



employer solutions staffing group_{llc}

PO Box 46270 Minneapolis, MN 55344-9956

Phone: (952) 767-0053 Fax: (952) 767-0740

Email Address: wc@employersolutionsgroup.com

**First Report of Accident or Injury
RECRUITER/SUPERVISOR NEEDS TO COMPLETE THIS FORM ASAP AFTER INJURY
Email: wc@employersolutionsgroup.com**

Last Name:		First and Other Names:	
Date of Birth:	Jobsite:	Start Date at Jobsite:	
Social Security #:		Position:	
Employee's Phone (Home):		Employee's Phone (Mobile):	
Date of incident:	Time of incident:	AM	PM
Name of witness(es):		Witness(es) phone #(s):	
Name of Supervisor:		Date and time notified:	

Cause of Injury/Source (please select one)

Type of Injury/Illness (please select one)

- Was the employee paid for 4+ hours the date of injury? **Yes** **No**
- What shift does the employee work? 1ST 2ND 3RD
- Is the employee missing time from work? Yes No
- Does the site location offer light duty work? Yes No
- Is there surveillance footage of the incident? Yes No
- Did employee go to the E.R. or Clinic? Yes No
- Does the employee need a translator? Yes No Language: _____

INJURY DETAILS: (Describe the incident in detail and which body part(s) that are affected. Please be specific).

Describe how injury(s) occurred - please be specific:

Name and Address of Hospital/Clinic where taken for treatment:	
Hospital/Clinic Phone:	
Recruiter/Supervisor Signature:	Recruiter/Supervisor Phone:
Recruiter/Supervisor Print Name:	

AUTHORIZATION FOR THE RELEASE OF INFORMATION

RE Employee: _____ Birth Date: _____

Address: _____ SSN: _____

This will authorize: _____
(Medical Provider/Facility)

To release to an authorized representative of _____ and/or **Employer Solutions Staffing**

Group, LLC any and all Medical and/or Treatment records maintained while I am/was a patient at the above facility **at**

any and all dates and times, and further authorizes said entities to re-disclose the Medical Records to independent

medical evaluators, vocational evaluators, rehabilitation providers, photocopying services, investigators, state agencies,

other relevant employers and insurers and their attorneys, and any other individual or entity related to this litigation.

The Information to be disclosed is:

Entire Medical Record for all Dates

History/Physical

AIDS/HIV Records

Consultation Reports

X-Ray/Scan reports and Films

Pathology Reports

Laboratory Reports

Other (Specify): _____

Operative Reports

Psychological Tests/Reports

Correspondence

Discharge Summaries

Diagnostic Testing Reports and Films

Any and all Chart Notes, Narrative Reports, Billings and Medical Records

Mental Illness/Chemical Dependency, and/or Alcohol Abuse records

This information is needed for the following purpose: **WORKERS' COMPENSATION**

I authorize the use and disclosure of my individually identifiable health information as described above.

I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy regulation and could be re-disclosed.

I understand that my receiving treatment, payment, enrollment or eligibility of benefits is not conditional on my signing this form.

I understand that I may revoke this consent at any time by notifying, in writing, the healthcare facility listed above. Revoking this authorization does not apply to information that has already been released under this authorization. Upon fulfillment of the above stated purposes, this consent will automatically expire. A photocopy or fax of this authorization is as valid as the original bearing my signature.

Date: _____ Patient Signature _____
(Patient or Guardian Signature)

(Relationship to patient IF guardian signs)

(Reason patient is unable to sign)



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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 an on the job incident. My employer and/or worksite has offered me medical attention. 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 myself or others. I understand that if my condition changes in relation to this work related incident that I must notify my supervisor and/or employer representative before seeking any medical attention.

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

Employee Signature

Date

Recruiter/Supervisor Signature

Date



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Employee Restriction Responsibility Form

In the event that you must seek further medical attention, you are obligated to inform the treating physician that Employer Solutions Staffing Group, LLC is willing to accommodate modified job duties.

Drop it off the day of the appointment with the Human Resources Department.

Know your restrictions and be aware of them at all times.

Please do not attempt tasks that exceed the restrictions. If a question exists about the task(s) at hand and your restrictions, advise your supervisor immediately. If you feel you are being required to do tasks outside of your restrictions, please call 952-767-0053.

The medical restrictions are in effect 24 hours per day. Exercise good judgement in your personal time to see that the *restrictions* are maintained. If you have hobbies or other outside interests, consult with the treating physician on extra restrictions and possible side effects.

Employees who conduct activities which are inconsistent with medical restrictions and/or treatment patterns, either on or off the job site, may affect your entitlement to benefits.

(initial)_____ I have read, understand; and agree to the above responsibilities

(initial)_____ I acknowledge that I have received a separate copy of this form

Employee Signature

Date

Employee Printed Name



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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 Staffing 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.



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Injured Employee Questionnaire

Employee's Name: _____ Phone Number _____

Date of Injury: _____ Date Reported _____

Please complete this Questionnaire as accurately as possible to help process your injury information. Incompletion of this form may affect or cause delay of claim.

How are you feeling now?

Please tell me the nature of your injury. Where does it hurt? What type of injury? (strain, sprain, cut, bruise, etc...)

Have you experienced an injury like this before?

Please tell me what you were doing when the injury occurred?

Is this part of your normal job functions? If not, what training did you receive prior to this job function?

What tools and equipment were you using at the time of injury?

Please describe the training you received prior to using this equipment.

Is there anything else you can tell us about how the injury occurred?

Employee Signature

Date

Employee Form

Job Description Recruiter/Supervisor Statement

Employee Name: _____

Job Title: _____

NOTE: In terms of an 8-hour workday.

Occasionally, equals 1% to 33%. Frequently, 34% to 66%. , or Continuously, 67% to 100%.

In an 8-hour workday, Employee does the following: (Check full capacity for each activity)

TOTAL AT ONE TIME

Sit	0	1	2	3	4	5	6	7	8	HRS
Stand	0	1	2	3	4	5	6	7	8	HRS
Walk	0	1	2	3	4	5	6	7	8	HRS
Drive	0	1	2	3	4	5	6	7	8	HRS

TOTAL DURING ENTIRE 8-HOUR DAY

Sit	0	1	2	3	4	5	6	7	8	HRS
Stand	0	1	2	3	4	5	6	7	8	HRS
Walk	0	1	2	3	4	5	6	7	8	HRS

Lifting OCCASIONALLY FREQUENTLY CONTINUOUSLY NONE

Up to 10 lbs.				
11-20 lbs.				
21-25 lbs.				
26-50 lbs.				
51-100 lbs.				

Carrying: OCCASIONALLY FREQUENTLY CONTINUOUSLY NONE

Up to 10 lbs.				
11-20 lbs.				
21-25 lbs.				
26-50 lbs.				
51-100 lbs.				

	SIMPLE		PUSHING	LOW SPEED	HIGH
Use of Hands	GRASPING	FINE WORK	PULLING	ASSEMBLY	SPEED
Left					
Right					

Comments: _____

Worker needs to: OCCASIONALLY FREQUENTLY CONTINUOUSLY NONE

Bend				
Squat				
Crawl				
Climb				
Reach				
Kneel				
Twist				

Please explain in detail what the employee does on a daily basis:

Recruiter/Supervisor Signature

Date