

**BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO**

BEDFORD BROWN,	)	
	)	
Claimant,	)	<b>IC 2005-528346</b>
	)	
v.	)	
	)	
FIRST UNITED METHODIST CHURCH,	)	
	)	
Employer,	)	<b>FINDINGS OF FACT,</b>
	)	<b>CONCLUSION OF LAW,</b>
and	)	<b>AND RECOMMENDATION</b>
	)	
STATE INSURANCE FUND,	)	Filed: October 1, 2007
	)	
Surety,	)	
Defendants.	)	
_____	)	

**INTRODUCTION**

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Rinda Just, who conducted a hearing in Boise, Idaho, on March 27, 2007. Claimant, Bedford Brown, appeared *pro se*. Rachael M. O’Bar of Anderson, Julian and Hull represented Defendants. The parties submitted oral and documentary evidence. One post-hearing deposition was taken. Claimant did not file an opening brief, but did reply to Defendants’ post-hearing brief. The matter came under advisement on May 15, 2007, and is now ready for decision.

**ISSUES**

By agreement of the parties at hearing, the issues to be decided are:

1. Whether and to what extent Claimant is entitled to the following benefits:

- a. medical care; and
- b. temporary partial and/or temporary total disability benefits (TPD/TTD).

### **CONTENTIONS OF THE PARTIES**

It is undisputed that Claimant injured his low back on December 6, 2006, while working as a janitor for Employer, was diagnosed with a low back strain, and received conservative treatment. Claimant contends his injury was misdiagnosed, and that he actually sustained an injury to a lumbar disc as a result of the industrial accident. Claimant asserts that he has had on-going back pain that has never resolved since the accident. He seeks further medical treatment by a spine specialist, as well as further time loss benefits.

Defendants argue that Claimant received substantial conservative treatment from a number of medical providers for a low back sprain/strain that resolved without permanent impairment. There is no objective medical evidence to support Claimant's assertion that he was misdiagnosed, or that Claimant's current symptoms and/or condition are related to the industrial accident.

### **EVIDENCE CONSIDERED**

The record in this matter consists of the following:

1. Joint Exhibits 1-20, admitted at hearing;
2. The post-hearing deposition of Nancy Greenwald, M.D., taken April 11, 2007;  
and
3. The Idaho Industrial Commission legal file.

Defendants' objection at page 43 of Dr. Greenwald's deposition is sustained. All other objections are overruled.

## **PRELIMINARY EVIDENTIARY ISSUES**

At hearing, Claimant sought to introduce evidence in the form of a report of a March 14, 2007, MRI ordered by Cathy Engle, M.D. Defendants objected to the admission of any evidence introduced after March 9, 2007, and filed a Motion to Exclude in support of their objection. Defendants argued that Claimant had failed to disclose Dr. Engle as a potential witness in response to discovery requests. Further, Claimant had not provided Defendants copies of the proposed exhibits as required by J.R.P. Rule 10 and the Pre-hearing Order filed on January 31, 2007. Defendants also argued that the MRI report was irrelevant because Dr. Engle opined in a March 18, 2007, letter that the MRI findings did not explain Claimant's pain complaints, and were "very unlikely" to be related to his industrial accident.

Defendants' Motion To Exclude is GRANTED. Claimant's obligation to prove his claim with medical evidence was discussed on numerous occasions.<sup>1</sup> The original hearing date was vacated in order to allow him additional time to seek such evidence. During the status conference on December 15, 2006, Claimant admitted that he had no medical evidence to support his claim at that time. At that same status conference, Claimant agreed to consider dismissing his claim without prejudice, with the understanding that he could re-file anytime prior to December 5, 2010, if and when he obtained medical evidence to support his claim. Claimant requested dismissal without prejudice in a December 28, 2006, letter to the Commission. An Order Dismissing Complaint Without Prejudice was prepared and was awaiting Commission approval when Claimant again contacted the Commission asking that the matter be set for hearing.

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<sup>1</sup> August 21, 2006, September 6, 2006, September 18, 2006, October 30, 2006, December 15, 2006, and January 9, 2007.

