

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

K.M., Appellant)	
)	
and)	Docket No. 18-0185
)	Issued: September 7, 2018
DEPARTMENT OF JUSTICE, FEDERAL)	
CORRECTION CENTER, Pollock, LA,)	
Employer)	
)	

Appearances:
Sara Kincaid, Esq., for the appellant¹
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On November 2, 2017 appellant, through counsel, filed a timely appeal from an August 24, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act² (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the claim.

¹ In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

² 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has met his burden of proof to establish a bilateral shoulder injury causally related to the accepted April 30, 2010 employment incident.

FACTUAL HISTORY

On July 29, 2010 appellant, then a 47-year-old correctional institution administrator, filed a traumatic injury claim (Form CA-1) alleging that on April 30, 2010 he sustained injury to his ribs when a prisoner who was fighting another inmate fell on top of him as he tried to separate the combatants. He listed the injury as bruise on left side of upper rib cage area. Appellant stopped work on May 3, 2010, but returned to work full-time regular duty on May 4, 2010. He retired in September 2012. Appellant submitted no evidence with his claim.

A Form CA-110 memorandum from OWCP's telephone records indicates that on January 23, 2014 appellant called and informed OWCP that he no longer worked for the employing establishment and that he recently had surgery on his shoulder. OWCP advised appellant to submit a claim for a recurrence (Form CA-2a) along with medical treatment records discussing his treatment since his original date of injury. It was noted that his April 30, 2010 claim had been administratively accepted.

Subsequently, on February 5, 2014, appellant filed a notice of recurrence of disability (Form CA-2a) of the claimed April 30, 2010 employment injury. He contended that the recurrence occurred on October 1, 2010 and that he stopped work on December 20, 2013. Appellant indicated that he returned to work on April 18, 2014. He stated that when taking a shower and raising his arm, it started to hurt. Appellant indicated that he had on and off difficulty with normal activities. He stated that he had no other issues before the assault in the prison.³

In a note from appellant received by OWCP on October 1, 2014, appellant related that he was currently recovering from right shoulder rotator cuff surgery. He claimed that he sustained an injury on April 3, 2010 during an inmate-on-inmate assault in which he had to place one of the inmates on the ground. Appellant related that in doing so, he fell on his right side with both of his arms around the inmate's upper torso. He noted that he could feel both of his shoulders shift. Appellant explained that he restrained the inmate and later reported to safety and went to the emergency room, where a physician diagnosed bursitis and gave him something for pain and inflammation. He alleged that he saw Dr. Joan Brunson, a Board-certified family practitioner, about a month later, and she referred him to Dr. Jeffrey L. Garrison, an orthopedic surgeon, who found no findings of a cuff tear, mild-to-moderate pattern of subacromial bursitis, mild-to-moderate acromioclavicular degenerative disease; and mass effect upon the cuff on the basis of acromial configuration.

³ In response to OWCP's instructions, appellant filed another Form CA-2a on April 15, 2014. He indicated that following the original injury he returned to unrestricted work activities. However normal activities became problematic and appellant's arm hurt when raised.

On October 1, 2014 appellant submitted multiple medical documents detailing his medical treatment starting October 1, 2001.

Medical reports covering dates prior to the alleged April 3, 2010 employment incident indicated that appellant was treated from October 16, 2001 to October 29, 2012 by Dr. Garrison for left rotator cuff tendinitis and impingement syndrome. Appellant's left shoulder was treated successfully with injections and physical therapy. Dr. Garrison noted that appellant sustained an injury to his left shoulder many years ago when he ran into someone during a football game.

Appellant submitted progress notes and other medical documents for the period after the alleged April 30, 2010 employment incident. In an April 25, 2011 report, Dr. Brunson noted that appellant presented with shoulder pain after working out.

