/United States Department of Labor
Employees' Compensation Appeals Board

M.R., Appellant	)	
and	)	**Docket No. 11-2084**
	)	**Issued: July 23, 2012**
U.S. POSTAL SERVICE, POST OFFICE, Kansas City, MO, Employer	)	

Appearances:
Melford V. McCormick, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 23, 2011 appellant, through her attorney, filed a timely appeal from a September 6, 2011 decision of the Office of Workers' Compensation Programs (OWCP) denying a shoulder condition. Pursuant to the Federal Employees' Compensation Act[1] (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 established that her claim should be expanded to include a diagnosed right shoulder condition due to the accepted June 7, 2004 employment injury.

[1] 5 U.S.C. § 8101 *et seq.*

[2] This case was previously before the Board. In an order dated November 10, 2010, the Board dismissed appellant's appeal of a December 1, 2009 decision denying appellant's recurrence claim, at the request of appellant's representative. Docket No. 10-569 (issued November 10, 2010).

On appeal, counsel argued that appellant's right shoulder condition was caused by the June 7, 2004 injury. Further, he contends the fact that OWCP paid medical bills related to the shoulder condition for over six years supports her claim.

FACTUAL HISTORY

On June 7, 2004 appellant, then a 38-year-old mail processor, filed a traumatic injury claim alleging that she sustained injuries to her neck, back, right leg and the back of her left arm when she was struck by a box being transported by a power equipment operator on that date. In an undated statement, she noted that she felt a hard push or bump and while trying to catch her balance, she landed on her right side to feel impact on her right shoulder.

Appellant was treated by Dr. Arthur R. Turner, a chiropractor. In a June 21, 2004 report, Dr. Turner stated that appellant's major symptom was neck pain and headache, which began on June 7, 2004 when she was injured on the job. He noted that the pain extended across the top of both shoulders. Examination revealed restricted cervical range of motion with end-point tenderness, trapezius spasms and palpable tenderness bilaterally, Erb's point was positive bilaterally and O'Donoghue maneuver was positive for ligament sprain of the cervical spine. Dr. Turner's initial diagnoses were cervical brachial syndrome; cervical degenerative joint disease (DJD); stiffness and restriction; and myofasciitis.

On July 28, 2004 Dr. Turner stated that appellant's cervical and shoulder range of motion and pain levels had improved. Appellant had, however, experienced an exacerbation of the right cervical and shoulder pain during the prior week, which she attributed to reaching for things above shoulder level at work. Dr. Turner recommended that she be restricted from any repetitive lifting and from working above shoulder level for three weeks.

In a September 29, 2004 report, Dr. Turner reported the history of injury, as related by appellant, who stated that she was accidentally knocked down to the floor on June 7, 2004 while performing her normal work duties by a gaylord box and landed on her right shoulder and back. He opined that his findings on June 17, 2004 were consistent with this type of injury to the neck, upper thoracic spine and right shoulder. Dr. Turner expanded his diagnoses to include cervical subluxation, cervical sprain/strain, right shoulder restrictions/pain/bursitis, thoracic subluxation and muscle spasms. He stated that x-ray findings demonstrated the presence of multiple subluxations that were directly related to the injuries sustained on June 7, 2004.

On October 8, 2004 OWCP accepted appellant's claim for subluxation of the cervical spine. Appellant returned to work full time on May 5, 2006. On December 5, 2008 she filed a notice of recurrence (Form CA-2a).