Rule 10(C), J.R.P., requires proposed exhibits be served on all parties “at least 10 days prior to hearing” unless good cause is shown to the contrary. The Rule 10(C) requirements were discussed with Claimant at the in-person status conference held January 29, 2007, and were explicitly set out in the January 31, 2007, Pre-Hearing Order. Because the question of medical evidence was of fundamental concern in the case, the Pre-Hearing Order reiterated that any evidence tendered after the Rule 10 deadline would be subject to objection.

A fundamental purpose of Rule 10(C) is to avoid surprise and to ensure that each party has full opportunity to review proposed evidence. While some Rule 10 violations do not unduly prejudice the opposing party, and can be easily remediated, the last-minute production of new medical evidence is often problematic. When, as in this case, the very existence of medical evidence is at the heart of a dispute, such surprise fairly mandates exclusion of the evidence.

Given the procedural history of this matter, the frequent admonitions regarding critical procedures and deadlines, and the prejudice that would accrue to Defendants if the new medical evidence were allowed, the Referee excludes all of Dr. Engle’s records and any testimony pertaining thereto, as well as references to the excluded material that may appear in the parties’ post-hearing briefs.

After having considered all the remaining evidence and the briefs of the parties, the Referee submits the following findings of fact and conclusion of law for review by the Commission.

### **FINDINGS OF FACT**

1. At the time of the hearing, Claimant was 40 years of age and living in Boise, Idaho. He had moved to Boise from Twin Falls, Idaho. Claimant has a strong, athletic build, and an unremarkable medical history.

2. Approximately two years before the industrial accident that gave rise to this proceeding, Claimant injured his upper left back lifting weights. He received no medical treatment and the condition apparently resolved.

3. In late November 2005, Claimant began working for Employer as a full-time janitor, earning \$7.95 per hour.

4. Claimant's industrial accident and low back injury occurred on December 6, 2005. After moving an old, heavy refrigerator through snow and ice with his supervisor, Claimant experienced increasing low back pain over the next several days.

#### ***MEDICAL TREATMENT***

5. On December 8, 2005, Claimant was evaluated at Primary Health by Dr. Jim Yerger. Claimant denied pain radiating down into his leg, but reported that tenderness had moved up from his low back into his mid back and into his neck. Cramping and some significant spasms were noted on exam. The doctor diagnosed acute myofascial strain of the dorsal and lumbar muscles with significant back spasm. He prescribed Naprosyn, Skelaxin, and Norco for pain, imposed physical restrictions, and directed Claimant return in three days.

6. Claimant returned to Primary Health on December 12, 2005. Physician Assistant Tim Loewenstein noted Claimant reported significant improvement but still had some low back and upper back pain, particularly with standing and with increased activity. Claimant reported no radiating pain or lower extremity weakness, numbness, tingling, or pain. The diagnosis remained a back strain. Claimant was released to return to work with restrictions of no lifting greater than 30 pounds, and no pushing or pulling over 50 pounds. P.A. Loewenstein instructed Claimant to return for a final evaluation in three to five days.

7. Claimant ceased working for Employer on December 12, 2005, under disputed circumstances relating to the industrial injury and the availability of suitable work within his restrictions.

8. On December 14, 2005, Claimant saw Chiropractor Keith Berning, who diagnosed lumbar and sacroiliac sprain/strain with muscle spasm and sciatica neuritis. Claimant had chiropractic treatments December 15, 16, 19, 21, and 28, 2005, and January 4, 2006. Claimant testified the chiropractic care did not relieve his symptoms.

9. Claimant saw Dr. Stephen Martinez at Primary Health on January 3, 2006. He reported increased pain in his mid low back, with occasional shooting pains down both legs, but denied numbness in his feet or toes or urinary symptoms. On exam, Claimant exhibited low back tenderness on palpation over left and right paravertebral muscles at L4, L5, and S1. Low back x-rays were normal. The diagnosis remained a lumbar strain. Prescriptions included Vicodin and Lodine. Dr. Martinez prescribed physical therapy three times a week for two weeks. Physical restrictions included a 25-pound lifting restriction, and no kneeling or squatting. Claimant attended nine physical therapy sessions between January 5 and January 31, 2006.

10. The Idaho Industrial Commission Rehabilitation Division (ICRD) assisted Claimant starting January 10, 2006. Rehabilitation services included a job site evaluation, vocational counseling, medical follow-up, and an employer lead list.

