U. S. DEPARTMENT OF LABOR

OFFICE OF WORKERS' COMPENSATION PROGRAMS
DIVISION OF ENERGY EMPLOYEES OCCUPATIONAL
ILLNESS COMPENSATION
FINAL ADJUDICATION BRANCH

APR - 7 2011

RECEIVED
4.12.11
Amanda G Stevens

Gary S. Vander Boegh
Commonwealth Environmental Services, LLC
4645 Village Square Drive, Suite F
Paducah, KY 42001

Dear Mr. Vander Boegh:

Enclosed please find a Final Decision on the claim of Don C. Vander Boegh for compensation under the Energy Employees Occupational Illness Compensation Program Act. 42 U.S.C. § 7384 *et seq.* His claim has been approved for $142,500.00 for a 57% whole person impairment due to his covered illnesses of peripheral neuropathy and hearing loss. I have enclosed a copy of his cover letter along with his final decision.

Please note that the representative is limited to a fee of 2% of the amount of lump-sum compensation awarded for the filing of an initial claim; and an additional 10% of the difference between the amount of potential lump-sum compensation listed in the recommended decision and the amount actually awarded in the final decision with respect to any objections to a recommended decision. *See* 20 C.F.R. § 30.603(b) (2010).

Any future correspondence, inquiries, or telephone calls should be directed to the Jacksonville district office. Thank you for your cooperation.

Sincerely,

Carolina R. Betts

Carolina R. Betts
Hearing Representative

U. S. DEPARTMENT OF LABOR

OFFICE OF WORKERS' COMPENSATION PROGRAMS
DIVISION OF ENERGY EMPLOYEES OCCUPATIONAL
ILLNESS COMPENSATION
FINAL ADJUDICATION BRANCH

APR - 7 2011

Don C. Vander Boegh
[redacted] Avenue
Paducah, KY 42001

Dear Mr. Vander Boegh:

Enclosed please find a Final Decision on your claim for compensation under the Energy Employees Occupational Illness Compensation Program Act. 42 U.S.C. § 7384 *et seq.* Your claim has been approved for $142,500.00 for a 57% whole person impairment due to your covered illnesses of peripheral neuropathy and hearing loss. Please wait two years before filing any further claims for an increase in impairment percentage for the accepted condition. A copy of this decision has been sent to your authorized representative.

In addition, I have enclosed the Acceptance of Payment form (EN-20), which is required before the Office of Workers' Compensation Programs can issue payment to you. You must complete the form in permanent ink and there can be no cross outs or other marks. **Do not use** white out or correction tape. Any alteration of the form will result in it being rendered unusable for purposes of issuing payment. If you make a mistake or need another form, please contact the district office handling your claim. You must submit the form with an original signature. The DEEOIC can not accept faxes or other copied versions of the EN-20. Please check with your financial institution before returning the form to us to verify **the routing number** and **your account number** so that your money arrives promptly and to the correct account.

Please mail the completed and signed original EN-20 to:

US Department of Labor, DEEOIC
Charles E. Bennett Federal Building
400 West Bay Street, Suite 722
Jacksonville, FL 32202

State Workers' Compensation and Tort Actions: If you receive or have received any money (settlement, compensation benefits, etc.) from a state workers' compensation program or related to a tort action (law suit) for the same condition(s) being accepted in this decision, you must notify the district office immediately. This includes any monies received after the issuance of this final decision.

Please be advised that the final decision on your claim may be posted on the agency's website if it contains significant findings of fact or conclusions of law that might be of interest to the public. If it is posted, your final decision will not contain your file number, nor will it identify you by name.

Please note that the representative is limited to a fee of 2% of the amount of lump-sum compensation awarded for the filing of an initial claim; and an additional 10% of the difference between the amount of potential lump-sum compensation listed in the recommended decision and the amount actually awarded in the final decision with respect to any objections to a recommended decision. *See* 20 C.F.R. § 30.603(b) (2010).

A new claim form may be filed with the district office for any conditions you consider related to toxic exposures during employment at a Department of Energy covered facility. Any claim filed will be evaluated and/or developed for compensability under the Act.