Appellant submitted a March 31, 2008 duty status report from Dr. Turner, who diagnosed cervicobrachial syndrome. Dr. Turner stated that appellant was bumped on June 7, 2004 and knocked to the floor, landing on her right shoulder. His findings included "injury to cervical

spine and right shoulder." Dr. Turner indicated that repetitive movement, heavy lifting and reaching above the head exacerbated the problem.[3]

In a December 8, 2008 narrative report, Dr. Turner provided examination findings, which revealed restricted cervical range of motion. He diagnosed cervicobrachial syndrome and opined that appellant had a chronic cervical and right shoulder dysfunction due to her on-the-job injury, which had been exacerbated by new job requirements. Dr. Turner stated that her original on-the-job injury occurred when she was struck by a "gaylord" and knocked to the ground, landing on her right shoulder. From that injury, appellant continued to experience pain in the neck that radiates into the right shoulder and occasionally down the right arm to the hand. Dr. Turner noted that on October 25, 2008 appellant was moved to a new work section and engaged in new job duties, which included lifting and moving heavy flats. The performance of these new job activities resulted in an exacerbation of the right shoulder pain, with a loss of strength in the right arm and loss of grip in the right hand. Dr. Turner recommended restrictions, which included lifting, pushing and pulling no more than 10 pounds, and no reaching above her shoulder level with the right upper extremity. He noted that appellant stopped working on December 5, 2008 because her employer was unable to accommodate her restrictions.

Appellant submitted reports dated January 30 and February 6, 2009 from Dr. Terrence Pratt, a Board-certified physiatrist. On February 6, 2009 Dr. Pratt provided a history of injury reflecting that in 2004, appellant was knocked down by a coworker and fell on her right side, "resulting in disability with a disabling condition, more probable than not caused by her employment." Appellant reportedly experienced severe cervical discomfort, with symptoms radiating to the upper back and right shoulder, and weakness of the right hand and shoulder. Her symptoms were increased by overhead lifting and excessive activities while working. On examination, appellant had limited cervical range of motion and findings of impingement at the shoulder level. Dr. Pratt diagnosed cervicothoracic syndrome with right greater than left shoulder syndrome with impingement and restricted appellant from lifting more than 20 pounds, pushing or pulling more than 50 pounds and no repetitive overhead activities.

By decision dated May 4, 2009, OWCP denied appellant's recurrence claim on the grounds that the evidence was insufficient to establish that the claimed disability was due to the accepted June 7, 2004 injury.

On May 19, 2009 appellant requested an oral hearing, which was conducted on September 15, 2009. At the hearing, appellant testified that she was transferred in October 2008 to a flat sorter area, where she was forced to work outside of her restrictions. She was informed by the employing establishment in November 2008 that there was no work available within her restrictions.

In a September 3, 2009 report, Dr. Turner stated that appellant's neck and shoulder pain continued to be exacerbated by her work activities. He noted that on "June 16, 2004" appellant had told him that her major symptom was neck pain spread that across the top of both shoulders and into the right deltoid muscle, with an occasional sharp pain in the shoulder with neck or arm

[3] The record contains periodic duty status reports from Dr. Turner which provided work restrictions related to her diagnosed cervicobrachial syndrome.

movement. Muscle strength testing demonstrated a weakness in the shoulder abduction, which indicated nerve impingement.

By decision dated December 1, 2009, an OWCP hearing representative affirmed the May 4, 2009 decision denying appellant's recurrence claim.[4]

On November 18, 2009 appellant requested a schedule award. OWCP referred her to Dr. George Varghese, a Board-certified physiatrist, for an opinion as to whether appellant had any permanent impairment related to her accepted cervical subluxation. In a February 23, 2010 report, Dr. Varshese stated that appellant had significant cervical and right upper extremity pain, there was no evidence of cervical radiculopathy. He opined that she had no permanent impairment for cervical pain according to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). By decision dated March 5, 2010, OWCP denied appellant's schedule award request.

In a June 2, 2010 report, Dr. Turner stated that appellant continued to experience neck and shoulder pain resulting from her June 7, 2004 injury. He opined that her condition was chronic and not improving. For that reason, he discharged her from his care. Dr. Turner noted that appellant had recently changed jobs and that although she was no longer required to lift heavy objects, her new job involved "a lot of repetitive movements that can be stressing the neck and shoulder."