In a May 24, 2011 report, Dr. Garrison described the history of the present illness. He noted that appellant was complaining of pain in his right shoulder that was present for approximately five to five and one-half months after an injury that occurred at work when he was taking down a prisoner, wrapped his arms around him, and ended up landing on his right shoulder. Dr. Garrison diagnosed right shoulder pain with bursal irritation and impingement and postinjury rotator cuff tendinitis.

In an October 29, 2012 radiology consultation report, Dr. Michael Dale Allen, a radiologist, listed his impressions of a magnetic resonance imaging (MRI) scan of appellant's left shoulder as no findings of cuff tear, mild-to-moderate pattern of subacromial degenerative disease, mild-to-moderate acromioclavicular degenerative disease, and mass effect upon the cuff.

An MRI scan of the right shoulder taken on January 16, 2013 was interpreted by Dr. Garrison as showing a complete tear of the rotator cuff without retraction.

In a January 24, 2013 progress note, Mark A. Carbo, a physician assistant, noted that appellant continued to have some discomfort in his right shoulder. He also noted that the MRI scan was consistent with a small focal full-thickness tear of the supraspinatus tendon along the insertion of the tuberosity.

In a January 25, 2013 report, Dr. Garrison diagnosed right shoulder rotator cuff tear, full thickness.

In a December 13, 2013 progress note, Mr. Carbo noted that appellant was two weeks post rotator cuff repair of the right shoulder with a superior labral tear from anterior to posterior (SLAP) repair. He noted that appellant had pain in his shoulder joint.

In a March 23, 2015 operative report received by OWCP on April 18, 2016, Dr. Garrison noted that he performed a diagnostic arthroscopic and debridement of degenerative superior labral tear, arthroscopic subacromial decompression, arthroscopic distal clavicle excision, and arthroscopic rotator cuff repair of appellant's left shoulder.

By development letter dated March 26, 2015, OWCP informed appellant that his initial claim had not been fully developed as it was treated as a minor injury with no time lost from work, and a payment for a limited amount of medical expenses was approved. It explained that a

determination must now be made as to whether he experienced an employment-related injury on April 30, 2010. OWCP afforded appellant 30 days to submit the requested information.

In a response dated April 23, 2015, appellant described his medical treatment since the alleged April 30, 2010 employment incident.

In an April 23, 2015 report, Dr. Garrison noted that appellant originally presented to his office on May 24, 2011 with complaints of right shoulder pain, which started following an incident at work when he was taking down a prisoner. He noted that appellant originally went to an emergency department where an x-ray was found to be negative. Appellant was then seen by his personal physician and referred to his office. He noted that based on his findings on examination, he suspected a possible rotator cuff injury or SLAP-type injury. Appellant returned to Dr. Garrison's office on August 9, 2011 with complaints of bilateral shoulder pain. He noted that he had no injuries since the original incident at prison. Dr. Garrison continued to treat appellant with Cortisone injections administered in bilateral shoulders. Appellant continued to have pain despite conservative treatment, so an MRI scan was ordered, and the result showed a complete tear of the rotator cuff of the right shoulder. Surgery was recommended on appellant's return visit on January 24, 2013. Appellant underwent surgery on the right shoulder for rotator cuff repair on December 20, 2013, and was released to regular duty on April 15, 2014. However, he returned on December 23, 2014 complaining of left shoulder pain. On February 17, 2015 an MRI scan was ordered, which showed a full-thickness tear. Appellant had surgery for rotator cuff repair on March 23, 2015. In an April 23, 2015 report, Dr. Garrison related that appellant had no issues with shoulder pain prior to the incident at work in 2010 when he had to take down a prisoner during an altercation. He noted that appellant was treated at his office shortly after that incident. Dr. Garrison opined that the incident that occurred at appellant's place of employment in 2010 could definitely have caused appellant's injuries.

By decision dated September 21, 2015, OWCP denied appellant's claim. It determined that appellant had not met the requirements for establishing fact of injury as he had not established that an incident occurred at the time, place, and in the manner alleged.

On April 18, 2016 appellant submitted further documentation to OWCP.