Any future correspondence, inquiries, or telephone calls should be directed to the Jacksonville district office. Thank you for your cooperation.

Sincerely,

Carolina R. Betts
Hearing Representative

cc:

Gary S. Vander Boegh
Commonwealth Environmental Services, LLC
4645 Village Square Drive, Suite F
Paducah, KY 42001

U.S. DEPARTMENT OF LABOR

OFFICE OF WORKERS' COMPENSATION PROGRAMS
DIVISION OF ENERGY EMPLOYEES OCCUPATIONAL
ILLNESS COMPENSATION
FINAL ADJUDICATION BRANCH

EMPLOYEE:	Don C. Vander Boegh
CLAIMANT:	Don C. Vander Boegh
FILE NUMBER:	XXX-XX-6292
DOCKET NUMBER:	10069077-2008
DECISION DATE:	APR - 7 2011

NOTICE OF FINAL DECISION

This decision of the Final Adjudication Branch (FAB) concerns your claim for compensation under the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended, 42 U.S.C. § 7384 *et seq.* (EEOICPA or the Act). For the reasons set forth below, your claim has been approved for $142,500.00 for a 57% whole person impairment due to your covered illnesses of peripheral neuropathy and hearing loss

STATEMENT OF THE CASE

On September 12, 2007, you filed a form EE-1, Claim for Benefits under the Act, for cataracts, glaucoma, hypothyroid, high blood pressure, "breathing problems," arthritis, edema, and peripheral neuropathy. On March 22, 2010, you filed an EE-1 form for hearing loss (diagnosed as early as th e1960s).

On September 2, 2010, the FAB issued a Final Decision under Part E of the Act, concluding that you were entitled to medical benefits for your peripheral neuropathy and hearing loss. This decision found that you were a covered DOE contractor employee with the covered illnesses of peripheral neuropathy and hearing loss due to exposure to a toxic substance at a DOE facility.

On August 5, 2010, the Jacksonville district office received your request for an impairment evaluation and to have Dr. Craig Uejo of Impairment Resources to calculate your whole person impairment based on the accepted covered illnesses of peripheral neuropathy and hearing loss.

The district office received the impairment evaluation report of Dr. Uejo, dated December 27, 2010.. The report stated that you were at maximum medical improvement (MMI) for your peripheral neuropathy and hearing loss. Dr. Uejo opined that you sustained a 57% impairment of the whole person as a result of your peripheral neuropathy and hearing loss. This opinion was based on the American Medical Association's (AMA) *Guides to the Evaluation of Permanent Impairment,* 5th Edition, and referenced specific pages and tables.

On February 22, 2011, the district office received your written confirmation that you had not filed any lawsuit in relation to radiation or toxic exposure or state workers' compensation claim for peripheral neuropathy or hearing loss or received any settlement or award from such a lawsuit or claim and that you have not pled guilty to or been convicted of workers' compensation fraud.

On March 7, 2011, the district office issued a recommended decision, concluding that you are entitled to $142,500.00 in benefits for 57% whole person impairment due to your peripheral neuropathy and hearing loss.

On March 8, 2011, the FAB received written notification that you waived any and all objections to the recommended decision.

FINDINGS OF FACT

1) You filed an impairment claim for benefits under the Act based on peripheral neuropathy and hearing loss.

2) You are a "covered DOE employee" with the covered illnesses of peripheral neuropathy and hearing loss under Part E of the Act.

3) Dr. Uejo concluded that your peripheral neuropathy and hearing loss have reached MMI and your whole person impairment is 57% due to your peripheral neuropathy and hearing loss.

CONCLUSIONS OF LAW

Section 30.316(a) of the EEOICPA regulations provides that, if the claimant waives any objections to all or part of the recommended decision, the Final Adjudication Branch may issue a final decision accepting the recommendation of the district office, either in whole or in part. 20 C.F.R. § 30.316(a) (2010). You have waived your rights to file objections to the findings of fact and conclusions of law in the recommended decision.

