January 16, 2001

Office of the City Clerk
Milwaukee, Wisconsin

To Whom It May Concern:

On September 21, 2000, at approximately 4 p.m., on the sidewalk in front of 411 East Wisconsin Avenue, I fail and broke my right wrist, broke my right arm and injured my left knee. I was running to catch a city bus when I ran into (city apparatus used when repairing streets and sidewalks) left on the sidewalk.

With the help of two gentlemen I was helped up and placed in a cab. I asked the driver to take me to my home at which time I was transported immediately to St. Joseph's Hospital by my daughter and had emergency surgery on my right wrist.

- Dr. Carl F. Moyer, Covenant Medical Group, PO Box 689711, Milwaukee, WI 53268-9711 – Surgeon.
- St. Joseph's Hospital, 5000 W. Chambers, Milwaukee, WI

In discussions with the Security staff and insurance representative from the 411 Building they determined that the City, because of an event occurring that weekend, placed the apparatus on the sidewalk. I did speak with several departments with the City (i.e., Water and Sewerage, Street Maintenance, and Sanitation Department); they found no record of placing the apparatus at that time.

At this time I am formally submitting a claim to the City of Milwaukee for reimbursement of loss of wages (approximately $10,000 to-date), and pain and suffering in the amount of $40,000 – this amount includes future earnings potential. Totals **$50,000**.

Enclosed you will find a copy of the doctor's statement, medical bills*, and any other material that may substantiate my claim. I am still receiving medical care for this fall.

Also, as a result of this fall, my employer took the opportunity to terminate my employment without cause because of the Company Leave of Absence Policy – which gives the Company the right to terminate an employee if they have not been employed for a year with the company due to medical problems. I was a personal service administrator earning $23,000 annually.

If you need any additional information to substantiate my claim, please contact me at:

Loretta Haynes-Jordan
1823 N. 53rd Street
Milwaukee, WI 53208
Home no. 414/443-1727

* Medical expenses have been paid for by the employer's insurance (approximately $10,000). Enclosed are just a few of the medical bills received but will help prove that this accident did occur.

Thanks

Loretta Haynes Jordan

Phone: 1-800-379-1517
FAX: 1-800-793-1610

Short Term Disability
Employee's Application for Benefits

Employer: ~~Loretta Haynes-Jordan~~ American Appraisal Assoc.

Full Name: Haynes Jordan (Last) Loretta (First) (Middle) Social Security Number: 273-46-2056

Residence: 1823 N. 53rd St. (Street Address) Milwaukee (City) WI (State/Province) 53208 (Zip Code)

Date of Birth: 11,02,46 ☒ Female ☐ Male ☐ Left-handed ☒ Right-handed

Home Telephone: (414) 443-1727 Work Telephone: (414) 271-7240

Occupation: personal service adm. I Describe your job duties: clerical

Is your condition related to your occupation? ☐ Yes ☐ No If Yes, explain:

If Yes, have you filed a claim for Workers' Compensation? ☐ Yes ☐ No If Yes, date applied: / /

Have you returned to work: ☐ Yes Part Time on / / Full Time on / / ☐ No

If you haven't returned to work, do you expect to? ☒ Yes Part Time on / / Full Time on / / ☐ No

Please provide the name, specialty, address and telephone number of your doctor. Include dates of treatment as indicated.

Name and Specialty	Full Address	Telephone Number	Treated From	To
Carl Moyer, MD	12011 W North Ave, Wauwatosa	771-8228		

Is this the only doctor you are seeing for treatment and care? ☒ Yes ☐ No If No, attach a list of all other doctors' names, addresses, telephone numbers and specialties.

IF YOUR CLAIM IS FOR PREGNANCY, PLEASE PROVIDE THE FOLLOWING: Date first treated: / /

Expected or Actual Delivery Date: / / Type of delivery: ☐ Vaginal ☐ C-Section . . . Date Scheduled: / /

Last day worked: / / Expected or Actual return to work date: / /

IF AN ILLNESS, what is the nature of your condition?