On July 15, 2010 appellant appealed OWCP's December 1, 2009 decision to the Board. Upon the request of appellant's representative, the Board dismissed the appeal.[5]

In an undated letter, received on September 13, 2010, appellant requested that her claim be expanded to include a right shoulder condition. She argued that her shoulder condition had previously not been accepted because she had been treated by a chiropractor, who was apparently not qualified to diagnose her shoulder condition, but that it did, in fact, occur as a result of the June 7, 2004 injury.

Appellant began treatment with Dr. Lisa Hermes, a Board-certified physiatrist. On July 28, 2010 Dr. Hermes related the history of injury as reported by appellant. Appellant stated that her pain began as a result of a June 7, 2004 injury when she was struck by another employee who was operating a vehicle that was transporting boxes and fell onto her right shoulder, sustaining trauma to her right shoulder and neck. On examination, right shoulder abduction had significant giveaway to her strength when tested. Appellant was able to move her arm against gravity in all planes without difficulty. Assessment of her passive range of motion revealed near-normal forward flexion, deficits to shoulder abduction and internal and external rotation. Sensation was grossly intact to light touch in all dermatomal distributions of her upper extremities. Deep tendon reflexes were 2/4 in bilateral biceps, brachioradialis, and triceps. Spurling's test was positive for radicular symptoms down her right arm when her neck was

[4] In a March 5, 2010 decision, OWCP denied appellant's request for a schedule award. By decision dated September 24, 2010, an OWCP hearing representative affirmed the March 5, 2010 decision.

[5] Docket No. 10-569 (issued November 10, 2010).

extended to the right. There was no evidence of clonus and she had a negative Hoffman's sign bilaterally. Appellant had limited cervical spine flexion, extension, side bending and rotation. She had numerous tender points throughout her upper trapezius and levator scapula on the right and had positive Hawkins test for shoulder impingement. Dr. Hermes diagnosed chronic neck pain with underling disc degeneration, stenosis, and secondary myofascial pain and right shoulder pain concerning for underlying RTC or joint pathology. She recommended MRI scan of the cervical spine and right shoulder due to her complex presentation.

In a July 20, 2010 report, Dr. Pratt stated that he first examined appellant on January 30, 2009 when she informed him that she injured her neck and right shoulder when she was knocked down by a coworker in 2004. He opined that appellant had a right shoulder syndrome in direct relationship to vocationally-related activities, as well as cervicothoracic syndrome. Dr. Pratt stated that she had reached maximal medical improvement and had a 16 percent permanent disability of her shoulder.

By letter dated September 17, 2010, OWCP informed appellant that the evidence of record was insufficient to establish that her shoulder condition was causally related to the accepted injury. It advised her to submit a medical report with a diagnosis and a rationalized medical opinion as to the cause of the claimed shoulder condition.

In a September 20, 2010 letter, appellant stated that her right shoulder had been a constant problem since the June 7, 2004 accepted injury. She insisted that her shoulder condition was a result of the original injury, rather than a new injury.

On September 14, 2010 Dr. Hermes repeated the history of appellant's injury and provided examination findings. She diagnosed right shoulder pain with concern for underlying joint pathology; right posterior shoulder girdle myofascial pain; and chronic neck pain with underlying cervical spondylosis.

By decision dated October 22, 2010, OWCP denied appellant's request to expand her claim to include a right shoulder condition, finding that the medical evidence did not provide a firm diagnosis of a right shoulder condition or a rationalized medical opinion explaining the causal relationship between the shoulder condition and the June 7, 2004 injury.

On December 1, 2010 appellant requested that OWCP reconsider the decision denying expansion of her claim. She contended that the evidence submitted was sufficient to establish that her shoulder condition was caused by the June 7, 2004 injury. Appellant submitted copies of authorization request forms and medical reports which had been previously submitted and reviewed by OWCP.

In a December 22, 2010 report, Dr. Joshua D. Nelson, an orthopedic surgeon, stated that appellant was being seen for a follow-up visit for right shoulder pain, noting that she had received both a subacromial and glenohumeral injection, which had improved her range of motion rapidly. Examination of the right shoulder revealed some tenderness over the AC joint, as well as over the bicipital groove. External and internal rotation, forward flexion and abduction were 90, 70, 130 and 110 degrees, respectively. Dr. Nelson indicated that appellant

would be undergoing right shoulder arthroscopy and rotator cuff repair, subacromial decompression, distal clavicle resection and likely biceps tenotomy.