The assessment of impairment evaluations needs to determine the following: that the opining physician possesses the requisite skills and requirements to provide a rating as set out under the regulations; that the evaluation was conducted within 1 year of receipt at DEEOIC; whether the report addresses the covered illness; and whether the whole body percentage of impairment is listed with a clearly rationalized medical opinion as to its relationship to the covered illness. Any physicians whose services are utilized shall possess appropriate expertise and experience in the evaluation and determination of the extent of permanent physical impairments or in the evaluation and diagnosis of illness or deaths aggravated, contributed to, or caused by exposure to toxic substances. 42 U.S.C. §7685s-7(b). Dr. Uejo's report addresses all of the criteria listed and Dr. Uejo is appropriately experienced and an expert in determining impairment.

The amount of compensation under Part E for a covered DOE contractor employee is based on a determination of the minimum impairment rating, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment,* 5th Edition, of the employee expressed as a number of percentage points, as well as the number of those points that are the result of any covered illness contracted by that employee through exposure to a toxic substance at a Department of Energy facility. 20 C.F.R. § 30.901. The employee shall receive an amount equal to $2,500.00 multiplied by the number of percentage points. 42 U.S.C. § 7385s-2(a)(1)(A)(B), 7385s-2(b), 20 C.F.R. § 30.902.

You are a covered DOE contractor employee with the covered illnesses of peripheral neuropathy and hearing loss under Part E of the Act. According to Dr. Uejo your peripheral neuropathy and hearing loss have reached MMI and you have a whole person impairment of 57% as a result of the covered illnesses of peripheral neuropathy and hearing loss. 20 C.F.R. § 30.900. Accordingly, you are entitled to impairment benefits in the amount of $142,500.00 under Part E of the Act. 42 U.S.C. § 7385s-2(a)(1)(B), 20 C.F.R. § 30.902.

Jacksonville, FL

Carolina R. Betts
Hearing Representative

CERTIFICATE OF SERVICE

I hereby certify that on APR - 7 2011, a copy of the Notice of Final Decision was sent to the following:

Don C. Vander Boegh
[redacted] Avenue
Paducah, KY 42001

Gary S. Vander Boegh
Commonwealth Environmental Services, LLC
4645 Village Square Drive, Suite F
Paducah, KY 42001

Carolina R. Betts
Hearing Representative

U.S. DEPARTMENT OF LABOR

Office of Workers' Compensation Programs
Division of Energy Employees Occupational
Illness Compensation
Final Adjudication Branch

APR - 7 2011

Don C. Vander Boegh
[redacted] Avenue
Paducah, KY 42001

File Number: [redacted]6292
Payee Name: Don C. Vander Boegh
Payee SSN: [redacted]6292

Dear Mr. Vander Boegh:

I am pleased to inform you that your claim for benefits under the Energy Employees Occupational Illness Compensation Program Act of 2000 (EEOICPA) has been approved in the amount of: $142,500.00

Enclosed is the EN-20 Payment Information form which you, your legal guardian, or the person with power of attorney to act for you must complete, sign and return to the Division of Energy Employees Occupational Illness Compensation district office handling your claim. The person completing the EN-20 must submit it with an original signature; we cannot accept faxes or other copied versions of the EN-20. The form must also be completed in permanent ink and there can be no cross outs, trace-over marks, or other marks. Any alteration of the form, including the use of white out or correction tape, will result in it being rendered unusable for purposes of issuing payment; this will cause a delay in processing your payment.

If you elect to have the funds electronically transferred, please read the instructions carefully to avoid any delays. To ensure your money arrives promptly and to the correct account, check with your financial institution before submitting the form to verify **the accuracy of the routing number** and **your account number.**

The completed EN-20 should be returned within sixty (60) days of the date of this correspondence. **Failure to return the signed form within this period may be deemed a rejection of payment.** If you have questions about completing the EN-20 or you make a mistake or need another form, please contact your district office at (877) 336-4272 .

