

**United States Department of Labor
Employees' Compensation Appeals Board**

D.C., Appellant

and

U.S. POSTAL SERVICE, PORT ARTHUR POST
OFFICE, Port Arthur, TX, Employer

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**Docket No. 20-1655
Issued: August 9, 2021**

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:

JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 22, 2020 appellant filed a timely appeal from a July 21, 2020 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act¹ (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.²

ISSUE

The issue is whether appellant has met her burden of proof to establish greater than 37 percent permanent impairment of the left upper extremity, for which she previously received a schedule award.

¹ 5 U.S.C. § 8101 *et seq.*

² The Board notes that appellant timely requested oral argument pursuant to section 501.5(b) of the Board's *Rules of Procedure*. 20 C.F.R. § 501.5(b). On January 1, 2021 appellant requested withdrawal of her request for oral argument.

FACTUAL HISTORY

On February 14, 2019 appellant, then a 56-year-old city carrier, filed a traumatic injury claim (Form CA-1) alleging that on that date she sustained multiple dog bites to her left hand while in the performance of duty. OWCP accepted her claim for open bite of the left hand, initial encounter, laceration without foreign body of left hand, and fracture of the unspecified phalanx of the left ring finger, initial encounter for open fracture. Appellant stopped work on the date of injury.

On February 15, 2019 Dr. Mathew Kergosien, a Board-certified orthopedist, performed an irrigation and debridement of open wounds to the dorsum of the left hand, ulnar aspect of the left small finger, and to the volar aspect of the left thumb with closure of traumatic wounds, irrigation and debridement of the left ring finger open proximal phalanx fracture, irrigation and debridement of left ring finger degloving wound, and closed reduction, percutaneous pinning of the left ring finger proximal phalanx. He diagnosed dog bite, left hand with multiple open wounds including the left thumb, left small finger, dorsal hand, large degloving wound of the left ring finger, with soft tissue loss and exposed extensor tendon left ring finger proximal phalanx open fracture, and complete disruption with segmental loss of ulnar-sided digital artery and nerve.

Appellant came under the treatment of Dr. Robert C. Kramer, a Board-certified orthopedist, on February 20, 2019 for a left hand injury that occurred when she was attacked by two dogs while delivering mail at work. X-rays of the left hand demonstrated a comminuted fracture, extra articular, at the base of the ring proximal phalanx with evidence of percutaneous pin stabilization and near anatomic alignment noted in both coronal and sagittal planes. Dr. Kramer diagnosed complex dog bite injury of the left hand with large defect and left ring finger. He advised that the defect would require flap closure with a full-thickness skin graft from the proximal volar forearm. On February 28, 2019 Dr. Kramer performed a left fourth dorsal metacarpal artery rotational flap closure of the left ring finger and diagnosed complex dog bite injury, left ring finger.³ On October 8, 2019 he performed a left ring proximal interphalangeal joint capsulotomy, left ring ulnar digital neuroplasty, excision, left hand dorsal scar neuroma, release A1 pulley flexor tendon sheath, left middle, and excision, left ring scar contracture. Dr. Kramer diagnosed left ring proximal interphalangeal joint traumatic contracture, left ring ulnar digital neuroma, left hand dorsal scar neuroma, stenosing flexor tenosynovitis, left middle finger, and left ring scar contracture.

Dr. Kramer treated appellant in follow-up on November 25 and December 23, 2019 and noted that she was six weeks' postsurgery. He indicated that she was attending physical therapy and had returned to work with restrictions. Dr. Kramer diagnosed left ring proximal interphalangeal joint traumatic contracture, status post capsulotomy, left ring ulnar digital neuroma, status post neuroplasty, left hand dorsal scar neuroma, status post excision, stenosing flexor tenosynovitis of the left middle, status post release, and left ring scar contracture, status post excision. He opined that appellant was not at maximum medical improvement (MMI). On January 13, 2020 appellant reported finishing her physical therapy. Examination demonstrated

³ On May 3, 2019 the employing establishment offered appellant a full-time modified city carrier position, effective May 6, 2019. On May 6, 2019 appellant accepted the position and returned to work.

approximately 40 degree flexion contraction at the ring proximal interphalangeal (PIP) joint, 10 degree flexion contracture at the ring metacarpophalangeal (MCP) joint, wounds were flat, dorsal scar nontender, and with no tenderness over the middle A1 pulley. Dr. Kramer noted that appellant's restrictions were permanent and opined that she was at MMI.