11. On January 16, 2006, Claimant returned to Dr. Martinez complaining of back pain he rated as an eight on a scale of one to ten. Dr. Martinez referred Claimant to occupational medicine, continued to prescribe Lodine and Vicodin, directed Claimant to remain in physical therapy, and increased the physical restrictions to include no twisting, limited bending, and no kneeling or squatting.

12. Claimant presented to Primary Health's occupational medicine clinic on January 24, 2006. The notes reflect Claimant's frustration that his back was not getting better. Dr. Scott Lossman's examination, however, reflected little objective symptomatology. Dr. Lossman noted no mid-line tenderness of the lumbar spine, minimal tenderness in a quarter-sized area of the right lumbrosacral region, normal heel and toe walk, and mild pain when moving from a squat to fully upright position. Claimant did report minimal numbness in the gluteal areas bilaterally when Dr. Lossman broached the topic. Dr. Lossman ordered an MRI due to the "mild gluteal radiculopathy," replaced the Vicodin prescription with Ultracet, and reassigned Claimant to a new physical therapist. Restrictions imposed at that time included no lifting over 25 pounds, only occasional bending or twisting, and no pushing or pulling over 40 pounds. In late January, Dr. Lossman ordered a heel lift for Claimant.

13. A lumbar MRI was performed January 25, 2006. The report was normal with no "evidence of annulus bulge, focal disk protrusion, central canal stenosis or neural foraminal narrowing at any lumbar intervertebral disk level." Ex. 6, p. 9.

14. Between February 2 and March 1, 2006, Claimant attended 12 physical therapy sessions.

15. Claimant returned to Dr. Lossman on February 15, 2006, expressing continued frustration about his slow recovery. Claimant's report was contradicted by that of his physical therapist, who had reported he was making progress. Claimant stated that his pain was eight out of ten on a scale of one to ten, but Dr. Lossman noted:

I believe that there is a discrepancy between his stated level of pain, describing 8/10 pain at this time, but his blood pressure is not significantly elevated, pulse rate is not significantly elevated, respiratory rate is not significantly elevated.

*Id.*, at p. 13. Claimant reported continued use of Vicodin and Lodine. Dr. Lossman questioned

Claimant regarding his use of Vicodin, since Dr. Lossman had never prescribed Vicodin. Dr. Lossman continued Claimant's restrictions and referred him to Dr. Greenwald for a second opinion.

16. Dr. Greenwald saw Claimant on February 28, 2006. She noted the history of Claimant's medical treatment with Dr. Lossman, Dr. Berning, and physical therapy. Claimant reported central low back pain with numbness in the anterior portion of both legs. Claimant reported using as much as two Vicodin a day when the pain was at its worst. Dr. Greenwald recommended weaning Claimant off narcotics, prescribing Flexeril and Lidoderm instead. She recommended Claimant for the WorkFit work-hardening program. Dr. Greenwald also informed Claimant of the possibility that an annular tear (disk herniation) could be present although undetected on the MRI. Dr. Greenwald explained that even if Claimant had a disk herniation, her treatment plan would remain the same. Dr. Greenwald recommended restrictions similar to those imposed by Dr. Lossman.

17. Claimant participated in the WorkFit program from March 6 through March 24, 2006. According to Dr. Greenwald, the goal of WorkFit was to strengthen muscles and promote a positive attitude. The program measures patient success on evidence of function while downplaying subjective pain complaints. The therapists noted Claimant met or exceeded each week's goal with full compliance and cooperation.

18. On March 15, 2006, Michael H. McClay, Ph.D., a clinical psychologist for the WorkFit program, evaluated Claimant at Dr. Greenwald's request. Dr. McClay diagnosed pain disorder, related to psychological factors, and chronic pain syndrome. His impression was that Claimant was depressed and unhappy, with symptom magnification syndrome. Dr. McClay

notified WorkFit that he prescribed a therapeutic process for Claimant to practice at night due to a moderate sleep disturbance.

19. Also on March 15, 2006, Dr. Greenwald noted that Claimant was “doing great” in the work hardening program. He reported persistent swelling in his back, which Dr. Greenwald confirmed had been present since the start of the program.

20. On March 21, 2006, while in the last week of the WorkFit program, Claimant met with Dr. Greenwald. Claimant reported having “horrible spasms” in his back the night before, for which he had taken two muscle relaxants. The doctor recorded a normal physical examination, despite Claimant’s continuing complaints of significant low back pain. She instructed Claimant to proceed with the Functional Capacity Evaluation (FCE) scheduled for that afternoon.