When did you first notice symptoms? / /

IF AN INJURY, date of injury: 09,21,00 Where did injury occur? ☐ Home ☑ Work ☐ Other

How did the injury occur? fell on sidewalk At what time of day? ☐ AM ☒ PM

Date first treated for this condition by a physician: 09,21,00 Last day worked: 09,21,00 Do you have a pending lawsuit for this injury? ☐ Yes ☒ No

If you were hospitalized or received emergency room treatment, please complete the following:

Name of Hospital: St. Joseph's Telephone number: ( )

Complete address: 5000 W. Chambers St.

Date admitted: 09,21,00 Date discharged: 09,22,00 Date of emergency room treatment: 09,21,00

Have you been treated for this or a similar condition in the past? ☐ Yes ☒ No If Yes, when? / /

Has your doctor advised you to restrict your activities in any way? ☒ Yes ☐ No Explain: two broken arms, scarred left knee, taken to surgery on 09-21-00

I hereby certify that the answers I have provided on this form are full, complete and true.

X Loretta Haynes-Jordan Signature 10-04-00 Date

By NDM

Be sure to read and sign the *Authorization & Agreements* on the other side of this form.

FOR SELF-INSURED PROGRAMS/PORTLAND

1581-95 (9/96)

Phone: 1-800-379-1517
FAX: 1-800-793-1610

Short Term Disability
Attending Physician's Statement

Employer: American Appraisal Assoc.

Patient's Name: Jordan, Loretta
Last First Middle

Social Security Number: 274-46-2056

Height 170 Weight 5' 5 1/2 lbs.

Primary Diagnosis: Fracture Right Distal Radius + ulna — 813.83 — ICD-9 code — DSM-III-R code

Secondary Diagnosis: Fracture Left Radial Head — 813.05 — ICD-9 code — DSM-III-R code

☐ **Pregnancy** Date of LMP: / / Date first treated / / Delivery date: / / ☐ Actual ☐ Estimated

If Actual delivery date, type of delivery:
Has patient been released from your care? ☐ Yes ☐ No If no, estimated date of release: / /

☒ **Illness/Injury/Pregnancy Complications** Objective findings: Tenderness + deformity R wrist

Complications:

Subjective Symptoms: Pain Right Wrist + Left Elbow

Has this patient ever had the same or similar condition: ☐ Yes ☒ No If YES, what year(s):

Describe:

Date symptoms first appeared (or date of accident) 9/21/2000 Is the patient still under your care for this condition? ☑ Yes ☐ No

Dates of treatment: FIRST 9/21/2000 Next appointment date: 10/12/00

Has the patient undergone surgery? ☑ Yes ☐ No If yes, provide date, procedure and result: 9/21/00

CPT-4 code: Closed Reduction + Percutaneous Pinning of Rt Colles' Fx

If No, do you expect surgery to be performed in the future? ☐ Yes ☐ No If yes, provide date & type: / /

Medication, frequency and dosage:

Other types of treatment and frequency: Cast changes, pin removal

Date first unable to work: 9/21/00

Is condition due to injury/sickness arising out of patients employment? ☐ Yes ☑ No

Patient Status: ☐ Recovered ☑ Improved ☐ Unchanged ☐ Retrogressed
Patient is: ☑ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospitalized – From 9/21/00 To 9/22/00

What is your prognosis? favorable When will patient recover:

Please describe any restrictions (what your patient SHOULD NOT do): Not to use R arm. No lifting or pushing with R arm

Please describe any limitations (what your patient CANNOT do): move R elbow or wrist (in in a cast)

Please describe any physical and/or mental impairments: Rt arm is immobilized in a long arm cast

Do you believe your patient is competent to endorse checks and direct the use of the proceeds? ☑ Yes ☐ No

Has the patient been released from your care? ☐ Yes ☑ No
If No, estimated date of release: 12/21/00

Carl F Mayer	MD	☑ Yes ☐ No	(414) 771 8228	(414) 256 1909
Name of Attending Physician	Degree/Specialty	Board Certified	Telephone No.	Facsimile No.
12011 W North Ave	Wauwatosa		Wis	53226
Street Address	City		State	Zip Code
X Carl F Mayer		10/2/00		
Original Signature		Date		Tax ID No.