Appellant filed a claim for compensation (Form CA-7) for a schedule award dated April 2, 2020. In support of her claim, she submitted a March 16, 2020 report from Dr. Kramer on March 27, 2020. Dr. Kramer diagnosed left hand dog bite, left hand contracture, left hand laceration without foreign body, and left finger fracture of unspecified phalanx of left ring finger. Dr. Kramer noted that appellant reached MMI on March 12, 2020. He noted findings on physical examination of a well-healed scar without signs of infection, deformity of the left hand/ring finger, atrophy from the muscles in the compensable palmar and dorsal side of the left hand and in the hypothenar hand as compared to the unaffected wrist and hand, large tender area over the dorsal side of the left hand, considerable loss of function of the left hand with contractures and ankyloses joints of the right finger, abnormal muscle tone, and atrophy of the compensable left hand.

Dr. Kramer referred to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)⁴ and utilized the diagnosis-based impairment (DBI) rating method to find that, under Table 15-2 (Digit Regional Grid), page 392, the class of diagnosis (CDX) for left thumb digital stenosing tenosynovitis (the closest tendon pathology on the grid as there was no grid for hand contracture) was a class 1 impairment, grade C, with a default value of six percent for the digit. He assigned a grade modifier for functional history (GMFH) of 4 based on the *QuickDASH* score of 91 per Table 15-7, page 406. Dr. Kramer assigned a grade modifier for physical examination (GMPE) of 1 due to mild palpatory findings and decreased range of motion (ROM) pursuant to Table 15-8, page 408. Dr. Hebert assigned a grade modifier for clinical studies (GMCS) of one for mild pathology pursuant to Table 15-9, page 410. He utilized the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX) = (4-1) + (1-1) + (1-1) = +3, which resulted in a grade E or eight percent permanent impairment of the left thumb, which converted to three percent permanent impairment of the left hand pursuant to Table 15-12, page 421.

Dr. Kramer also utilized the ROM rating method and referenced Figure 15-13, page 462 and Table 15-30, page 468 (Upper Extremity Range of Motion Impairments) to find one percent permanent impairment for flexion of the interphalangeal (IP) joint at 70 degrees, zero percent permanent impairment for extension of the IP joint at 40 degrees, two percent permanent impairment for flexion of the MCP joint at 50 degrees, zero percent permanent impairment for extension of the MCP joint at zero degrees, four percent permanent impairment for adduction of the carpometacarpal (CMC) joint at 4 centimeters, zero percent permanent impairment for radial abduction of the CMC joint at 50 degrees. He combined these values pursuant to the Combined Values Chart on page 604 to equal seven percent permanent impairment for the digit converted to three percent permanent impairment for the left hand pursuant to Table 15-12, page 421.

With regard to the DBI rating method, under Table 15-2 (Digit Regional Grid), page 392, the CDX for left index finger digital stenosing tenosynovitis resulted in a class 1 impairment, grade

⁴ A.M.A., *Guides* (6th ed. 2009).

C, with a default value of six percent for the digit. Dr. Kramer assigned a GMFH of 4 based on the *QuickDASH* score of 91 per Table 15-7, page 406. He assigned a GMPE of 3 due to severe decrease in ROM findings pursuant to Table 15-8, page 408. Dr. Kramer assigned a GMCS of 1 for mild pathology pursuant to Table 15-9, page 410. He utilized the net adjustment formula $(4-1) + (3-1) + (1-1) = +5$, which resulted in a grade E or eight percent permanent impairment of the left index finger, which converted to three percent permanent impairment of the left hand pursuant to Table 15-12, page 421.

Dr. Kramer also utilized the ROM rating methodology and referenced Figure 15-13, page 462 and Table 15-31, page 470 (Upper Extremity Range of Motion Impairments) to find 0 percent permanent impairment for flexion of the distal interphalangeal (DIP) joint at 70 degrees, 0 percent permanent impairment for extension of the DIP joint at 0 degrees, 21 percent permanent impairment for flexion of the PIP joint at 60 degrees, 0 percent permanent impairment for extension of the PIP joint at 0 degrees, 19 percent permanent impairment for flexion of the MCP joint at 50 degrees, 7 percent permanent impairment for extension of the MCP joint at 5 degrees. He combined these values pursuant to the Combined Values Chart on page 604 to equal 42 percent permanent impairment for the digit converted to eight percent permanent impairment for the left hand pursuant to Table 15-12, page 422.

