

OFR65011

TYPE OF RECORD: PERMANENT

CATEGORY OF RECORD: MINUTES

CITY DEPARTMENT: ADMINISTRATIVE SERVICES

YEAR: 1965

FIREMENS PENSION FUND BOARD MEETING - NOV 19, 1965

Attendance: Tomlinson, Hannigan, Schmidt, McKissen and Manchester.

The meeting was called to consider possible action to be taken as a result of a recent heart attack suffered by Fireman Carl Shriver.

Notification has been received (see attached) that the State Compensation Insurance Fund has denied liability. A hearing before the Industrial Commission of Colorado will apparently be necessary to determine liability.

A motion was made by Helen Tomlinson and seconded by Orville Hannigan to place Carl Shriver on temporary disability until the claim is settled but not to exceed one year. The beginning date of the temporary disability period to be October 27, 1965. Motion carried by unanimous vote.

William Manchester

William Manchester
Board Secretary

STATE COMPENSATION
INSURANCE FUND

586 STATE CAPITOL ANNEX, DENVER, COLORADO

Administered by the Industrial Commission of Colo.



H. C. WORTMAN, MANAGER

To insure prompt answer to your
inquiry, please refer to our

No. 148922
IC 1-877-770
November 10, 1965

Industrial Commission of Colorado,
State Capitol Annex,
Denver, Colorado.

Claimant: Carl M. Shriver
Employer: City of Grand Junction
Dated Injured: 10-11-65
D-1

NOTICE OF CONTEST

Gentlemen:

The respondents hereby give notice that liability will be contested in the above case, and as grounds therefor allege:

1. That if the claimant sustained an accident as alleged, which is not admitted, but denied, the alleged accident did not arise out of and in the course of his employment.

2. That at the time of claimant's alleged accident, he was not performing service arising out of and in the course of his employment.

3. The claimant's alleged disability is not the result of injury proximately caused by accident arising out of and in the course of his employment.

Yours very truly,

STATE COMPENSATION INSURANCE FUND

By 

D-1

Copy to Claimant, Employer, Hospital, Doctor

Denial of Liability: General



The **EQUITABLE** Life Assurance Society of the United States
P.O. BOX 580, NEW YORK, N. Y. 10001

DEPARTMENT OF POLICY CLAIMS
DISABILITY CLAIM DIVISION

**ATTENDING PHYSICIAN STATEMENT
OF CONTINUED DISABILITY**

The insured is responsible for the completion of this form without expense to the Company. Space is available on the reverse if you wish to amplify your answers.

Name <i>Carl M. Shriver, Jr.</i>					Disability Claim No. <i>2W19213</i>
Present Address	No.	Street	City	State or Province	Zip Code
	<i>827</i>	<i>Grand</i>	<i>Grand Junction</i>	<i>Col</i>	<i>81501</i>

PRESENT CONDITION

- (a) Subjective symptoms
(b) Objective findings
Give report of latest x-rays, E.K.Gs., or any other special tests.
- (c) Is insured

*Shortness of breath on exertion.
Occasional pain in chest.
Shortness of breath, slow recovery of heart rate following exertion.*

- | | | |
|---|--------------------------|-------------------------------------|
| { | Ambulatory? | <input checked="" type="checkbox"/> |
| | Bed confined? | <input type="checkbox"/> |
| | House confined? | <input type="checkbox"/> |
| | Hospital confined? | <input type="checkbox"/> |

DIAGNOSIS *"Old antero septal myocardial infarction & possible septal aneurism". "Septal involvement" EKG Jan 1966.*

TREATMENT

- (a) Date of last visit *7/20/67*
(b) Frequency of visits
(c) When did you last examine the insured?

*Every 1 or 2 months.
7/20/67*

PROGRESS

- | | | |
|---|--------------------|-------------------------------------|
| { | Recovered | <input type="checkbox"/> |
| | Improved | <input type="checkbox"/> |
| | Unimproved | <input checked="" type="checkbox"/> |
| | Retrogressed | <input type="checkbox"/> |

DEGREE OF DISABILITY

- (a) Has the insured been able to do any work; if so, from what date?
- (b) If not, when do you think he will be able to work?

REGULAR WORK	OTHER WORK
Mo.....Day.....Yr.....	Mo.....Day.....Yr.....
Mo.....Yr.....	Mo.....Yr.....
<input type="checkbox"/> <i>Does about 10 hours light work per week.</i>	

MENTAL CONDITION

- (a) Does disability involve a mental condition?
(b) If "Yes," is the insured competent to endorse checks and direct use of proceeds thereof?

- | | |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |



Signed *J. J. Parker* M.D.
Address *725 Brookcliff Grand Jct. Colo 81501*
Date *July 24, 1967*