In a May 24, 2011 report, Dr. Garrison noted his impressions as right shoulder pain with bursal intrusion and impingement and rotator cuff tendinosis status post injury. He gave appellant an injection. In a December 12, 2013 report, received by OWCP on April 18, 2016, Dr. Garrison noted that appellant continued to have a fairly disabling right shoulder pain and some persistent complaints of aching-type pain in the left shoulder. He opined that appellant had impingement and acromioclavicular joint arthritis in the left shoulder, but no rotator cuff tear on that side, and a complete rupture of the rotator cuff. In a December 23, 2013 operative report, Dr. Garrison noted that he performed a diagnostic arthroscopy and arthroscopic superior labral repair from anterior to posterior and arthroscopic rotator cuff repair along with decompression and distal clavicle excision. On January 29, 2016 he performed a diagnostic arthroscopy and revision rotator cuff repair, left shoulder.

On September 9, 2016 appellant, through counsel, requested reconsideration.

In an August 23, 2016 report, Dr. John Ellis, a Board-certified family practitioner, described appellant's history of injury. He noted that on April 30, 2010 while working for the employing establishment, he injured both shoulders when he grabbed one inmate involved in a fight, and that as he was taking him down, both arms hit the ground with the inmate. Dr. Ellis related that appellant had immediate pain in both shoulders, by that evening he had pain in his neck and both shoulder joints, and the next day the pain was worse. He reviewed appellant's medical history. Dr. Ellis noted that appellant still had pain in both shoulder joints, and tightness between his shoulders and the base of his neck. He also noted headaches in the back of his neck, tingling in his arms, and weakness in his shoulders. Dr. Ellis reviewed appellant's medical history and conducted a physical examination. He diagnosed right shoulder rotator cuff tear right shoulder superior labral tear, right shoulder acromioclavicular joint arthritis, right shoulder impingement syndrome, right brachial plexus impingement, left shoulder rotator cuff tear, left shoulder impingement syndrome, left shoulder acromioclavicular joint arthritis, left shoulder superior labral tear from anterior to posterior, muscle tendon unit strain of the cervical spine, and left brachial plexus impingement. Dr. Ellis opined that, based upon his examination of appellant, review of the medical and other records, and this training, education, and experience, and upon reasonable medical certainty, that it was more probable than not that the injuries, impairments, and disabilities set forth in his diagnosis, findings and impairments arose out of the course of appellant's employment and that employment factors and work duties contributed to, aggravated, and/or caused this employee's injuries, disability, and impairment. He noted that, while appellant was holding the inmate with both arms and struggling and as he fell forward with the inmate under him, he jarred both arms causing the elbows to jam up into his shoulders causing an acute separation of the labrum in both shoulders as well as tearing the tendons in the shoulders and rotator cuff. With the fall, he also strained his neck, which is not so severe. With the continued tightness of the shoulder girdle muscles, the strain of his neck has not healed. He restrains it easily with just the activities of daily living due to the tightness of the shoulder girdle muscles and ligaments. The tightness of the shoulder girdle muscles and ligaments is causing mild brachial plexus impingement, but not thoracic outlet syndrome. Dr. Ellis continued that this claim was easy to understand in that appellant fell and jerked the tendons in his shoulder and the labrum which is the cartilage that attaches to the bone of the shoulder joints. He noted that the tight muscles in the shoulder girdle area were causing brachial plexus impingement. Dr. Ellis indicated that at this time appellant did not need any work restrictions as he had learned to be careful with his shoulders. He opined that appellant was temporarily totally disabled as a result of this injury due to the required surgery.

By decision dated October 26, 2016, OWCP found that appellant had established fact of injury, but denied the claim as he had not established that the accepted employment incident caused the diagnosed conditions.

