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February 20, 2026

[redacted], Attorney at Law

[redacted]

Oklahoma City, OK [redacted]

Re: Causation and Maximum Medical Improvement (MMI) Narrative Evaluation of the Examinee

Claim / Case No.: [redacted]

Date of Injury / Date of Awareness: 09/01/2022

Date of Evaluation: 02/12/2026

Dear [redacted]:

At your request, I have performed an independent medical narrative review and evaluation of the above-referenced examinee regarding causation and maximum medical improvement. Please find the attached report for your review and records.

This examination and report were conducted solely in the capacity of an independent medical examiner. No physician-examinee treating relationship was established, and no treatment was provided or implied. The examinee was a right-handed female who was a good historian and was cooperative throughout the evaluation. The information provided was consistent with the medical records reviewed.

In summary, it is my opinion that the alleged bilateral upper extremity conditions are not, within a reasonable degree of medical probability, causally related to the examinee's employment, and do not represent a significant and identifiable aggravation of a pre-existing condition. It is further my opinion that the examinee has not reached maximum medical improvement as of the date of this evaluation, as more fully explained in the attached report.

My opinions are based on the available medical records, diagnostic studies, history provided, and my physical examination of the examinee. Should additional information or documentation become available, I would be pleased to review and amend my conclusions if warranted. If you have any questions or require clarification, please do not hesitate to contact me.

Respectfully submitted,

Leslie R. Welch, DC, CICE, NRCME

Independent Medical Examiner

NARRATIVE MEDICAL OPINION REPORT

Causation / MMI Narrative

SAMPLE REPORT — REDACTED FOR ILLUSTRATIVE PURPOSES

Examinee:	[redacted] (44-year-old female)
Date of Birth:	[redacted]
Date of Injury / Awareness:	09/01/2022
Claim Number:	[redacted]
Referral File Number:	[redacted]
Referral Source:	[redacted], Attorney at Law
Employer:	[redacted] (paper products manufacturer)
Insurance Carrier:	[redacted]
Examiner:	Leslie R. Welch, DC, CICE, NRCME
Date of Evaluation:	02/12/2026
Report Type:	Causation / MMI Narrative

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1. DISCLAIMER AND SCOPE

My opinions are rendered within a reasonable degree of medical probability and are based on objective medical evidence. These conclusions are based on the information available as of the date of this report. The validity of the findings depends upon the accuracy and completeness of the history provided and the cooperation of the examinee during the evaluation. No speculative opinions are intended, and no guarantees regarding medical treatment, recovery, employability, or litigation outcomes are made.

This report was prepared at the request of the referring party and is intended solely for that purpose. I have no financial interest in the outcome of this case. My compensation is solely for my time and expertise in conducting this evaluation and is not contingent on the conclusions reached. Should additional records be provided, I am happy to review and, if warranted, amend this report.

2. REASON FOR REFERRAL AND QUESTIONS PRESENTED

This evaluation was requested by defense counsel on behalf of the employer/insurer regarding a disputed workers' compensation claim. The examinee, a 44-year-old Operator Technician II, filed a claim alleging cumulative trauma injury to both shoulders, both elbows, and both hands from operating heavy machinery and forklifts, with an alleged date of awareness of September 1, 2022. The referring party disputes that the examinee's job duties were repetitive in nature and disputes causation and aggravation of documented pre-existing conditions. The referring party has requested my opinion regarding the following:

1. Whether the examinee's bilateral upper extremity conditions (carpal tunnel syndrome, cubital tunnel syndrome, and shoulder complaints) are causally related, within a reasonable degree of medical probability, to her reported work activities.

2. Whether the reported work activities represent a significant and identifiable aggravation of the examinee's well-documented pre-existing bilateral upper extremity condition, or whether the condition is pre-existing and unrelated to the alleged work exposure.

3. Whether the examinee has reached maximum medical improvement and, if not, the anticipated basis and timeframe for reaching MMI.

3. GENERAL OBSERVATIONS

The examinee presented for the evaluation appropriately dressed and in no acute distress. She was alert, oriented to person, place, and time, and demonstrated appropriate mood, affect, and behavior throughout the examination. Speech was clear and coherent. Thought processes were logical and goal-directed. She was a reliable historian and answered questions appropriately.

