) 730-9909
Facsimile: (800) 861-0585
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Secondary e-mail: admin@hammondlawcenter.com

By: /s/ Keith L. Hammond
Keith L. Hammond
Fla. Bar No. 0164798
Attorney for Appellant, Carlos F. Villaverde

INDEX TO APPENDIX

Appendix 1

1632 C. Villaverde

TEMPORARY/SEASONAL EMPLOYMENT CONTRACT

THIS AGREEMENT, made and entered into this 13 day of January, 2016, by and between the City of Orlando, a municipal corporation organized and existing under the laws of the State of Florida, hereinafter referred to as the "City," and Carlos Villaverde, an individual, hereinafter referred to as the "Employee."

WITNESSETH THAT:

WHEREAS, the City is desirous of augmenting its work force from time to time with persons who will be employed by the City, on a temporary or seasonal basis, for a definite length of time by contract and who will complete the contractual period of employment; and

WHEREAS, the employee is desirous of obtaining employment with the City on the basis of the aforementioned contractual provision as a condition of employment;

NOW THEREFORE:

1. The ,City hereby agrees to employ Employee in the Orlando Police Department as an Airport Specialist, for the period beginning on or about the 14th day of January, 2016, and ending on the 13th day of January, 2017, (but in no event to exceed one (1) year) at the rate of $32.00 per hour. The temporary/seasonal Employee shall work the hours required and shall be regarded as a probationary employee regardless of service tenure. Employee shall not be entitled to any of the benefits received by permanent employees. Employee shall not exceed thirty-nine (39) hours per week.

2. Employee hereby agrees to be employed by and to work for the City for the definite period of time set forth in paragraph one (1) above and to complete the contractual period, both being conditions of this employment.

3. Nothing in this Agreement shall preclude the City from terminating Employee, prior to the expiration date set forth in paragraph one (1), upon twenty-four (24) hours notice.

4. Employee agrees to abide by and comply with all laws, ordinances, rules, regulations, policies and procedures of the City during this period of employment.

5. This Agreement contains all terms and conditions agreed upon by the parties. No other agreements, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind either of the parties hereto.

IN WITNESS WHERETO, the parties have hereunder set their hands and seals the day and year first above written.

CITY OF ORLANDO

By: _____

Print Name: John W. Mina
Chief of Police

EMPLOYEE:

Carlos Villaverde
Print Employee Name: Carlos Villaverde

AS TO FORM AND LEGALITY
For the use and reliance of the
City of Orlando, Florida, only

Jan 20, 2016

Natasha Wilson
Chief Assistant City Attorney
Orlando, Florida

WITNESS:

Print Name: Scott Ross

Appendix 2

CITY OF ORLANDO

POLICE DEPARTMENT

December 14, 2016

MEMORANDUM

TO: John W. Mina
Chief of Police

VIA: Chain of Command

FROM: Carlos Villaverde, #16312
Airport Division

SUBJECT: Alternative Duty Update

On 09/08/2016, I sustained an on-duty injury due to a marked patrol vehicle crash, 2016-366408.

On 12/13/2016, I had a follow-up appointment with Dr. Tall at the Jewett Orthopaedic Clinic. He determined that I could not yet come back to full duty and recommended surgery to correct the issue.

Dr. Tall completed a Florida Worker's compensation reporting form and noted the following duty restrictions: Not to lift, push or pull anything over 10 lbs., limited bending, no overhead work and to change my seated or standing position every 30-60 minutes.

My next appointment date is pending the Risk Management approval for surgery.

If you have any questions, please contact me at your convenience.