With regard to the DBI rating method, under Table 15-2 (Digit Regional Grid), page 392, the CDX for left middle finger digital stenosing tenosynovitis resulted in a class 1 impairment, grade C, with a default value of six percent for the digit. Dr. Kramer assigned a GMFH of 4 based on the *QuickDASH* score of 91 per Table 15-7, page 406. He assigned a GMPE of 3 due to severe decrease in ROM findings pursuant to Table 15-8, page 408. Dr. Kramer assigned a GMCS of 1 for mild pathology pursuant to Table 15-9, page 410. He utilized the net adjustment formula $(4-1) + (3-1) + (1-1) = +5$, which resulted in a grade E or eight percent permanent impairment of the left middle finger, which converted to three percent permanent impairment of the left hand, Table 15-12, page 421.

Dr. Kramer also utilized the ROM rating method and referenced Figure 15-13, page 462 and Table 15-31, page 470 (Upper Extremity Range of Motion Impairments) to find 10 percent permanent impairment for flexion of the DIP joint at 40 degrees, 0 percent permanent impairment for extension of the DIP joint at 0 degrees, 21 percent permanent impairment for flexion of the PIP joint at 50 degrees, 0 percent permanent impairment for extension of the PIP joint at 0 degrees, 35 percent permanent impairment for flexion of the MCP joint at 20 degrees, 7 percent permanent impairment for extension of the MCP joint at 10 degrees. He combined these values pursuant to the Combined Values Chart on page 604 to equal 59 percent permanent impairment for the digit, which converted to 12 percent permanent impairment for the left hand, Table 15-12, page 422.

With regard to the DBI rating method, under Table 15-2 (Digit Regional Grid), page 392, the CDX for left ring finger digital stenosing tenosynovitis resulted in a class 1 impairment, grade C, with a default value of six percent for the digit. Dr. Kramer assigned a GMFH of 4 based on the *QuickDASH* score of 91 per Table 15-7, page 406. He assigned a GMPE of 4 due to very severe decrease in ROM findings pursuant to Table 15-8, page 408. Dr. Kramer assigned a GMCS of 3 due to severe pathology pursuant to Table 15-9, page 410. He utilized the net adjustment formula $(4-1) + (4-1) + (3-1) = +8$, which resulted in a grade E or eight percent permanent

impairment of the left ring finger, which converted to three percent permanent impairment of the left hand, pursuant to Table 15-12, page 421.

Dr. Kramer also utilized the ROM rating method and referenced Figure 15-13, page 462 and Table 15-31, page 470 (Upper Extremity Range of Motion Impairments) to find 30 percent permanent impairment for flexion and extension of the DIP joint, 54 percent permanent impairment for flexion of the PIP joint at 10 degrees, 3 percent permanent impairment for extension of the PIP joint at -10 degrees, 48 percent permanent impairment for flexion of the MCP joint at 10 degrees, 7 percent permanent impairment for extension of the MCP joint at -10 degrees. He combined these values pursuant to the Combined Values Chart on page 604 to equal 90 percent permanent impairment for the digit, which converted to 9 percent permanent impairment for the left hand.

With regard to the DBI rating method, under Table 15-2 (Digit Regional Grid), page 391, the CDX for left little finger digital stenosing tenosynovitis resulted in a class 1 impairment, grade C, with a default value of six for the digit. Dr. Kramer assigned a GMFH of 4 based on the *QuickDASH* score of 91 per Table 15-7, page 406. He assigned a GMPE of 4 due to very severe decrease in ROM findings pursuant to Table 15-8, page 408. Dr. Kramer assigned a GMCS of 3 due to severe pathology pursuant to Table 15-9, page 410. He utilized the net adjustment formula $(4-1) + (4-1) + (3-1) = +8$, which resulted in a grade E or eight percent permanent impairment of the left little finger, which converted to three percent permanent impairment of the left hand pursuant to Table 15-12, page 421.

Dr. Kramer also utilized the ROM rating method and referenced Figure 15-13, page 462 and Table 15-31, page 470 (Upper Extremity Range of Motion Impairments) to find 25 percent permanent impairment for flexion of the DIP joint at 30 degrees, 2 percent impairment for extension of the DIP joint at -10 degrees, 42 percent permanent impairment for flexion of the PIP joint at 20 degrees, 3 percent permanent impairment for extension of the PIP joint at -10 degrees, 48 percent permanent impairment for flexion of the MCP joint at 10 degrees, 7 percent permanent impairment for extension of the MCP joint at 0 degrees. He combined these values pursuant to the Combined Values Chart on page 604 to equal 82 percent permanent impairment for the digit converted to 8 percent permanent impairment for the left hand, Table 15-12, page 422.