By decision dated March 7, 2011, OWCP denied modification of its October 22, 2010 decision. The claims examiner found that the evidence did not establish that appellant sustained a right shoulder injury as a result of the accepted June 7, 2004 injury.

On June 5, 2011 appellant, through her representative, requested reconsideration based on additional evidence, including a November 18, 2010 MRI scan report, notes dated September 14, 2010 through January 6, 2011 and a December 1, 2010 report from the University of Kansas Medical Center, a January 6, 2011 operative report, a January 19, 2011 follow-up report and an April 27, 2011 report prepared by appellant's operating physician. Counsel noted that the reports submitted "inferred that appellant's shoulder injury was work related."

Appellant submitted hospital records and reports relating to a January 6, 2011 right shoulder arthroscopy and rotator cuff repair performed by Dr. Nelson, a September 15, 2010 physical therapy referral from Dr. Hermes, a September 14, 2010 return-to-work slip from Dr. Hermes and a November 18, 2010 report of a right shoulder MRI scan.

In a December 1, 2010 report, Dr. Nelson stated that appellant fell on her right shoulder when she was pushed down by a fellow worker on June 7, 2004 and had experienced continuous pain in this right shoulder since that time. Examination of the right shoulder revealed external rotation to 45 degrees and internal rotation to 40 degrees without significant pain. Appellant had bicipital tenderness with deep palpation and pain with forward flexion beyond 90 degrees. Reports of MRI scans and x-rays showed some degenerative change to the posterior glenoid. There was some concern for intra-substance tendinosis of the rotator cuff and a posterior labral tear with a spinal glenoid cyst. Dr. Nelson diagnosed right shoulder pain, likely due to arthrofibrosis/adhesive capsulitis and posterior labral tear with rotator cuff tendinosis.

In an April 27, 2011 report, Dr. Nelson opined that appellant's June 7, 2004 injury would be causally related to her current condition "if [the fall] resulted in posterior subluxation of the humeral head and posterior labral tear." He stated:

> "[Appellant's] injury is a posterior and superior labral tear, AC arthritis, and subacromial impingement as well as biceps pathology. Repetitive work with arms coming in forward flexion would aggravate the outlet impingement, bursitis, and biceps pathology that she has developed. Posterior labral tear is likely due to some forced load humeral head posteriorly. AC joint arthritis is due to repetitive overhead activity and activity across the body and lifting a significant amount of weight."

In reports dated July 30, 2010 and June 16, 2011, Dr. Sequita L. Richardson, a Board-certified family practitioner, treated appellant for high blood pressure and stated that she suffered from chronic neck and shoulder pain. She stated that appellant injured her shoulder at work in June 2004. On examination, range of motion of the right shoulder was grossly intact and there was some tenderness in the trapezius area.

The record contains reports of diagnostic testing, including a March 8, 2011 arthrogram; a November 18, 2010 MRI scan and physical therapy notes. Appellant also submitted follow-up reports from Dr. Nelson dated December 22, 2010, March 2 and May 11, 2011.

In a November 24, 2010 report, Dr. Hermes diagnosed chronic right shoulder pain with remote history of trauma and MRI scan findings concerning for labral tear with significant underlying degenerative joint disease and subdeltoid bursitis, right shoulder girdle myofascial pain secondary and cervical spondylosis with transient radiculitis. Dr. Hermes related the results of a right shoulder MRI scan, which revealed a possible labral tear as well as degenerative changes of the humeral head, a significant amount of subdeltoid bursitis and arthritic changes to her right AC joint. She expressed concern that most of appellant's arm pain was related to a shoulder joint pathology. Examination of the right shoulder revealed diffuse tenderness along the left cervical paraspinals down to the levator scapulae, trapezius muscles, deltoids, rhomboids, and through the latissimus and teres minor. Positive impingement sign with limits in shoulder abduction to just 90 degrees and significantly limited right internal rotation even more so than external rotation.