Attachment: (1) Form DFS-F5-DWC-25

CV/jkb

ENDORSEMENT/COMMENT:

4993

Lieutenant Scott M. Boos
Airport Division

APPROVED ☐ NOT APPROVED ☐
RECOMMENDED ☒ NOT RECOMMENDED ☐

12-19-16
Date

4993

Captain Dean A. DeSchryver
Airport Division

APPROVED ☐ NOT APPROVED ☐
RECOMMENDED ☒ NOT RECOMMENDED ☐

12-19-16
Date

TGW

Deputy Chief Eric D. Smith
Special Services Bureau

APPROVED ☐ NOT APPROVED ☐
RECOMMENDED ☑ NOT RECOMMENDED ☐

12/28/16
Date

John W. Mina
Chief of Police

APPROVED ☒ NOT APPROVED ☐
RECOMMENDED ☐ NOT RECOMMENDED ☐

1-3-17
Date

Claim no: WC5122016131076

Jewett Orthopaedic Clinic, LLC
1285 Orange Avenue
Winter Park, FL 32789

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 1

BEFORE COMPLETING THIS FORM, PLEASE CAREFULLY REVIEW THE INSTRUCTIONS BEGINNING ON PAGE 3

NOTE: Health Care providers shall legibly and accurately complete all sections of this form, limiting their responses to their area of expertise.

1. Insurer Name:	2. Visit/ 30-Calendar Day Review Date:	5. FOR INSURER USE ONLY
ASCENSION	12/13/2016	
3. Injured Employee (Patient) Name: Villaverde, Carlos 872611	4. Date of Birth: 7-28-1962	
6. Date of Reported Injury: 9/8/2016	7. Name of Employer: City Of Orlando	8. Initial visit with this physician? ■ YES ☐ NO

SECTION I CLINICAL ASSESSMENT

9. ☐ **No Change in Clinical Assessment (Items 10 - 13) since last report submitted. (Go to Section II)**

10. Injury/illness for which treatment is sought is:
☐ a) **NOT WORK RELATED** ■ b) **WORK RELATED** ☐ c) **UNDETERMINED** as of this date

11. Has the patient been determined to have Objective Relevant Medical Findings? Pain or abnormal anatomical findings, in the absence of objective relevant medical findings, shall not be an indicator of injury and/or illness and are not compensable.
☐ a) NO ■ b) YES ☐ c) UNDETERMINED as of this date
IF YES or UNDETERMINED, explain: **SEE NOTES**

12. Diagnosis(es): **CERVICAL PAIN/RADICULITIS /CERVICAL HNP/ LUMBAR PAIN**

13. **Major Contributing Cause:** When there is more than one contributing cause, the reported work-related injury must contribute more than 50% to the present condition and be based on the findings in Item 11.
a) Is there a pre-existing condition contributing to the current medical disorder?
■ a_1) NO ☐ a_2) YES ☐ a_3) UNDETERMINED as of this date
b) Do the objective relevant medical findings identified in Item 11 represent an exacerbation (temporary worsening) or aggravation (progression) of a pre-existing condition?
■ b_1) NO ☐ b_2) exacerbation ☐ b_3) aggravation ☐ b_4) UNDETERMINED as of this date
c) Are there other relevant co-morbidities that will need to be considered in evaluating or managing this patient?
■ c_1) NO ☐ c_2) YES
d) Given your responses to the items above, is the injury/illness in question the major contributing cause for:
☐ d_1) NO ■ d_2) YES the reported medical condition?
☐ d_3) NO ■ d_4) YES the treatment recommended (management/treatment plan)?
☐ d_5) NO ■ d_6) YES the functional limitations and restrictions determined?

SECTION II PATIENT CLASSIFICATION LEVEL

■ 14. LEVEL I - Key issue: specific, well-defined medical condition, with clear correlation between objective relevant physical findings and patients' subjective complaints. Treatment correlates to the specific findings.

☐ 15. LEVEL II - Key issue: regional or generalized deconditioning (i.e. deficits in strength, flexibility, endurance and motor control. Treatment: physical reconditioning and functional restoration.

☐ 16. LEVEL III- Key issue: poor correlation between patient's complaints and objective, relevant physical findings, indicating both somatic and non-somatic clinical factors. Treatment: interdisciplinary rehabilitation and management.

