employer solutions staffing group
Leveraging Resources in a Changing Market

7301 Ohms Lane / Suite 405 / Edina, MN 55439
Phone: (952) 835-1288 Fax: (952) 835-4881
Website: www.employersolutionsgroup.com

Accident or Injury Reporting Procedures

Drug and Alcohol Screening

If a reportable accident or injury occurs, a drug and alcohol screening will be automatically given to the employee. Employee understands that failure to consent to a drug and alcohol screening following any accident or injury will result in discipline up to and including discharge.

Accident or Injury Report

Every Employer Solutions Staffing, LLC employee must immediately report any illness, accident or injury to his/her supervisor and Employer Solutions Staffing, LLC Workers' Compensation Department, at 952-767-0053 or wc@employersolutionsgroup.com, no matter how small or insignificant it may appear.

- Many injuries, initially thought as minor in nature, have later developed into serious and permanent disability.
- Early reporting works to the advantage of everyone.

Medical Treatment

Incident No Clinic

- Please use the "Decline of Medical Treatment Form"
  - If minor injury or the employee does not wish to seek treatment, please use this form.

Incident w/ Clinic

- Please use the Work Status Report Treatment Form—
  - Some clinics do not always use this form, or
  - Medical provider just briefly puts down that "Employee is not able to work from _____ to _____"—this is not helpful
    - We want to know why (what is it that the employee cannot do because of the injury?)

Accommodations Check list and Initial Contact letter

- These documents will generate as soon as a claim has been filed.
  - Accommodation Check list is for you.
    - Please fill that out the form; this is not for us; it so that we are able to send this to the carrier.
- Initial Contact letter is for the Employee.
  - This will let the Employee know of the Carrier's contact information.

Workers' Compensation Business Card

  - Please use this so the employee is able to contact us.
    - Saves you time from explaining the WC process (lost time, bill payment, etc.)

employer solutions staffing group
Leveraging Resources in a Changing Market

7301 Ohms Lane / Suite 405 / Edina, MN 55439
Phone: (952) 835-1288 Fax: (952) 835-4881
Website: www.employersolutionsgroup.com

Employee's First Report of Accident or Injury

PERSON REPORTING TO COMPLETE THIS FORM ASAP AFTER INJURY—FAX TO ESSG AT 952-767-0740

Personal and Incident Details (Circle and/or complete responses)

Last Name:	First and Other Names:	
Date of Birth:	Length of time on this assignment:	
Sex:	Social Security #:	Assigned at:
Phone: (Home):	Phone: (Message):	
Date of incident:	Time of incident:	
How did the incident occur?		
Name(s) of witness:	Phone:	

Supervisor Notification

Name of Supervisor:	Date and time notified:

Cause of Injury/Source (please circle or check mark)

Allergic Reaction	Bitten by Animal	Bitten by Human	Bitten by Insect	Caught in/On/Under/Between Object
Cut, Puncture or Scrape	Dust, Gases, Fumes, or Vapors	Electric Current	Exposure to Bodily Fluids	Exposure to Chemicals
Fall-Different Level	Fall-Ladder or Scaffolding	Fall-on Snow or Ice	Fall-Slip Trip on Same Level	Fall-Stairs
Foreign Body in Eye	Hearing Loss	Holding or Carrying	Jumping	Latex Allergy
Lifting and Lowering	Misc-Unknown and/or Insufficient Info	Motorized Non Licensed Vehicle	Motor Vehicle	Needle Stick
Occupational Disease	Pushing or Pulling	Reaching and Bending	Repetitive Motion	Resident/Patient-Assisting
Resident/Patient-Combative	Resident/Patient-Lifting from Floor	Resident/Patient-Repositioning	Resident/Patient-Transfer	Robbery or Criminal Assault
Stress	Struck by/Against Object	Struck by Human	Temperature Extremes	Using Tool or Machine
Walking/Running (non specific)	Welding Operation			