Sincerely,

Carolina R. Betts

Carolina R. Betts
Hearing Representative

Enclosure: EN-20

PRIVACY ACT STATEMENT: In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Energy Employees Occupational Illness Compensation Program Act (42 USC 7384 *et seq.*) (EEOICPA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information received will be used to determine eligibility for, and the amount of, benefits payable under EEOICPA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agencies or private entities that employed the employee to verify statements made, answer questions concerning the status of the claim and to consider other relevant matters. (4) Information may be disclosed to physicians and other health care providers for use in providing treatment, performing evaluations for the Office of Workers' Compensation Programs, and for other purposes related to the medical management of the claim. (5) Information may be given to Federal, state, and local agencies for law enforcement purposes, to obtain information relevant to a decision under EEOICPA, to determine whether benefits are being paid properly, including whether prohibited payments have been made, and, where appropriate, to pursue debt collection actions required or permitted by the Debt Collection Act. (6) Disclosure of your social security number (SSN) or tax identification number (TIN) is mandatory. We are authorized to collect your SSN or TIN under Executive Order 9397 (November 22, 1943). Your SSN or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (7) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision.

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995, no persons are required to respond to the information collections on this form unless it displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 5 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is required to obtain EEOICPA benefits (20 CFR 30.505). Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S3524, 200 Constitution Avenue N.W., Washington, D.C. 20210, and reference OMB Control No. 1240-0002 and Form EE/EN-20. **Do not submit the completed form to this address.**

File Number: [redacted]-6292
Payee Name: Don C. Vander Boegh
Payee SSN: [redacted]-6292

Authorized Payment

You have been found eligible to receive compensation in the amount of: $142,500.00

Authorizing Claims/FAB Examiner (signature): Carolin R. Betts

Payment Options

If you choose to accept the authorized payment, we need to know if you want to receive the award by Electronic Funds Transfer (EFT) or by Paper Check. Provide all of the requested information and mail this form to the DEEOIC district office handling your claim within sixty (60) days from the date of this letter.

I elect to receive my award by (check one box only):

☐ **Option 1 – Electronic Funds Transfer:** Provide all the financial institution and account information requested below. DEEOIC cannot accept wire numbers or issue EFT payments to brokerage firms or other financial institutions that have a third party routing system. Check with your financial institution before submitting the form to ensure an EFT can be made directly to your account and to verify the accuracy of all information provided in this section. Please print clearly.

Financial Institution Information

Name of Financial Institution: _____

Street Address: (P.O. Boxes not accepted) _____

City: _____ State: _____ Zip: _____

Telephone Number: ( ) _____

Account Information

Transfer funds to: (***check one***)

☐ Checking Account – provide checking account number: _____

☐ Savings Account – provide savings account number: _____

Names of ALL persons listed on the account: _____

Financial Institutions Nine (9) Digit Routing Number or ID#: | | | | | | | | | |

☐ **Option 2 – Paper Check:** Provide the address where you want to receive the check. The address you provide will be considered as your payment address only. Please print clearly.

Street Address: _____ P.O. Box/Apt. #: _____

City: _____ State: _____ Zip: _____

Certification

I hereby certify that I have reported to DEEOIC any third party settlement I have received, any tort suit I have filed against a beryllium vendor or an atomic weapons employer, any state workers' compensation awards I have received, any information I have regarding survivors (if applicable), and any conviction for fraud against this program or any other federal or state workers' compensation program. I affirm that the information provided on this form is true and that the method of payment is correct.

VERIFICATION STATEMENT FOR POWER OF ATTORNEY: I know that anyone who fraudulently conceals or fails to report information that would have an effect on benefits, or who makes a false statement or misrepresentation of a material fact in claiming a payment or benefit under the EEOICPA may be subject to criminal prosecution, from which a fine and/or imprisonment may result. As the power of attorney, my signature below serves to verify that, to the best of my knowledge and belief, the power of attorney I have to act on behalf of the above-named claimant is still valid under the existing law in the state in which the claimant executed the power of attorney, as of the date of my signature on the EN-20. I also affirm that the information provided on this form is true and that the method of payment is correct.