☐ 17. LEVEL UNDETERMINED AS OF THIS DATE.

SECTION III MANAGEMENT / TREATMENT PLAN

☐ 18. No clinical services indicated at this time. If checked, GO TO SECTION IV

☐ 19. No change in Items 20a - 20g since last report submitted. If checked, GO TO SECTION IV

20. The following proposed, subsequent clinical service(s) is/are deemed medically necessary.
THIS IS A PROVIDER'S WRITTEN REQUEST FOR INSURER AUTHORIZATION OF TREATMENT OR SERVICES

☐ a) Consultation with or referral to a specialist. Identify principal physician: _____
Identify specialty & provide rationale:
☐ a_1) CONSULT ONLY ☐ a_2) REFERRAL & CO-MANAGE ☐ a_3) TRANSFER CARE

☐ b) Diagnostic Testing: (Specify) _____

☐ c) Physical Medicine. Check appropriate box and indicate specificity of services, frequency and duration below:
☐ c_1) Physical/Occupational therapy, Chiropractic, Osteopathic or comparable physical rehabilitation.
☐ c_2) Physical Reconditioning (Level II Patient Classification)
☐ c_3) Interdisciplinary Rehabilitation Program (Level III Patient Classification)
Specific Instruction(s): _____

☐ d) Pharmaceutical(s) (specify): _____

☐ e) DME or Medical Supplies: _____

■ f) Surgical Intervention - specify procedure(s):
☐ f_1) In-Office: _____
■ f_2) Surgical Facility: **CERVICAL FUSION C6-7**
☐ f_3) Injectable(s) (e.g. pain management): _____

☐ g) Attendant Care: _____

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 2

Patient Name: **Villaverde, Carlos** D/A: **9/8/2015** Visit/Review Date: **12/13/2016**

SECTION IV FUNCTIONAL LIMITATIONS AND RESTRICTIONS

Assignment of limitations or restrictions must be based upon the injured employee's specific clinical dysfunction or status related to the work injury. However, the presence of objective relevant medical findings does not necessarily equate to an automatic limitation or restriction in function.

☐ 21. No functional limitations identified or restrictions prescribed as of the following date:

☐ 22. The injured workers' functional limitations and restrictions, identified in detail below, are of such severity that he/she cannot perform activities, even at a sedentary level (e.g. hospitalization, cognitive impairment, infection, contagion), as of the following date: . *Use additional sheet if needed.*

■ 23. The injured worker may return to activities so long as he/she adheres to the functional limitations and restrictions identified below. Identify ONLY those functional activities that have specific limitations and restrictions for this patient.
Identify joint and/or body part: **CERVICAL/LUMBAR** Use additional sheet if needed.

Functional Activity	Load	Frequency & Duration	ROM/Position & Other Parameters
■ Bend			**LIMITED**
■ Carry	**10LB**		
☐ Climb			
☐ Grasp			
☐ Kneel			
■ Lift - floor > waist	**10LB**		
■ Lift - waist > overhead	**10LB**		
■ Pull	**10LB**		
■ Push	**10LB**		
■ Reach - overhead			**NO OVERHEAD WORK**
■ Sit			**CHANGE POSITION EVERY 30-60MIN**
☐ Squat			
■ Stand			**CHANGE POSITION EVERY 30-60MIN**
☐ Twist			
☐ Walk			
☐ Other:			
☐ Other:			

COMMENTS:

Other choices: Skin Contact/ Exposure; Sensory; Hand Dexterity; Cognitive; Crawl; Vision; Drive/Operate Heavy Equipment; Environmental Conditions: heat, cold, working at heights, vibration; Auditory; Specific Job Task(s); etc.

NOTE: Any functional limitations or restrictions assigned above apply to both on and off the job activities, and are in effect until the next scheduled appointment unless otherwise noted or modified prior to the appointment date. Specify those functional limitations and restrictions, in Item 23, which are permanent if MMI / PIR have been assigned in Item 24.