21. Chad Bainbridge performed the FCE. He deemed it invalid due to Claimant’s failure to exert to his true capacity as evidenced by blood pressure and heart rate readings taken during the evaluation. At hearing, Claimant testified the FCE was very painful, and that the program caused his symptoms to worsen. Claimant did not attend the March 22, 2006, WorkFit session.

22. On March 23, Claimant reported hugging his girlfriend after the FCE and experiencing “an incredibly sharp stabbing pain in his mid-lumbar area,” worse on the left, that radiated upward into the lower thoracic level. At the same time, he started to experience tingling in both of his hands. Ex. 7, p. 8. Upon examination, Dr. Greenwald found no objective irregularity other than a two-centimeter discrepancy between the Claimant’s right and left calf

circumference.<sup>2</sup> Dr. Greenwald attributed the discrepancy to a pre-existing injury. Dr. Greenwald determined that Claimant was medically stable as of March 27, and released him to work full time with no restrictions, and with no permanent impairment. Dr. Greenwald did recommend that Claimant pursue a managed fitness program three to five times per week at a local athletic facility for an additional three months.

23. The State Insurance Fund discontinued temporary total disability benefits (TTDs) on March 27, 2006.<sup>3</sup>

#### ***ADDITIONAL MEDICAL CARE***

24. On April 16, 2006, Claimant presented to Saint Alphonsus Regional Medical Center Emergency Services complaining of back pain with radicular symptoms that he rated at nine out of ten on a one-to-ten scale. He advised that the pain had persisted since his industrial injury despite treatment by Primary Health, a chiropractor, WorkFit, and Dr. Greenwald. Claimant brought the MRI and x-rays in the hopes that he could be referred for further medical evaluation. Christopher Tobe, M.D., examined Claimant and observed no objective signs of spine or disc pathology. Dr. Tobe declined ordering another MRI, and referred Claimant to a pain specialist. Claimant told Dr. Tobe that he was taking Vicodin, muscle relaxants, and anti-inflammatory medications.

25. On April 19, 2006, the ICRD file was closed because Claimant had been declared medically stable and he was not interested in pursuing work at that time.

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<sup>2</sup> In her February 28, 2006 chart note, Dr. Greenwald noted that Claimant had “no obvious muscle atrophy” and that his reflexes and sensory responses in his lower extremities were normal. Ex. 7, p. 3.

<sup>3</sup> Surety had paid Claimant TTD’s in the amount of \$244.35 and \$254.25 from the date of the industrial accident.

26. K. Cheri Wiggins, M.D., a physical medicine and rehabilitation specialist, evaluated Claimant on November 17, 2006. She noted a general understanding of Claimant's industrial accident, injury, and medical history. Claimant reported ongoing back pain in his low back just above the belt line. He said the pain was stabbing, with pins and needles, and constant. He said it radiated down both legs, into his thighs and posterior calves. His feet sometimes went numb, particularly in the middle toes. He could not bend or lift more than one gallon of milk. Standing longer than ten minutes caused significant pain. Nothing but Vicodin seemed to help. He reported weakness in his legs, parasthesias, and that he "feels like he is going to lose bladder control." (Ex. 17, p. 2). On exam, Claimant's gait, muscle tone, and posture were normal. His low back region was tender to the touch. Dr. Wiggins observed that Claimant had "good muscle bulk with no atrophy noted." *Id.* Dr. Wiggins diagnosed back pain with some radicular symptoms. She wanted to see the prior medical records, and speculated that an L-4 radiculopathy was possible. She ordered EMG nerve testing to confirm or rule out an L-4 condition.

27. The EMG was performed December 4, 2006, by Dr. Wiggins' partner, Richard J. Hammond, M.D. The results were normal, with no indication of radiculopathy. Dr. Wiggins' notes from the same day indicate she reviewed the previous MRI and saw no abnormalities. She pondered whether the physical therapy had been too aggressive. She then expressed concern over discrepancies in Claimant's statements. He described himself as in very good shape, while at the same time asserting that he had been unable to do anything in the last year because of his back pain. *Id.*, at p. 6. Dr. Wiggins prescribed physical therapy and Flexeril.