FOR SELF-INSURED PROGRAMS/PORTLAND

1581-95 (9/96)

St Joseph's
HOSPITAL · MILWAUKEE
5000 West Chambers Street
Milwaukee, WI 53210

COMMUNICATION
MEMORANDUM

DATE: 10/2/00

TO:

FROM: Dr Moyer

RE: Loretta Jordan

COMMUNICATION:

Mr Jordan should remain off work thru 10/23/00.

Carl E Moyer MD

RESPONSE:

☑ FYI - No response necessary ☐ Respond by: _____

☐ Review w/me by: _____

WHITE - ORIGINATOR YELLOW - RESPONDER PINK - ORIGINATOR
(SEE DISTRIBUTION INSTRUCTIONS ON REVERSE SIDE)

FORM 20566 REV. 6/94

Memo

To: Gail Reimer
From: Loretta Haynes-Jordan
Date: October 4, 2000
Subject: Leave of Absence

Please accept this memorandum as my request for a leave of absence from American Appraisal.

As you are aware, I experienced a fall on Thursday, September 21, 2000. In that fall I broke my right wrist and required emergency surgery on that same evening. I also sustained a fracture in my left arm which did not require surgery.

At this time I am unable to perform work of any kind. I am attaching my doctor's statement indicating that I am unable to return to work at least through October 23, 2000. Hopefully I can return to work on a part time basis at that time. I have been told that after the cast is removed from my right arm I will require physical therapy treatments.

At this time my doctor has said that my estimated date of release will be December 21, 2000. I will keep you informed of my progress with each doctor's appointment.

I am asking that you hold my position open for me for an indefinite period of time while I recover from this accident.

Thank you
Loretta Haynes Jordan
By (NSM)

COVENANT MEDICAL GROUP-HAR
P O BOX 689711
MILWAUKEE, WI 53268-9711

ADDRESS SERVICE REQUESTED

STATEMENT

STATEMENT DATE	ACCOUNT NUMBER	TOTAL DUE
11/29/00	123057	1,524.00

PLEASE LIST PAYMENTS

VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS ACCEPTED. PLEASE CHECK BOX AND COMPLETE INFORMATION ON REVERSE SIDE

☐ VISA ☐ MasterCard ☐ DISCOVER NOVUS ☐ American Express

INVOICE NO.	AMOUNT
AMOUNT ENCLOSED	

LORETTA JORDAN
1823 N 53RD ST
MILWAUKEE, WI 53208-1759

COVENANT MEDICAL GROUP-HAR
P O BOX 689711
MILWAUKEE, WI 53268-9711

IF ADDING CHANGE OF ADDRESS OR INSURANCE INFORMATION ON REVERSE, PLEASE CHECK BOX ☐
RETURN THIS PORTION WITH YOUR PAYMENT. RETAIN LOWER PORTION FOR YOUR TAXES.

DATE OF SERVICE	PATIENT NAME	INVOICE NUMBER / DESCRIPTION	SERVICES PROVIDED BY	AMOUNT	INVOICE BALANCE
09/21/00	LORETTA	INV#: 932320	DR MOYER		
09/21/00		HOSPITAL ADMIT; MOD (PRE-SURG)		190.00	
09/21/00		TREAT; FOREARM FRACT-DEVICE		1,105.00	
					1,295.00
10/16/00	LORETTA	INV#: 952333	DR MOYER		
10/16/00		APPLY; LONG ARM CAST		119.00	
10/16/00		POST-OP VISIT		0.00	
					119.00
10/26/00	LORETTA	INV#: 952334	DR MOYER		
10/26/00		APPLY; SHORT ARM CAST		110.00	
10/26/00		POST-OP VISIT		0.00	
					110.00
10/02/00	LORETTA	INV#: 952335	DR MOYER		
10/02/00		POST-OP VISIT		0.00	
					0.00

BILLING INQUIRIES CALL (414) 527-8689
OR 1-888-414-2509, MONDAY-FRIDAY 8:00 AM-4:30 PM
STATEMENTS MAY NOT REFLECT ALL PAYMENTS THAT HAVE BEEN RECEIVED.