Gait was normal and non-antalgic. She ambulated independently without assistive devices. Posture was upright, and balance appeared intact during observed ambulation and transitions from seated to standing positions. No obvious instability or ataxia was noted.

At the time of examination, the right upper extremity was maintained in a sling, reportedly two weeks status post right upper extremity surgery. The sling was appropriately positioned and worn throughout the evaluation except when removed for limited inspection as tolerated.

4. CREDIBILITY AND RELIABILITY OF EXAMINEE REPORT

The examinee demonstrated a high degree of reliability and credibility during the evaluation. She provided a detailed and consistent chronological history of her symptoms, treatment course, and medication history. Her clinical presentation during examination was consistent with her reported history and the medical records reviewed. Her effort during the examination was good, and her responses were consistent and reliable. No inconsistencies were identified between reported symptoms, observed functional abilities, and objective examination findings.

5. HISTORY AS PRESENTED BY THE EXAMINEE

The examinee reports longstanding bilateral upper extremity symptoms predating the current workers' compensation claim. She describes a gradual onset of hand pain and tingling “years back,” with prior diagnostic testing reportedly demonstrating carpal tunnel syndrome. She states she used wrist braces over time and experienced progressive symptoms. She is unable to identify a specific date, mechanism, or discrete occupational event causing her condition, and describes the condition as cumulative in nature, with uncertainty as to whether work activities caused or merely aggravated pre-existing issues.

She reports multiple prior upper extremity surgeries involving both hands and elbows, most recently right wrist surgery introducing hardware approximately two weeks prior to the examination. She denies any current plans for additional surgery and is undergoing postoperative therapy. She reports fluctuating pain levels, historically reaching severe intensity prior to surgery, with recent average pain approximately 6/10 over the past week.

She states she does not intend to return to factory-type work and plans to determine future work capacity following completion of therapy. She reports that she is pursuing disability benefits, which have been denied on two prior occasions.

Past medical history is significant for Type 2 diabetes mellitus, described as previously uncontrolled but currently improving, with a recent A1C reportedly in the range of 6–6.4%. She reports use of both oral medications and insulin at various times and currently uses combination therapy, with regular glucose monitoring. She also reports seasonal allergies, tension headaches, longstanding intermittent night sweats, and chronic low back pain attributed to a slip-and-fall injury approximately fifteen years prior to her employment with the current employer. She reports bilateral upper-extremity numbness and tingling, right greater than left.

She reports a thirty-year smoking history and rare alcohol use. She reports gastrointestinal side effects related to medications, including nausea associated with injectable diabetic medication and sensitivity to NSAIDs.

She denies a specific traumatic incident related to the claimed upper extremity condition and describes the progression as gradual over time. She feels that she has reached the end of anticipated treatment and improvement and has expressed a desire to close her case.

6. RECORDS REVIEWED

All medical records, diagnostic studies, correspondence, and related documentation provided to the undersigned at the time of this evaluation were reviewed in their entirety. These materials included prior treatment records, operative reports, diagnostic test results, disability documentation, and referral correspondence. The opinions expressed in this report are based upon the history provided by the examinee, the physical examination performed, and the complete set of records made available for review.

- Advanced Orthopedics of Oklahoma (Shelton, MD) — new patient evaluation and clinical notes, 2023–2024
- Tahlequah HC-Orthopedics (Whitener, DO) — operative reports and postoperative follow-up notes, 2023–2024
- Tahlequah HC-PT Therapy — postoperative physical therapy documentation, 2024
- The Orthopaedic Center (Chalkin, DO) — IME evaluations, work status reports, and MRI/EMG orders, 11/2024–1/2025
- Oklahoma Physical Medicine & Rehabilitation (Pettingell, MD) — electrodiagnostic study, 01/22/2025
- Tahlequah HC-Ancillaries — MRI right wrist without contrast, 12/06/2024
- Prior internal medicine correspondence and independent narrative opinion, 06/03/2024
- Employer/insurer referral correspondence and Form 3 filing

7. MEDICAL TREATMENT AND CLINICAL STUDIES TIMELINE

(Complete Records Review)