By decision dated September 6, 2011, OWCP denied modification of its March 7, 2011 decision, finding that the medical evidence was insufficient to establish that the accepted June 7, 2004 incident caused her claimed right shoulder condition.

LEGAL PRECEDENT

Where an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, she bears the burden of proof to establish that the condition is causally related to the employment injury.[6] To establish a causal relationship between the condition claimed, as well as any attendant disability, and the employment event or incident, an employee must submit rationalized medical evidence based on a complete medical and factual background supporting such a causal relationship.[7] Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.[8] Rationalized medical evidence is evidence which includes a physician's rationalized medical opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty and must be supported by rationalized medical evidence explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[9] Neither the fact that a disease or condition manifests itself during a

[6] *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[7] *Jennifer Atkerson*, 55 ECAB 317 (2004).

[8] *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[9] *Leslie C. Moore*, 52 ECAB 132 (2000).

period of employment, nor the belief that the disease or condition was caused or aggravated by employment factors or incidents, is sufficient to establish causal relationship.[10]

ANALYSIS

The Board finds that appellant has not established that she has a right shoulder condition causally related to her accepted injury. OWCP accepted the claim for subluxation of the cervical spine. Appellant contends that it should accept her right shoulder condition. A review of the medical evidence does not reveal a reasoned medical opinion establishing a causal relationship between appellant's right shoulder condition and the accepted injury.

The record reflects appellant's treatment by her chiropractor, Dr. Turner, for the accepted cervical subluxation and a right shoulder injury, which he opined was a direct result of the June 7, 2004 fall. Chiropractors are considered to be physicians under FECA only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray. The Board finds that Dr. Turner qualifies as a physician under FECA only as to treatment of appellant's cervical subluxation. His opinion on the cause of appellant's shoulder condition does not constitute probative medical evidence.[11] Dr. Turner's statement that work activities, including repetitive movement, heavy lifting and reaching above the head, exacerbated appellant's shoulder condition, suggest that appellant experienced an occupational disease rather than traumatic injury.

On February 6, 2009 Dr. Pratt stated that on June 7, 2004 appellant was knocked down by a coworker and fell on her right side, "resulting in disability with a disabling condition, more probable than not caused by her employment." He provided examination findings and diagnosed cervicothoracic syndrome with right greater than left shoulder syndrome with impingement. Dr. Pratt's report is speculative and unsupported by rationalized medical evidence explaining the nature of the relationship between appellant's cervical condition and the accepted injury.[12] On July 20, 2010 Dr. Pratt opined that appellant had a right shoulder syndrome in direct relationship to vocationally-related activities, as well as cervicothoracic syndrome. Dr. Pratt did not sufficiently describe appellant's job duties or explain the medical process through which such duties would have been competent to cause the claimed shoulder condition. Medical conclusions unsupported by rationale are of little probative value.[13] Dr. Pratt did not provide findings on examination, or indicate that his opinion was based on a review of a complete factual and medical background. For these reasons, his report is of diminished probative value.

[10] *Ernest St. Pierre*, 51 ECAB 623 (2000).

[11] Section 8101(2) of FECA provides as follows: "(2) 'physician' includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law. The term 'physician' includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist and subject to regulation by the secretary." *See Merton J. Sills*, 39 ECAB 572, 575 (1988).

[12] *Leslie C. Moore*, *supra* note 9.

[13] *Willa M. Frazier*, 55 ECAB 379 (2004).