_____ ( ) _____
Printed Name Current Telephone Number

_____ _____
Signature Date

Instructions for Completing the EN-20

The EN-20 is used to collect financial information needed to pay compensation to an individual who has been found eligible for benefits under the Energy Employees Occupational Illness Compensation Program Act. This form is not to be completed if the named payee is deceased. Any change in the payee's status must be reported to the district office immediately. The beneficiary, his or her legal guardian, or the person with the power of attorney to act for the beneficiary, must complete the form in permanent ink. The requested information must be completed in its entirety. Any omission or alteration of the information will result in it being found invalid and another EN-20 will have to be completed. Contact the district office handling your claim if you have any questions or need assistance completing the form.

Authorized Payment

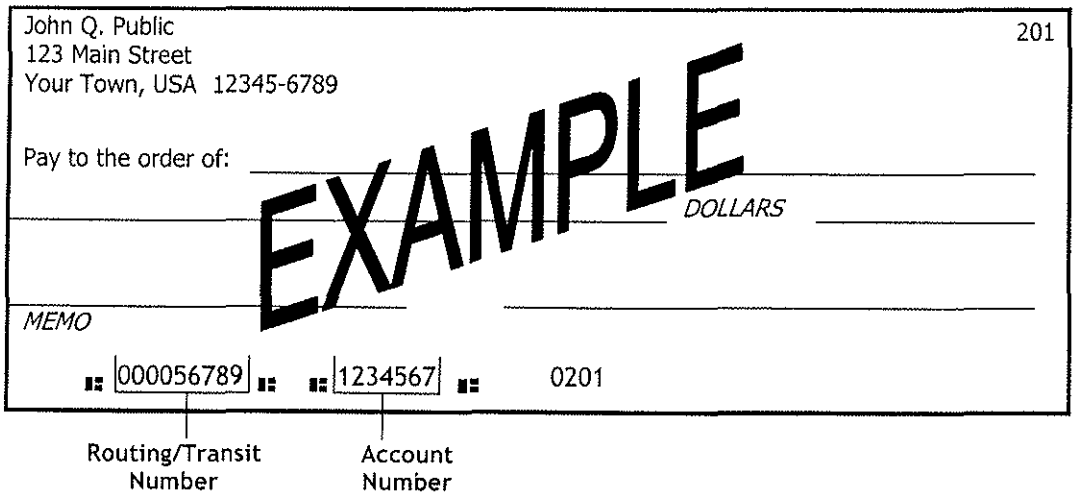
The amount of compensation to be paid is listed in this section. The signature of the claims examiner or Final Adjudication Branch (FAB) representative authorizing payment must be present.

Payment Options

You must first check the box electing one of the two options presented. Select to have your payment issued by Electronic Funds Transfer (EFT) or paper check. Mark the box next to the selected method of payment and fill in the appropriate information.

OPTION 1 - ELECTRONIC FUNDS TRANSFER

EFT payments are generally viewed as more secure and expeditious than a paper check. However, you must provide certain information that will allow the payment to be made to the account of your choosing. List the name, telephone number and address for the financial institution processing the deposit. In the account information section, list the name of the primary account holder. The nine digit routing number and the account number should be clearly printed in the appropriate sections. Do not use a deposit slip for purposes of reporting a routing or account number; they do not necessarily contain valid routing numbers. You can obtain the routing number and checking account number off one of your personal checks. Below is an example of where to find these numbers. *However, to ensure the numbers are correct and to minimize any potential delays in paying your award, you should confirm all information reported in the EFT section with your bank or financial institution before submission.*



OPTION 2 – PAPER CHECK

A paper check can be issued to the address of your choosing. You must clearly mark that you want a paper check by checking the appropriate box and providing the complete address where the payment is to be mailed. This will not affect any address maintained on file. If you have moved and would like to request a permanent address change, you must submit a signed statement listing your new address in a separate letter.

CERTIFICATION

If you have provided all the required information, print your name and sign and date the form. Submit the original EN-20 to the district office handling your claim. You may make copies of the form for your records. If you are signing this form with "power of attorney" and have not submitted the documents granting this authority, please submit them with the completed EN-20.

Most common reasons the form must be resubmitted:

- No original signature
- Did not check a box for payment options or checked both boxes
- Faxed the form or submitted a copy
- Did not complete the form in permanent ink
- There are cross outs, trace-over marks, or other marks
- Use of white out or correction tape
- Incorrect routing or account numbers