Date	Provider	Encounter / Procedure	Findings / Result	Plan / Prognosis
06/26/2013	Goldman, MD (Neurology)	EMG/NCS bilateral upper extremities	Bilateral carpal tunnel syndrome, right > left; no diabetic polyneuropathy identified	Objective confirmation of median neuropathy more than 9 years prior to alleged awareness date
08/09/2023	Shelton, MD (Advanced Ortho.)	New patient eval., bilateral hand numbness	Positive Tinel's/Phalen's bilaterally; symptoms longstanding (10+ yrs per history)	Bilateral hand X-rays and updated EMG/NCS ordered
09/28/2023	Whitener, DO	Right open carpal tunnel release & right ulnar nerve decompression	Surgical decompression of right median and ulnar nerve compression	Postoperative recovery and monitoring
11/16/2023	Whitener, DO	Left carpal tunnel release & left ulnar nerve decompression	Surgical decompression of left median and ulnar nerve compression	Postoperative recovery and monitoring
06/03/2024	Internal Medicine (independent narrative)	Independent narrative evaluation	Cumulative trauma impression; opined injuries work-related with pre-existing aggravation	Referral to upper extremity/shoulder specialists; opined TTD
06/12/2024	Whitener, DO	Revision right carpal tunnel release & revision right ulnar nerve decompression	Recurrent right median and ulnar nerve compression addressed surgically	Postoperative rehabilitation recommended
08/02–09/09/2024	Tahlequah PT	Postoperative physical therapy (multiple visits)	Persistent right wrist pain; limited ROM; findings suggestive of De Quervain's; reduced grip strength	Continued therapy; thumb spica brace issued
09/10/2024	Whitener, DO	Post-revision follow-up	Ongoing right wrist and elbow pain; limited improvement after revision surgery	Referral to upper extremity specialist for further evaluation
11/27/2024	Chalkin, DO	Independent Medical Evaluation	Bilateral wrist, elbow, shoulder complaints; longstanding CTS and diabetes noted; no prior shoulder surgery	MRI right wrist and repeat EMG ordered; 10-lb lifting restriction
12/06/2024	Tahlequah HC Imaging	MRI right wrist without contrast	Enlarged median nerve within carpal tunnel; TFCC degeneration; small ganglion cyst; no acute fracture	Correlates with carpal tunnel syndrome and degenerative wrist pathology
12/20/2024	Chalkin, DO	Follow-up evaluation	MRI-confirmed enlarged median nerve; right De Quervain's tenosynovitis and bilateral CTS diagnosed	EMG ordered to further evaluate neuropathy

Date	Provider	Encounter / Procedure	Findings / Result	Plan / Prognosis
01/22/2025	Pettingell, MD	EMG/NCS right upper extremity	Demyelinating conduction slowing across wrist; sensory axonal loss; moderately progressed since 05/2024 study	Consider amyloidosis workup; findings correlate with recurrent median neuropathy
01/29/2025	Chalkin, DO	IME follow-up	Right De Quervain's tenosynovitis; not temporarily totally disabled; diabetes noted as predisposing factor	10-lb bilateral lifting restriction; De Quervain's release recommended; shoulder deemed non-work-related
01/30/2026	Treating surgeon (record on file)	Right upper extremity surgery	Surgical intervention performed	Postoperative sling and therapy; follow-up pending
02/12/2026	Leslie R. Welch, DC, CICE, NRCME	Independent medical examination (this evaluation)	See Physical Examination, below	See Summary of Opinions, below

8. MEDICATION MANAGEMENT SUMMARY

(Complete Records Review)

First Documented	Provider	Medication / Dose	Indication	IME Commentary
06/26/2013	Goldman, MD	Diabetes history noted (medications not detailed)	Type II DM	Confirms longstanding metabolic disease predating the alleged awareness date
08/09/2023	Shelton, MD	Ozempic (semaglutide); Novolog; Levemir	Type II DM	GLP-1 and combination insulin therapy for glycemic control
08/09/2023	Shelton, MD	Gabapentin	Neuropathic symptoms	Consistent with chronic neuropathic complaints, not acute injury
08/09/2023	Shelton, MD	Tramadol	Pain	Analgesic use prior to later escalation
08/09/2023	Shelton, MD	Rosuvastatin / Omeprazole / Zofran PRN	Hyperlipidemia / GERD / nausea	Non-industrial, unrelated conditions
05/14/2024	Whitener, DO	Gabapentin 600 mg BID	Neuropathic pain	Dose escalation; ongoing neuropathic management

9. PHYSICAL EXAMINATION

Right Shoulder Examination

The right upper extremity examination could not be fully performed due to the examinee's recent surgery; it was too painful for her to remove the extremity from the sling for more than brief inspection.