SECTION V MAXIMUM MEDICAL IMPROVEMENT / PERMANENT IMPAIRMENT RATING

24. Patient has achieved maximum medical improvement?
☐ a) YES, Date: ■ b) NO ☐ c) Anticipated MMI date:
☐ d) Anticipated MMI date cannot be determined at this time. Future Medical Care Anticipated: ☐ e) Yes ☐ f) No
Comments:

25. % Permanent Impairment Rating (body as a whole) Body part/system:

26. Guide used for calculation of Permanent Impairment Rating (based on date of accident - see instructions):
☐ a) 1996 FL Uniform PIR Schedule ☐ b) Other, specify:

27. Is a residual clinical dysfunction or residual functional loss anticipated for the work-related injury?
☐ a) YES ☐ b) NO ☐ c) Undetermined at this time.

SECTION VI FOLLOW-UP

28. Next Scheduled Appointment Date & Time: **PREOP** @

SECTION VII ATTESTATION STATEMENT

" As the Physician, I hereby attest that all responses herein have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient." *"I certify to any MMI / PIR information provided in this form."*

Physician Group: **Jewett Orthopaedic Clinic** Physician Specialty: **Orthopaedic Surgery**

Physician Signature: Date: **12/13/2016**

Physician Name: **Reginald L. Tall, MD** Physician DOH License #: **ME58351**

If any direct billable services for this visit were rendered by a provider other than a physician, please complete section below.

" I hereby attest that all responses herein relating to services I rendered have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."

Provider Signature: Date:

Provider Name: Provider DOH License #:

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished this 3rd day of April 2019, by electronic transmission to: Wayne L. Helsby, Esq., whelsby@anblaw.com, Marc A. Sugerman Esq., msugerman@anblaw.com, Allen, Norton & Blue, P.A., 1477 W. Fairbanks Avenue, Suite 100, Winter Park, Florida 32789.

By: /s/ Keith Hammond
Keith L. Hammond
Fla. Bar No. 0164798
Attorney for Appellant, Carlos F. Villaverde

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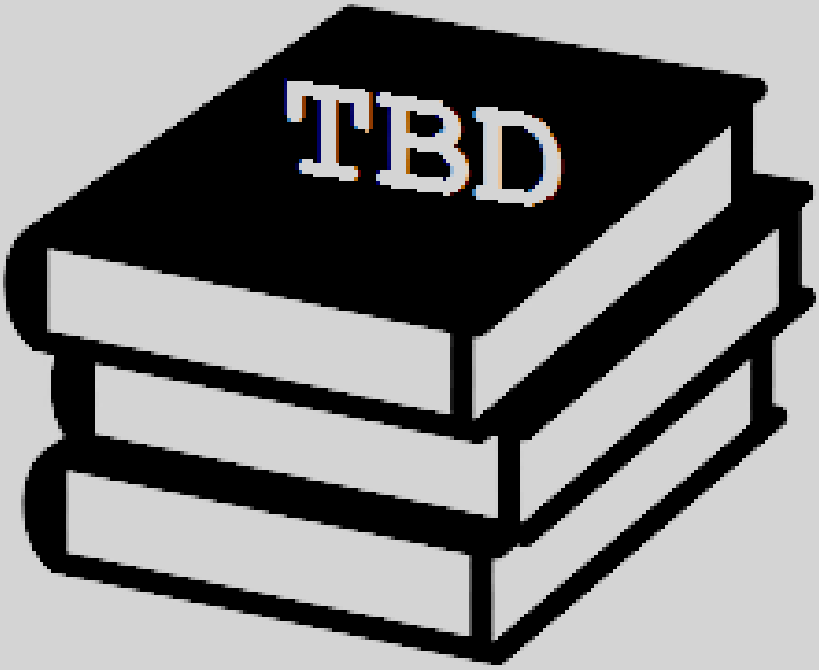

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