On April 20, 2017 appellant requested reconsideration. Counsel submitted a supporting brief contending that appellant clearly explained why he did not immediately obtain medical care, that appellant only needed to establish that the employment incident contributed in some manner to the disabling condition, and that the report of Dr. Ellis was sufficient to meet appellant's burden of proof to establish entitlement to compensation or to require further development of the evidence. She contended that Dr. Ellis's medical narrative, the May 10, 2010 emergency department records, and appellant's statement made it abundantly clear that appellant was experiencing symptoms from, and seeking medical treatment for, his diagnosed injuries from the accepted incident.

Counsel further contended that Dr. Ellis' narrative report provided an extensive and rationalized explanation of the causal relationship between appellant's work injury and his diagnosed condition. She concluded by noting that proceedings under FECA were not adversarial.

In a statement dated April 20, 2017, appellant related that, after the initial injury, he waited several days before going to the emergency room as he believed that his symptoms were not severe, but they worsened, and he believed he may have internal injuries. He noted that he then saw a physician in the emergency room and his primary physician. Appellant noted that his primary physician referred him to Dr. Garrison.

Appellant submitted notes indicating that he was treated at Rapides Regional Medical Center on May 10, 2010. He told the attendant that he was involved in a takedown of a prisoner a week prior and still had moderate pain in his heart and chest. Appellant also complained of right rib pain.

In a March 2, 2017 report, Dr. Ellis repeated the findings from his August 23, 2016 report. In addition, he noted that appellant's original injury of April 30, 2010 consisted of the chest and anterior shoulder and severe straining of the sternocleidomastoid junction, the shoulders AC joints, and the muscles and ligaments that attach to the shoulders. Dr. Ellis indicated that appellant was up in the air, came down with the inmate, and landed on his right shoulder, and that this would have caused the right shoulder joint to jam into the sternoclavicular junction of the shoulder, straining the left shoulder muscles and tearing the ligaments in the left shoulder. He related that by appellant having his left arm up abducted at about 90 degrees and then holding the prisoner's left hand with his left hand because the prisoner had a knife meant that the entire left upper arm was extremely tight when he fell so when the jerking motion of the inmate pulled on his left shoulder, it pulled not only the left shoulder joint muscles and ligaments, but also the sternoclavicular joint in the left shoulder. Dr. Ellis reported that this injury caused pain in the sternoclavicular joint of both shoulders and is indicative of severe, acute straining of the shoulders. He noted that, when appellant fell, he contused his right anterior deltoid muscle, right rib cage, and right anterior chest area, and these muscles and ligaments attach to the right shoulder. Dr. Ellis noted that appellant had a bruise that gradually got better. He related that appellant still had so much pain that he went to the emergency room on May 10, 2010, which was indicative that he suffered much more than simple contusion, but also had suffered significant straining of the muscles and ligaments in his shoulder. Once appellant suffered the severe injury to his shoulders on April 30, 2010, the activities of daily living would cause continued micro tearing of the muscles and ligaments of the shoulders and labrum of the shoulders. Dr. Ellis opined that the labral tear was not a cumulative trauma injury. He noted that appellant was unable to find a doctor that would treat him, so he treated himself with medications until his symptoms became so severe that he started seeking treatment. Dr. Ellis also noted that there was nothing more that appellant could do after the original injury until his condition became so severe that it warranted injections and surgeries to his shoulders.

By decision dated August 24, 2017, OWCP denied modification of the October 26, 2016 decision. It determined that the evidence presented was not of sufficient probative value to alter the decision dated October 26, 2016. OWCP noted that the report of Dr. Ellis was not probative as it was not contemporaneous with the incident and was equivocal as he did not specify how the incident caused the diagnosed conditions.

LEGAL PRECEDENT

A claimant seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim by the weight of the reliable, probative, and substantial evidence, including that an injury was sustained in the performance of duty as alleged and that any specific condition or disability claimed is causally related to the employment injury.⁴

To determine if an employee sustained a traumatic injury in the performance of duty, OWCP begins with an analysis of whether the fact of injury has been established. Generally, fact of injury consists of two components that must be considered in conjunction with one another. The first component is whether the employee actually experienced the employment incident that allegedly occurred.⁵ The second component is whether the employment incident caused a personal injury.⁶ An employee may establish that an injury occurred in the performance of duty as alleged, but fail to establish that the disability or specific condition for which compensation is being claimed is causally related to the injury.⁷

ANALYSIS

The Board finds that appellant failed to submit sufficient evidence to establish that he suffered an injury to either shoulder caused or aggravated by the employment incident of April 30, 2010.