Type of Injury/Illness (please circle or check mark)

AIDS	All Other cumulative injuries	All other occupational disease injuries	Amputation
Angina pectoris	Asbestosis	Asphyxiation	Black lung
Burn	Byssinosis	Cancer	Carpal Tunnel Syndrome (CTS)
Concussion	Contagious Disease	Contusion	Crushing
Dermatitis	Dislocation	Dust disease	Electric shock
Enucleation	Foreign body	Fracture	Freezing
Hearing loss or impairment	Heat prostration	Hepatitis C	Hernia
Infection	Inflammation	Laceration	Loss of hearing
Mental disorder	Mental stress	Multiple injures including both physical and psychological	Multiple physical injuries only
Myocardial infarction	No Physical injury	Other specific injury	Poisoning (chemical)
Poisoning (metal)	Poisoning (not overdose or cumulative injury)	Puncture	Radiation
Respiratory disorders (gases, fumes, chemicals)	Rupture	Severance	Silicosis
Sprain	Strain	Syncope	Vasculer
Video display terminal diseases	Vision Loss	Not Reported	

Affected Body Part (please circle or check mark)

Head	Lower extremities	Multiple body parts	Trunk	Upper extremities
Brain	Ankle	Artificial appliance	Abdomen including groin	Elbow
Ears	Foot	Body system (with no external injury)	Buttocks	Finger(s)
Eyes	Great toe	Multiple body parts	Chest	Hand
Facial bones	Hip	No physical injury	Disc (back)	Lower arm
Mouth	Knee	Unclassified-insufficient info to properly identify	Heart	Multiple upper extremities
Multiple head injuries	Lower leg		Internal organs	Shoulder(s)
Nose	Multiple lower appendages	**Neck**	Lower back area	Thumb
Skull	Toes	Disc (neck)	Lumbar or sacral vertebrae	Upper arm
Soft tissue (head)	Upper leg	Larynx	Lungs	Wrist
Teeth		Multiple neck injuries	Multiple trunk injuries	Wrist(s) and Hand(s)
		Soft tissue (neck)	Pelvis	
		Spinal cord (neck)	Ribs	
		Trachea	Sacrum and coccyx	**NOT REPORTED**
		Vertebrae	Spinal cord (back)	
			Stomach	
			Upper back area	

INJURY DETAILS: (Include if it is a part of his job duties and the object that cause it ex: welding tube, hoist, packing carrots, etc)

Description of injury(s): _____

Taken to Hospital / Clinic: Yes or No
If Yes, Name and Address of Hospital / Clinic where taken for treatment: _____

Phone:

Signed & Date:	Print Name & Position:	Phone:

employer solutions staffing group
Leveraging Resources in a Changing Market

7301 Ohms Lane / Suite 405 / Edina, MN 55439
Phone: (952) 835-1288 Fax: (952) 835-4881
Website: www.employersolutionsgroup.com

WORK STATUS REPORT/MEDICAL SERVICE FORM

EMPLOYEE INFORMATION:

Name: _____ Date of Birth: _____
Social Security Number: _____ Phone#: (___) _____-_____
Date Of Injury: _____ Time of Injury: _____ ☐ a.m. ☐ p.m.
Job Description: _____

Drug/Alcohol Test: Yes or No **(FOR ALL WORK RELATED INJURIES)**

EMPLOYER INFORMATION:

Company: Employer Solutions Group, LLC
Phone #: 952-767-0053 Fax #: 952-767-0740 Date Notified:
Authorized Employer Signature: _____

EMPLOYER HAS LIGHT DUTY WORK AVAILABLE

TO BE COMPLETED BY PROVIDER:

Diagnosis: _____
Date of Examination: ____/____/____ Time: _____ ☐ a.m. ☐ p.m.