Dr. Kramer referenced Table 15-11, page 420 and calculated 40 percent permanent impairment for the hand converted to 36 percent permanent impairment of the left upper extremity for the ROM method. He indicated that, since the ROM grade modifier was three and her functional history grade adjustment was three, modification of the net modifier was required under Table 15-36, page 477. The ROM impairment would be increased by ROM multiplied by 5 percent, or 1.8 percent rounded up to 2 percent upper extremity for a total permanent impairment of 38 percent of the left upper extremity.

On April 23, 2020 Dr. Arthur S. Harris, a Board-certified orthopedist, serving as a district medical adviser (DMA), reviewed a statement of accepted facts and the medical record, including Dr. Kramer's March 16, 2020 findings. He concurred with Dr. Kramer's findings. Dr. Harris indicated that the ROM method resulted in greater impairment and pursuant to the A.M.A., *Guides* if more than one method is available to rate a particular impairment condition the method producing the higher rating must be used. Using the Combined Values Chart, page 604, this

resulted in 36 percent impairment of the left upper extremity. The DMA advised that appellant had greater functional loss than one would normally expect and the A.M.A., *Guides* allows for an increase to the ROM impairment value for functional loss pursuant to Table 15-36, page 477. Dr. Harris calculated an additional two percent permanent impairment of the upper extremity. Using the Combined Values Chart this resulted in 37 percent left upper extremity impairment. Dr. Harris addressed the discrepancies between his evaluation and Dr. Kramer who found 38 percent permanent impairment of the upper extremity based on the ROM method including 36 percent permanent impairment for ROM and an additional 2 percent permanent impairment for pain, which significantly increases functional loss, indicating that Dr. Kramer mathematically added these figures instead of using the Combined Values Chart on page 604. He found that the date of MMI was March 12, 2020 when appellant was evaluated by Dr. Kramer.

On June 26, 2020 OWCP requested that Dr. Kramer review DMA Dr. Harris' April 23, 2020 report and indicate whether he concurred with the impairment rating. If he did not concur, it requested that he provide the specific reasons in a narrative report. In a note received on July 8, 2020, Dr. Kramer agreed with the findings of DMA Dr. Harris in his April 23, 2020 report.

By decision dated July 21, 2020, OWCP granted appellant a schedule award for 37 percent permanent impairment of the left upper extremity. The award ran for 115.44 weeks from March 12, 2020 through May 29, 2022 and was based on the March 12, 2020 report by Dr. Kramer and the April 23, 2020 impairment rating of DMA Dr. Harris.

LEGAL PRECEDENT

The schedule award provisions of FECA⁵ and its implementing regulations⁶ set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.⁷ As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).⁸ The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.⁹

⁵ 5 U.S.C. § 8107.

⁶ 20 C.F.R. § 10.404.

⁷ *Id.* See also, *Ronald R. Kraynak*, 53 ECAB 130 (2001).

⁸ See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *id.* at Chapter 2.808.5(a) (March 2017).

⁹ *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

In addressing upper extremity impairments, the sixth edition requires that the evaluator identify the impairment CDX, which is then adjusted by a GMFH, GMPE, and GMCS.¹⁰ The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).¹¹

The A.M.A., *Guides* also provide that ROM impairment methodology is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other DBI sections are applicable.¹² If ROM is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are measured and added.¹³ Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.¹⁴

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology versus the ROM methodology for rating of upper extremity impairments.¹⁵ Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides in pertinent part:

“Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify: (1) the methodology used by the rating physician (*i.e.*, DBI or ROM); and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the [A.M.A.,] Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used.*” (Emphasis in the original.)¹⁶

The Bulletin further advises: “If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allow for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE [clams examiner].”¹⁷

¹⁰ A.M.A., *Guides* 383-492.

¹¹ *Id.* at 411.

¹² *Id.* at 461.

¹³ *Id.* at 473.

¹⁴ *Id.* at 474.

¹⁵ FECA Bulletin No. 17-06 (issued May 8, 2017).

¹⁶ A.M.A., *Guides* 477.