28. Claimant saw Geff Anderson, D.C., on December 7, 2006. Claimant presented with complaints of low back pain that radiated into his buttocks and feet and complaints that he

could not sleep at all because of the pain. On his in-take forms, Claimant specifically denied having received any medical or chiropractic care for his back condition. Dr. Anderson saw Claimant again on December 11. On December 19, he wrote a letter to “Whom it may concern” in which he opined that Claimant’s low back pain and intermittent numbness over the past year was “related to his work incident given the fact that his condition has not resolved and has progressively worsened.” Ex. 18, p. 1. In response to Defendants’ inquiries, Dr. Anderson admitted that he had not reviewed any of the medical records from other providers and that his diagnosis was based on Claimant’s statements and his own examination.

### ***CLAIMANT CREDIBILITY***

29. Claimant is not a credible or reliable witness.

## **DISCUSSION AND FURTHER FINDINGS**

### ***CREDIBILITY***

30. Claimant’s method of communicating his recollections, self-perceptions, and human struggles made it easy to relate to him on a personal level. He is perceptive and obviously quite intelligent. His demeanor can be both charming and disarming. On the other hand, the record in this proceeding paints a picture of an individual who is neither as credible nor as reliable as he would like to appear. Examples abound, only a few of which are enumerated below:

- Claimant was not forthcoming with his medical providers:
  - Claimant was evasive with Dr. Lossman regarding his use of unprescribed Vicodin, and his complaints of extreme pain were so inconsistent with objective indicia of pain that Dr. Lossman became suspicious about the validity of the complaints;

- Claimant's statements to Dr. Wiggins were sufficiently inconsistent and contradictory as to raise her suspicions;
  - Claimant affirmatively (and admittedly) misrepresented his medical history to Dr. Anderson.
- Contradictions abound in Claimant's testimony as well:
- He asserted again and again that he received *no* medical care for his condition when the records prove otherwise;
  - He told his employer he was taken off work by his physicians when, in fact, he was released to return to work with restrictions;
  - He repeatedly averred that he could not work, yet pursued a claim for unemployment compensation.

The Referee had numerous opportunities during the pendency of this proceeding to both listen to and observe Claimant. The medical records, the hearing transcript, and Claimant's deposition all lend support to a finding that Claimant's testimony was neither reliable nor credible.

### ***MEDICAL CARE***

31. An employer shall provide for an injured employee such reasonable medical, surgical or other attendance or treatment, nurse and hospital service, medicines, crutches and apparatus, as may be required by the employee's physician or needed immediately after an injury or disability from an occupational disease, and for a reasonable time thereafter. If the employer fails to provide the same, the injured employee may do so at the expense of the employer. Idaho Code § 72-432 (1). It is for the physician, not the Commission, to decide whether the treatment was required. The only review the Commission is entitled to make of the physician's decision is whether the treatment was reasonable. *Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720,

779 P.2d 395 (1989).

32. It is undisputed that Claimant sustained a lumbar injury as a result of work he was performing for Employer. Claimant was seen and treated by Drs. Yerger, Martinez, and Lossman and P.A. Loewenstein at Primary Health. All diagnosed a lumbar sprain/strain. Claimant also sought treatment outside the chain of referral from a chiropractor, Dr. Berning, who also diagnosed lumbar strain/sprain. Claimant had x-rays and an MRI, all of which were negative. He was then treated by Dr. Greenwald and other medical professionals who participate in the WorkFit program. Dr. Greenwald diagnosed a lumbar strain/sprain, but advised Claimant that even if he had a herniated disc that had not shown up on the MRI, his treatment would be the same. Claimant completed the WorkFit program, and was determined to be at MMI on March 27, 2006. Claimant received extensive medical care for his relatively minor injury over a period of nearly four months.

Dr. Greenwald's recommendation that Claimant continue to participate in a fitness program after declaring him medically stable is not inconsistent with a determination of stability; rather, it is a recognition that maintaining one's physical fitness is critical to remaining healthy and avoiding re-injury.

After being declared at MMI, Claimant sought treatment at St. Alphonsus Regional Medical Center, and with Drs. Wiggins and Anderson in Twin Falls. Dr. Wiggins reviewed the MRI and ordered an EMG to rule out a disc problem at L-4. The EMG testing was done on December 6, 2006, almost exactly a year after Claimant's original injury, and was entirely normal. Dr. Wiggins told Claimant that it was "unlikely that there is anything dangerous that has been missed." Ex. 17, p. 6.