Inspection revealed visible muscle atrophy involving the right upper arm compared with the contralateral side. No acute swelling, deformity, or joint effusion was observed. A surgical scar was present, healing well without edema or drainage. Palpation revealed no acute warmth or fluctuance. Protective guarding was observed during the limited movement she was able to tolerate.

Strength testing was not performed given the postoperative status. Sensation was decreased in portions of the distal right upper arm in the ulnar, median, and radial nerve distributions compared to the contralateral side. Deep tendon reflexes could not be assessed.

Right Elbow Examination

Inspection revealed visible muscle atrophy involving the right upper arm compared with the contralateral side. No acute swelling, deformity, or joint effusion was observed. A surgical scar was present, healing well without edema or drainage.

Strength testing was not performed. Sensation was decreased in portions of the distal right upper arm in the ulnar and radial nerve distributions compared to the contralateral side. Deep tendon reflexes could not be assessed.

Right Wrist and Hand Examination

Inspection revealed visible muscle atrophy involving the forearm musculature and the intrinsic and extrinsic musculature of the hand. Well-healed surgical scars were present over the wrist region. No acute swelling or deformity was present.

Strength testing demonstrated reduced wrist flexion and extension, graded at approximately 4/5. Grip strength was reduced in the right hand compared to the contralateral side and was reproducibly diminished with repeated testing, also graded at 4/5. Fine motor coordination was impaired, with difficulty maintaining sustained grip and performing coordinated hand movements.

Decreased sensation to light touch was present in portions of the wrist and hand. Mild intention tremor was observed during voluntary movement of the right hand. Finkelstein/De Quervain's provocative testing was positive on the right.

Right Wrist Range of Motion

Range-of-motion measurements were obtained using a standard goniometer and represent the mean of three measurements for each tested motion, obtained in accordance with accepted clinical methodology consistent with the American Medical Association Guides to the Evaluation of Permanent Impairment, Sixth Edition.

Motion	Measured ROM	Normal ROM	End Feel
Flexion	50°	80°	Empty
Extension	42°	70°	Empty
Radial deviation	14°	20°	Empty
Ulnar deviation	20°	30°	Empty

Findings are consistent with chronic structural and neurologic impairment superimposed on a longstanding, pre-existing bilateral median and ulnar neuropathic process; they are not, standing alone, indicative of an acute occupational injury.

10. DIAGNOSTIC STUDIES REVIEWED

EMG/NCS, 06/26/2013 (Goldman, MD): Bilateral carpal tunnel syndrome, right greater than left, more than nine years prior to the alleged September 2022 date of awareness — the single most probative piece of objective

evidence establishing that the examinee's median neuropathy substantially predates her employment-related exposure.

MRI right wrist without contrast, 12/06/2024: Enlargement of the median nerve with faint carpal tunnel edema; degeneration and possible tearing of the triangular fibrocartilage complex with subcortical cystic change of the lunate; extensor carpi ulnaris tendinosis; ganglion cysts. These are chronic, degenerative-pattern findings rather than acute traumatic findings.

EMG/NCS right upper extremity, 01/22/2025 (Pettingell, MD): Demyelinating conduction slowing of the median motor and sensory nerve across the wrist with sensory axonal loss, moderately progressed compared to the May 2024 study; normal ulnar and radial sensory studies; no cervical radiculopathy. The interpreting physician specifically raised diabetes-associated metabolic neuropathy (amyloidosis workup) as a differential consideration.

11. OTHER OBJECTIVE FINDINGS

The examinee demonstrated protective guarding of the right upper extremity throughout the examination. Movement of the right upper extremity was not fully testable due to her recent surgery and use of a sling. No evidence of symptom exaggeration or non-physiological responses was observed. Examination findings were internally consistent and correlated with a longstanding, pre-existing, and progressive cumulative process rather than a discrete occupational injury.

12. COMORBID CONDITIONS AND CONFOUNDING FACTORS

Chronic Tobacco Use

Chronic tobacco use represents a medically recognized comorbid condition associated with impaired tissue healing. Nicotine induces vasoconstriction, reduces peripheral blood flow, and reduces tissue perfusion. Carbon monoxide exposure further impairs oxygen delivery by reducing hemoglobin's oxygen-carrying capacity, thereby causing tissue hypoxia. These factors directly impair cellular repair processes.