BOPS 100 (6/98)

PLEASE PAY THIS AMOUNT ➡ 1,524.00

1957 01/01 R252-191

(PLEASE SEE REVERSE SIDE FOR ADDITIONAL INFORMATION)

WPS HEALTH INSURANCE

Wisconsin Physicians Service Insurance Corporation
1717 W. Broadway—Box 8190—Madison, WI 53708

EXPLANATION OF BENEFITS

THIS IS NOT A BILL - SAVE FOR YOUR RECORDS
IMPORTANT INFORMATION ON REVERSE SIDE

QUESTIONS? CALL 1-888-915-5619 OR
608-221-5665 OR WRITE WPS AT,
P.O. BOX 8688
MADISON, WI 53708-8688

LORETTA HAYNESJORDAN
1823 N 53RD ST
MILWAUKEE, WI 53208-1759

CUSTOMER NO.	GROUP NO.	DIVISION NO.
274462056	143275	00001
GROUP : AMERICAN APPRAISAL ASSOC		
PATIENT : LORETTA HAYNESJORDAN		
CUSTOMER : LORETTA HAYNESJORDAN		
DATE PRINTED	10/24/2000	

ON 10/24/2000, WE PROCESSED $5,432.15 IN CHARGES FOR LORETTA HAYNESJORDAN
PLEASE READ BELOW TO SEE HOW YOUR BENEFITS WERE APPLIED.

PROVIDER ——> ST JOSEPHS HOSP CLAIM # 027863085 PATIENT ACCOUNT: 703097351

TYPE OF SERVICE	DATE(S) OF SERVICE	CHARGED AMOUNT	PROVIDER DISCOUNT	INELIGIBLE AMOUNT	REASON CODE	COPAY	DEDUCTIBLE	REMAINING AMOUNT	COIN-SURANCE	PAID AT %	AMOUNT PAID
360 OP ROOM	09-21-00 09-22-00	2146.00	751.10	0.00	HN	0.00	0.00	1394.90	0.00	100	1394.90
320 XRAY	09-21-00 09-22-00	783.00	274.05	0.00	HN	0.00	0.00	508.95	0.00	100	508.95
370 ANESTH	09-21-00 09-22-00	593.00	207.55	0.00	HN	0.00	0.00	385.45	0.00	100	385.45
121 HSP ROOM	09-21-00 09-22-00	490.00	171.50	0.00	HN	0.00	0.00	318.50	0.00	100	318.50
710 ROOM	09-21-00 09-22-00	421.75	147.61	0.00	HN	0.00	0.00	274.14	0.00	100	274.14
450 EMERG	09-21-00 09-22-00	405.00	141.75	0.00	HN	0.00	0.00	263.25	0.00	100	263.25
251 DRUGS	09-21-00 09-22-00	306.60	107.31	0.00	HN	0.00	0.00	199.29	0.00	100	199.29
278 HSP MISC	09-21-00 09-22-00	154.75	54.16	0.00	HN	0.00	0.00	100.59	0.00	100	100.59
730 LAB	09-21-00 09-22-00	82.25	28.79	0.00	HN	0.00	0.00	53.46	0.00	100	53.46
300 LAB	09-21-00 09-22-00	38.00	13.30	0.00	HN	0.00	0.00	24.70	0.00	100	24.70
250 DRUGS	09-21-00 09-22-00	11.80	4.13	0.00	HN	0.00	0.00	7.67	0.00	100	7.67
			PAYMENT TO PROVIDER ON 10-24-00								
CLAIM TOTALS		5432.15	1901.25	0.00		0.00	0.00	3530.90	0.00		3530.90

SUMMARY	5432.15	1901.25	0.00	0.00	0.00	3530.90	0.00	3530.90