¹⁷ FECA Bulletin No. 17-06 (May 8, 2017); *V.L.*, Docket No. 18-0760 (issued November 13, 2018); *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

The Board has held that, where the residuals of an injury to a member of the body specified in the schedule award provisions of FECA¹⁸ extend into an adjoining area of a member also enumerated in the schedule, such as an injury of a finger into the hand, of a hand into the arm or of a foot into the leg, the schedule award should be made on the basis of the percentage loss of use of the larger member.¹⁹

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.²⁰

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish more than 37 percent permanent impairment of the left upper extremity, for which she previously received a schedule award.

In support of her schedule award claim, appellant submitted a March 16, 2020 report from Dr. Kramer who found 38 percent permanent impairment of the left thumb, index finger, middle finger, and little finger digits under the sixth edition of the A.M.A., *Guides* based on the ROM methodology. Dr. Kramer indicated that the ROM method resulted in greater impairment than the DBI method and pursuant to the A.M.A., *Guides* if more than one method is available to rate a particular impairment condition the method producing the higher rating must be used. Referencing Table 15-11 on page 420 and Table 15-36, page 477, he determined that appellant's left thumb, index finger, middle finger, and little finger yielded 38 percent permanent impairment of the left upper extremity. On July 8, 2020 Dr. Kramer amended his report and concurred with the DMA's impairment rating, which used the Combined Values Chart to calculate 37 percent permanent impairment of the left upper extremity.

OWCP properly routed Dr. Kramer's report to its DMA, Dr. Harris.²¹ In an April 23, 2020 report, the DMA utilized both the DBI methodology and ROM methodology and determined that the ROM method provided the higher impairment rating. He properly calculated 36 percent permanent impairment of the left upper extremity for the thumb, index finger, middle finger, and little finger digits under the sixth edition of the A.M.A., *Guides* based on the ROM methodology. The DMA advised that appellant had greater functional loss than one would normally expect and the A.M.A., *Guides* allows for an increase to the ROM impairment value for functional loss pursuant to Table 15-36, page 477. Dr. Harris calculated an additional two percent upper extremity impairment. Using the Combined Values Chart this resulted in 37 percent permanent impairment

¹⁸ 5 U.S.C. § 8107.

¹⁹ C.W., Docket No. 17-0791 (issued December 14, 2018); *Asline Johnson*, 42 ECAB 619 (1991); *Manuel Gonzales*, 34 ECAB 1022 (1983). See *supra* note 8 at Chapter 2.808.5(e) (March 2017).

²⁰ See *supra* note 8 at Chapter 2.808.6(f) (March 2017); see *D.J.*, Docket No. 19-0352 (issued July 24, 2020).

²¹ See *supra* note 8 at Chapter 3.700, Exhibit 1 (January 2010); *supra* note 8 at Chapter 2.808.6a (March 2017); see *D.J.*, *id.*

of the left upper extremity. Dr. Harris determined that appellant attained MMI as of March 12, 2020, the date of Dr. Kramer's impairment evaluation. The DMA explained that the discrepancy between his and Dr. Kramer's impairment rating was due to his mathematically adding 36 percent left upper extremity impairment under the ROM methodology and the 2 percent impairment for increased functional loss pursuant to Table 15-36, page 477 of the A.M.A., *Guides* instead of using the Combined Values Chart on page 604. Upon review of the DMA's report, Dr. Kramer concurred in his impairment rating using the Combined Values Chart for 37 percent left upper extremity impairment.

Both Dr. Kramer and the DMA properly explained appellant's left hand permanent impairment should be rated based on ROM methodology as it yielded a higher permanent impairment rating than the DBI methodology.²²

The Board finds that OWCP properly determined that the clinical findings and reports of Dr. Kramer and the DMA constituted the weight of the medical evidence.²³ There is no probative medical evidence of record demonstrating greater impairment than previously awarded.²⁴

Appellant may request a schedule award or increased schedule award at any time based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish greater than 37 percent permanent impairment of the left upper extremity, for which she previously received a schedule award.

²² FECA Bulletin No. 17-06 (May 8, 2017); *V.L.*, Docket No. 18-0760 (issued November 13, 2018); *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

²³ *J.H.*, Docket No. 18-1207 (issued June 20, 2019); *M.C.*, Docket No. 15-1757 (issued March 17, 2016).

²⁴ *See J.M.*, Docket No. 18-1334 (issued March 7, 2019).

ORDER

IT IS HEREBY ORDERED THAT the July 21, 2020 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 9, 2021
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board