Additionally, tobacco impairs fibroblast proliferation, collagen synthesis, and connective tissue remodeling, which are essential for normal healing of musculoskeletal tissues. Smoking is also associated with microvascular compromise and endothelial dysfunction, resulting in reduced delivery of oxygen, nutrients, and reparative cells to injured tissues.

These physiological effects are associated with delayed healing, prolonged symptom duration, and reduced recovery efficiency. In cumulative trauma conditions, where recovery depends heavily upon adequate vascular perfusion and connective tissue repair, chronic tobacco use represents a significant negative prognostic factor. The examinee reports a thirty-year smoking history, contemporaneous with the entire period of her alleged occupational exposure.

This comorbid condition does not, standing alone, negate or preclude occupational causation; however, it represents an independent medical factor that materially affects healing capacity, recovery timeline, and overall prognosis, and it must be weighed alongside the other findings in this report.

Type 2 Diabetes Mellitus

Type 2 diabetes mellitus represents a medically recognized systemic comorbid condition associated with impaired tissue healing, microvascular compromise, and reduced connective tissue repair capacity. Chronic hyperglycemia results in microvascular disease, including thickening of the capillary basement membrane and endothelial dysfunction, which impair blood flow and oxygen delivery to tissues.

Diabetes also impairs fibroblast function, collagen synthesis, and connective tissue remodeling, which are essential for normal healing. Additionally, diabetes is directly associated with peripheral nerve dysfunction (diabetic peripheral neuropathy) and impaired nerve recovery, which is of particular relevance here given the examinee's median and ulnar neuropathy.

The examinee reports a diabetes diagnosis in her twenties, with poor long-term control for many years and only recent improvement. The 01/22/2025 EMG/NCS interpretation specifically identifies a metabolic (diabetic) neuropathy differential, and multiple treating and evaluating physicians have identified diabetes as a predisposing and contributing factor to her carpal and cubital tunnel presentations. This comorbid condition represents a significant, independent, non-occupational contributor to both the development and the progression of the examinee's bilateral upper extremity condition.

13. CAUSATION ANALYSIS

Mechanism of Injury

The examinee alleges cumulative trauma from six years of employment as an operator technician, involving use of hand tools, operation of forklifts, and operation of heavy machinery, with an alleged date of awareness of September 1, 2022. No discrete traumatic event is alleged. The employer disputes that these job duties were repetitive in nature sufficient to produce or aggravate the diagnosed conditions.

Temporal Relationship

The examinee's own history places the onset of bilateral hand symptoms approximately ten to thirteen years prior to the alleged date of awareness, with objective EMG confirmation of bilateral carpal tunnel syndrome on 06/26/2013 — more than nine years before September 1, 2022. The clinical course therefore does not support an acute or discretely work-related injury pattern; it instead documents a slowly progressive condition that substantially predates the alleged period of occupational exposure.

Pre-Existing Condition Consideration

The record demonstrates well-documented, objectively confirmed pre-existing bilateral median and ulnar neuropathy dating to at least 2013, treated conservatively with splinting at that time with reported resolution, followed by progressive recurrence over the subsequent decade. Where pre-existing pathology is this well-documented and this remote, and where the intervening record does not identify a specific aggravating occupational event or a measurable step-change in function coincident with a work exposure, the available evidence does not support a significant and identifiable material aggravation attributable to employment. Rather, the record reflects the natural, expected progression of a longstanding condition substantially influenced by non-occupational metabolic disease and tobacco use.

Treatment Correlation

The pattern of care — recurrent bilateral carpal and cubital tunnel releases, revision surgery for recurrent (not new) compression, and now a right-sided procedure in 2026 — is consistent with a chronic, recurrent compressive neuropathy of metabolic and constitutional origin rather than a single identifiable occupational injury or a discrete aggravation event. The absence of shoulder treatment prior to this litigation, despite the shoulders being alleged as injured body parts, is not concordant with a genuine acute or cumulative occupational shoulder injury.

Alternative Etiologies Considered

- Longstanding, objectively confirmed pre-existing bilateral carpal tunnel syndrome (EMG-documented 2013), predating the alleged period of occupational exposure by approximately nine years.
- Type 2 diabetes mellitus, a recognized independent cause of peripheral neuropathy and impaired nerve/tissue healing, specifically flagged as a differential by the interpreting electrodiagnostic physician.
- Thirty-year tobacco use history, a recognized independent contributor to microvascular compromise and impaired healing.
- Recurrent (rather than new) compression at the same anatomic sites following prior releases, consistent with the natural history of chronic compressive neuropathy rather than a new occupational insult.