On July 28, 2010 Dr. Hermes stated that appellant's pain began as a result of the June 7, 2004 injury when she sustained trauma to her right shoulder and neck. She provided detailed examination findings and diagnosed chronic neck pain with underling disc degeneration, stenosis and secondary myofascial pain and right shoulder pain concerning for underlying RTC or joint pathology. On November 24, 2010 Dr. Hermes diagnosed chronic right shoulder pain with remote history of trauma and MRI scan findings concerning for labral tear with significant underlying degenerative joint disease and subdeltoid bursitis, right shoulder girdle myofascial pain secondary and cervical spondylosis with transient radiculitis. She related the results of a right shoulder MRI scan, which revealed a possible labral tear as well as degenerative changes of the humeral head, a significant amount of subdeltoid bursitis and arthritic changes to her right AC joint. Dr. Hermes did not explain, however, how the accepted June 7, 2004 incident could have been responsible for the myriad of diagnoses provided. Such an explanation is particularly important given the six-year lapse in time between the accepted injury and the dates of her reports. Absent a rationalized opinion on causal relationship, her reports are insufficient to establish appellant's claim.

On December 1, 2010 Dr. Nelson stated that appellant had experienced continuous pain in her right shoulder since falling on it at work on June 7, 2004. He provided examination findings and diagnosed right shoulder pain, likely due to arthrofibrosis/adhesive capsulitis and posterior labral tear with rotator cuff tendinosis. In an April 27, 2011 report, Dr. Nelson opined that appellant's June 7, 2004 injury would be causally related to her current condition "if [the fall] resulted in posterior subluxation of the humeral head and posterior labral tear." He went on to explain that her labral tear was likely due to some forced load humeral head posteriorly; AC joint arthritis was due to repetitive overhead activity and activity across the body and lifting a significant amount of weight; and repetitive work with arms coming in forward flexion would aggravate the outlet impingement, bursitis, and biceps pathology. Dr. Nelson's reports are speculative and unsupported by rationalized medical evidence explaining the nature of the relationship between appellant's shoulder condition and the accepted injury.[14] The mere fact that a condition manifests itself during a period of employment is insufficient to establish causal relationship.[15] Therefore, Dr. Nelsons reports are of limited probative value, and do not support appellant's claim to expand the scope of accepted conditions.[16]

Reports of MRI scans and x-rays, which do not contain an opinion as to the cause of appellant's condition, are of diminished probative value and are insufficient to establish appellant's claim.[17]

The Board finds that appellant has failed to meet her burden of proof to establish that the left shoulder conditions claimed are causally related to the accepted employment injury.[18] The

[14] *Leslie C. Moore*, *supra* note 9.

[15] *Id.*

[16] *Michael E. Smith*, 50 ECAB 313 (1999).

[17] *Id.*

[18] *Jaja K. Asaramo*, *supra* note 6.

fact that a condition is mentioned in a medical report along with other accepted conditions does not infer that it is related to the work injury. An award of compensation may not be based on surmise, conjecture, speculation, or upon appellant's own belief that there was a causal relationship between her claimed condition and her employment.[19] Accordingly, OWCP properly denied expansion of appellant's claim.

On appeal, counsel argues that the evidence establishes that appellant's shoulder condition was caused by the June 7, 2004 injury. For reasons stated, the Board finds that the evidence is insufficient to establish appellant's claim for a left shoulder condition. Counsel also contends the fact that OWCP paid medical bills related to the shoulder condition for over six years supports appellant's claim for expansion. The Board has held, however, that OWCP's gratuitous payment of a medical bill, without more, does not constitute formal acceptance of a claim for injury.[20]

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant failed to establish that her claim should be expanded to include a cervical condition due to the accepted employment injury.

[19] *Patricia J. Glenn*, 53 ECAB 159 (2001).

[20] *See M.C.*, Docket No. 12-64 (issued May 10, 2012); *Gary L. Whitmore*, 43 ECAB 441 (1993) (where the Board found that payment of compensation by OWCP does not in and of itself, constitute acceptance of a particular condition or disability in absence of evidence from OWCP indicating that a particular condition or disability has been accepted as work related).

ORDER

IT IS HEREBY ORDERED THAT the September 6, 2011 decision of the Office of Workers' Compensation Programs be affirmed.

Issued: July 23, 2012
Washington, DC

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board