The evidence indicates that appellant had issues with his left shoulder prior to the accepted April 30, 2010 employment incident. In medical reports dated October 16 and November 15, 2001, Dr. Garrison noted that he treated appellant for left shoulder rotator cuff tendinitis impingement syndrome. He also noted that appellant had prior injuries to his left shoulder many years ago when he ran into someone during a football game.

The first medical report of a shoulder injury after the April 30, 2010 employment incident is in an April 25, 2011 report wherein Dr. Brunson noted that appellant had shoulder pain. Dr. Brunson did not indicate that appellant had a diagnosed medical condition causally related to his federal employment incident. In fact, he did not address appellant's employment at all and only noted that he had pain in his shoulder after working out. The Board has found that medical

⁴ S.S., Docket No. 16-1760 (issued January 23, 2018).

⁵ *Elaine Pendleton*, 40 ECAB 1143 (1989).

⁶ *John J. Carlone*, 41 ECAB 354 (1989). Causal relationship is a medical question that generally requires rationalized medical opinion evidence to resolve the issue. *Robert G. Morris*, 48 ECAB 238 (1996). A physician's opinion on whether there is a causal relationship between the diagnosed condition and the implicated employment factor(s) must be based on a complete factual and medical background. *Victor J. Woodhams*, 41 ECAB 345, 352 (1989). Additionally, the physician's opinion must be expressed in terms of a reasonable degree of medical certainty, and must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factor(s). *Id.*

⁷ *Shirley Temple*, 48 ECAB 404, 407 (1997).

evidence which fails to offer an opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.⁸

Dr. Garrison noted in a May 24, 2011 report that appellant had residual pain from his shoulder that had been ongoing for about five to five and one-half months after an injury occurred at the prison as he was taking down a prisoner. He noted that appellant's history was significant for prior left shoulder rotator cuff repair. Dr. Garrison diagnosed appellant with right shoulder pain and bursal irritation and impingement and rotator cuff tendinitis, status post injury. He noted that appellant may have some irritation within the shoulder itself, but he feared that he may have an underlying cuff injury or a SLAP-type injury to the shoulder. On December 12, 2013 Dr. Garrison conducted a diagnostic arthroscopy and arthroscopic superior labral repair from anterior to posterior and arthroscopic rotator cuff repair along with decompression and distal clavicle excision on appellant's right shoulder. On April 30, 2015 he noted that appellant reported no issues with shoulder pain prior to the 2010 employment incident that occurred when he had to take down a prisoner during an altercation. Dr. Garrison noted that appellant was treated by his office shortly after that incident. He opined that appellant's incident in 2010 could have definitely caused his injuries. On April 18, 2016 Dr. Garrison performed a diagnostic arthroscopic and debridement of degenerative superior labral tear, arthroscopic subacromial decompression, arthroscopic distal clavicle excision and arthroscopic rotator cuff repair of appellant's left shoulder. The Board finds that Dr. Garrison's opinions are insufficient to establish causal relationship. Initially, the Board notes that Dr. Garrison indicated in his May 24, 2011 report that appellant has had residual pain from his shoulder for about five and one-half months following a takedown of a prisoner. As the employment incident occurred on April 30, 2010, the incident actually occurred over one year prior to his report. In addition, Dr. Garrison noted in his April 23, 2015 report that appellant had no issues with shoulder pain prior to the incident in 2010. However, this is contradicted by Dr. Garrison's own reports, he treated appellant from October 16, 2001 to October 29, 2012 for left rotator cuff tendinitis and impingement syndrome. Dr. Garrison also noted that appellant sustained an injury to his left shoulder many years ago during a football game. The Board has held that a claimant must submit a rationalized medical opinion based on a complete and accurate factual and medical history.⁹ Furthermore, Dr. Garrison concluded that appellant's incident in 2010 "could definitely have caused" his injuries. The Board finds that his opinion is speculative in nature.¹⁰