Causation Opinion

Within a reasonable degree of medical probability, it is my opinion that the examinee's bilateral upper extremity conditions — including carpal tunnel syndrome, cubital tunnel syndrome, De Quervain's tenosynovitis, and the alleged bilateral shoulder complaints — are not causally related to her employment and do not represent a significant and identifiable aggravation of a pre-existing condition. The objective evidence instead supports a longstanding, pre-existing, and progressive condition whose course has been substantially influenced by non-occupational factors, specifically Type 2 diabetes mellitus and chronic tobacco use.

14. MAXIMUM MEDICAL IMPROVEMENT (MMI)

Maximum medical improvement (MMI) is defined as the point at which a condition has stabilized and is unlikely to substantially improve further with additional medical treatment, within a reasonable degree of medical probability.

As of the date of this evaluation, the examinee is approximately two weeks status post right upper extremity surgery (01/30/2026), remains in a postoperative sling, and is either beginning or about to begin postoperative therapy. On these facts, she has not reached maximum medical improvement. She would be expected to require a standard postoperative recovery and rehabilitation course, typically several months, before her condition can be expected to plateau.

This MMI opinion is rendered independent of, and without conceding, causation. Should causation and/or compensability of the surgical procedure or underlying condition otherwise be established, MMI would not reasonably be anticipated until the examinee has completed a full course of postoperative therapy and her surgeon has released her from active care, at which point re-evaluation would be appropriate to render a final MMI date and any associated permanent impairment rating.

15. WORK STATUS AND RESTRICTIONS

Independent of causation, the examinee is not currently released to unrestricted work given her recent right upper extremity surgery and ongoing postoperative recovery. Work status and any lifting or use restrictions for the right upper extremity should be governed by her treating surgeon through the completion of the postoperative course. This is consistent with the 10-pound bilateral lifting restriction previously documented by other evaluating physicians in this record.

16. TREATMENT RECOMMENDATIONS

Independent of causation, no further treatment is recommended as work-related, as the examinee's condition has been found not to be causally related to her employment. Continued postoperative care, therapy, and any further evaluation of her diabetes-related or constitutional upper extremity findings should be directed by her personal treating physicians.

17. SUMMARY OF OPINIONS

1. Causation: Within a reasonable degree of medical probability, the examinee's bilateral upper extremity conditions (carpal tunnel syndrome, cubital tunnel syndrome, De Quervain's tenosynovitis, and alleged shoulder complaints) are not causally related to her employment.

2. Aggravation of Pre-Existing Condition: The record does not support a significant and identifiable material aggravation of her pre-existing, EMG-confirmed (2013) bilateral median and ulnar neuropathy by her work activities.

3. Maximum Medical Improvement: The examinee has not reached MMI as of 02/12/2026, given her recent right upper extremity surgery (01/30/2026) and ongoing postoperative recovery; this opinion is rendered independent of and without conceding causation.

4. Work Status: Work status and restrictions should continue to be governed by her treating surgeon through completion of postoperative recovery.

5. Treatment Recommendations: No further treatment is recommended as work-related.

18. SUPPORTING LITERATURE AND REFERENCES

- Rodriguez-Fontan F, et al. Tobacco use and neural regeneration. Neural Regeneration Research. 2020.
- Kennedy JM, Zochodne DW. Impaired peripheral nerve regeneration in diabetes mellitus. Journal of the Peripheral Nervous System. 2005. PMID: 15958126.

19. ATTESTATION

I, Leslie R. Welch, DC, NRCME, CICE (Oklahoma Chiropractic License No. 3361), certify that I am qualified to perform independent medical evaluations.

This examination and report have been conducted solely in the capacity of an independent medical examiner. No physician-examinee treating relationship has been established, and no treatment is provided or implied.

Basis of Opinions

The opinions expressed herein are based on a thorough review of the medical records supplied, the history provided by the examinee, diagnostic studies as available, and the findings of my physical examination, and are held within a reasonable degree of medical probability.

Respectfully submitted,

Leslie R. Welch, DC, NRCME, CICE

Independent Medical Examiner