Treatment Plan:
_____ Must Return for re-evaluation on: ____/____/____
_____ To received PT/OT Services Duration: _____ x week _____x weeks
_____ Surgery Scheduled: ____/____/____
_____ Time:_____ ☐ a.m. ☐ p.m. ☐ Inpatient ☐ Outpatient
_____ No further care required Discharge Date: ____/____/____

Expected Healing Time:
_____ Days _____ Weeks _____ Months _____
_____ Other _____

Current Status:
_____ May work full duty now (no restrictions) ____/____/____ (Date)
_____ May work light duty now with identified restrictions through ____/____/____
_____ Presently working as of: ____/____/____
_____ Many not work until: ____/____/____ ☐ Full Duty ☐ Light Duty
_____ Lifting: Maximum Wight in Lbs.
_____ Pushing: ☐ 0 ☐ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 50 ☐ 60
_____ Pulling:
_____ Bending: Maximum Times/Hour: ☐ 0-2 ☐ 2-6 ☐ 6-10 ☐ 10-20
Degree of bend: ☐ 10-20 ☐ 20-45 ☐ Full
_____ No Sitting _____ No Standing _____No Walking
_____ Sitting Job Only _____ No Climbing or Overhead Work
_____ May not use: ☐ Right Hand ☐ Left Hand
_____ Keep dressing/wound clean & dry
Medication may cause drowsiness.
_____ Use caution operating machinery or equipment.

Comments: _____

Next Follow Up Appointment:

PHYSICIAN INFORMATION:

Physician Name: _____ Phone: (____) _____-_____
Physician Signature: _____ Date: ____/____/____

Employee: To expedite prompt claim handling, this complete form is to be returned to your employer either on the same day of the appointment or, should lost time be incurred, it is to be forwarded to your employer the day following the appointment.

employer solutions staffing group
Leveraging Resources in a Changing Market

7301 Ohms Lane / Suite 405 / Edina, MN 55439
Phone: (952) 835-1288 Fax: (952) 835-4881
Website: www.employersolutionsgroup.com

ACCOMMODATION CHECK LIST:

- Do you question the EE `s Injury? _____
  (Meaning; was this part of their job description/activities)
  If so, why?_____
  _____
  _____

- Fill in if Employee was or is scheduled to work following the work injury. Please place an "X" in the below chart.
  - For example:
    if the employee was hurt on Monday the 5th of January and was schedule to work that whole week, I would put an "X" on Monday thru. Friday.
  - Another example:
    if the Employee was not scheduled to work Tuesday and Thursday but employee is scheduled to work on Saturday & Sunday then I would not place an "X" on Tuesday and Thursday and I would then place an "X" on Saturday & Sunday.

DOI: _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

- Can Site Location Accommodate: _____
  - If you are not able to Accommodate,

    Which date was the Employee last work day:_____
    (Include dates he/she has been off due to his/her injury):

    _____, _____, _____, _____, _____, _____

- Have you discussed any questions regarding the injury with the Site Location?
  __ If Yes, why?
  _____
  _____
  _____

  __ No If No, will you be? _____

employer solutions staffing group
Leveraging Resources in a Changing Market

7301 Ohms Lane / Suite 405 / Edina, MN 55439
Phone: (952) 835-1288 Fax: (952) 835-4881
Website: www.employersolutionsgroup.com

DECLINE OF MEDICAL TREATMENT FORM

This form is only to be signed if you **do not** require medical attention in relation to your report of an on the job incident.

I, _____, acknowledge that I have reported on the job incident. The facility has offered me medical attention to be administered by the facility's designated workers' compensation physician. However, at this time I feel I **do not require** medical attention and by signing this form I am stating that I can safely complete the essential functions of my job without compromising the safety of my co-workers, residents, or myself. I understand that if my condition changes in relation to this work related incident that I must notify the facility's administrator before seeking any medical attention.

By signing this form I am declining medical attention by a physician at this time.

_____ _____

Employee Date Supervisor Date