33. Claimant's evidence in support of his entitlement to additional medical care

consists of: 1) a letter from Dr. Anderson, who admitted he had not reviewed any of Claimant's previous records, and to whom Claimant admittedly provided false information about his medical history; and 2) Claimant's own opinion regarding the qualifications of Drs. Yerger, Martinez, Lossman, and Greenwald. No medical professional opined that Claimant needed any further medical care relating to his industrial accident on and after March 27, 2006. Claimant has provided no relevant or persuasive evidence to contradict or even bring into question the opinions of the many qualified physicians and other medical professionals who provided his care. There is simply no evidence to support a finding that Claimant is entitled to additional medical care for his December 2005 industrial injury.

### ***TTDs***

34. Idaho Code § 72-408 provides in pertinent part:

Income benefits for total and partial disability during the period of recovery . . . shall be paid to the disabled employee subject to deduction on account of waiting period and subject to the maximum and minimum limits set forth in section 72-409, Idaho Code . . .

Claimant's last day of work was December 12, 2005. Defendants paid TTD benefits at the statutory rate from that date until Claimant was deemed medically stable and released to return to work on March 27, 2006. Claimant has received all the TTD benefits to which he is entitled, and having found that Claimant is not presently in need of further treatment for his industrial injury, the issue of future TTDs is moot.

### **CONCLUSION OF LAW**

1. Claimant has failed to carry his burden of proving his entitlement to additional medical care or additional TTD benefits relating to his December 2005 industrial injury.

**RECOMMENDATION**

The Referee recommends that the Commission adopt the foregoing findings of fact and conclusion of law and issue an appropriate final order.

DATED this 19 day of September, 2007.

INDUSTRIAL COMMISSION

/s/ \_\_\_\_\_  
Rinda Just, Referee

ATTEST:

/s/ \_\_\_\_\_  
Assistant Commission Secretary

**CERTIFICATE OF SERVICE**

I hereby certify that on the 1 day of October, 2007 a true and correct copy of **FINDINGS OF FACT, CONCLUSION OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon:

BEDFORD BROWN  
628 PARADISE PL APT 102  
TWIN FALLS ID 83301

RACHAEL M O'BAR  
PO BOX 7426  
BOISE ID 83707-7426

djb

/s/ \_\_\_\_\_

**BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO**

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 Employer, )  
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 and )  
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 STATE INSURANCE FUND, )  
 )  
 Surety, )  
 Defendants. )  
 \_\_\_\_\_ )

**IC 2005-528346**

**ORDER**

Filed: October 1, 2007

Pursuant to Idaho Code § 72-717, Referee Rinda Just submitted the record in the above-entitled matter, together with her proposed findings of fact and conclusion of law, to the members of the Idaho Industrial Commission for their review. Each of the undersigned Commissioners has reviewed the record and the recommendation of the Referee. The Commission concurs with this recommendation. Therefore, the Commission approves, confirms, and adopts the Referee's proposed findings of fact and conclusion of law as its own.

Based upon the foregoing reasons, IT IS HEREBY ORDERED that:

1. Claimant has failed to carry his burden of proving his entitlement to additional medical care or additional TTD benefits relating to his December 2005 industrial injury.
2. Pursuant to Idaho Code § 72-718, this decision is final and conclusive as to all

matters adjudicated.

DATED this 1 day of October, 2007.

INDUSTRIAL COMMISSION

/s/ \_\_\_\_\_  
James F. Kile, Chairman

/s/ \_\_\_\_\_  
R.D. Maynard, Commissioner

/s/ \_\_\_\_\_  
Thomas E. Limbaugh, Commissioner

ATTEST:

/s/ \_\_\_\_\_  
Assistant Commission Secretary

**CERTIFICATE OF SERVICE**

I hereby certify that on the 1 day of October, 2007, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following persons:

BEDFORD BROWN  
628 PARADISE PL APT 102  
TWIN FALLS ID 83301

RACHAEL M O'BAR  
PO BOX 7426  
BOISE ID 83707-7426

djb

/s/ \_\_\_\_\_