The Board also finds that the opinion of Dr. Ellis is insufficient to establish causal relationship or warrant further medical development by OWCP. Dr. Ellis first saw appellant on August 23, 2016, over six years after the April 30, 2010 employment incident. He provided a complete description as to how the employment incident occurred, discussed appellant's medical history, and conducted a physical examination. Dr. Ellis diagnosed multiple bilateral shoulder conditions including right shoulder rotator cuff tear, right shoulder superior labral tear, right shoulder acromioclavicular joint arthritis, right shoulder impingement syndrome, right brachial plexus impingement, left shoulder rotator cuff tear, left shoulder impingement syndrome, left

⁸ See *C.D.*, Docket No. 17-1713 (issued February 1, 2018).

⁹ *S.H.*, Docket No. 16-0114 (issued February 24, 2016).

¹⁰ *C.S.*, Docket No. 16-1784 (issued May 7, 2018).

shoulder acromioclavicular joint arthritis, left shoulder superior labral tear from anterior to posterior, muscle tendon unit strain of the cervical spine, and left brachial plexus impingement. He concluded that appellant's conditions were all causally related to the employment incident and noted that appellant jerked the tendons in his shoulder and labrum when he fell. However, Dr. Ellis did not explain with medical rationale how physiologically appellant's fall and shoulder jerk would have caused any of the diagnosed conditions. Without explaining how, physiologically, the movements involved in the employment incident caused or contributed to the diagnosed condition, his opinion on causal relationship is equivocal in nature and of limited probative value.¹¹ Furthermore, Dr. Ellis' report lacks bridging evidence from the accepted incident to his diagnoses.¹² The Board also notes that he did not evince that he was aware of appellant's prior issues with his left shoulder, which therefore further diminishes the probative value of his opinion. Accordingly, Dr. Ellis' opinion is insufficient to establish causal relationship.

The diagnostic studies of Dr. Allen and Dr. Taylor are of diminished value. Diagnostic test reports are not probative to the issue of causal relationship as they do not offer any opinion regarding the cause of an employee's condition.¹³

The Board also notes that the opinions of Mr. Carbo, a physician assistant, failed to establish appellant's claim because evidence from a physician assistant does not constitute medical evidence under FECA as he is not considered to be a physician as defined under section 8102(2) of FECA.¹⁴

As the evidence does not establish that appellant sustained a medically diagnosed condition causally related to the accepted employment incident, he has failed to meet his burden of proof to establish entitlement to benefits.

On appeal counsel for appellant contends that the medical evidence established causal relationship. In support thereof, she quotes large portions from the reports of Dr. Ellis. Counsel also contended that the reports of Dr. Ellis were at least sufficient to require further development of the evidence. However, for the reasons previously provided, the Board finds that the reports of Dr. Ellis are insufficient to establish causal relationship, nor are they sufficient to require further development of the medical evidence.

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.

¹¹ See *L.B.*, Docket No. 17-1600 (issued March 9, 2018).

¹² See *P.J.*, Docket No. 17-0722 (issued August 1, 2017).

¹³ *J.O.*, Docket No. 18-0057 (issued May 29, 2018).

¹⁴ 5 U.S.C. § 8101(2) provides that a physician includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by state law. *V.C.*, Docket No. 16-0542 (issued April 19, 2016); *Allen C. Hundley*, 53 ECAB 551, 554 (2002) (physician assistant).

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish a bilateral shoulder injury causally related to the accepted April 30, 2010 employment incident.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated August 24, 2017 is affirmed.

Issued: September 7, 2018
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

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