

employer solutions staffing group

PO Box 46270 Minneapolis, MN 55344-9956
Phone: (952) 767-0053 Fax: (952) 767-0740
Email Address: wc@employersolutionsgroup.com

Employee's Report of Injury

(to be completed by the employee)

Employee's Name: John A. Dochterman Male Female
Last First Middle

Date of Birth: 06/28/1980 Home Telephone: 720-829-1834

Home Address: 8982 Kent St.

City: Westminster State: Colorado Zip Code: 80031

Name of Company: Employer Solution Staffing group Job Title: Lighting Technician

Social Security #: 523-43-4883 Rate of Pay: 15.00

Location of Accident: Walgreens- Hamden and Chambers
Name of building Area (loading dock)

Date of accident: 04/03/2018 Time of accident: 4:00pm

Please describe fully how the accident occurred:

(Continue on the back side, if necessary)

What body part(s) are affected? (be specific):

Name of your Supervisor: Jason Trujillo

Name(s) of witness(es): N/A

[attach witness(es) report(s)]

When did you report the accident to your Supervisor? 5 minutes after fall

Employee Signature:  Date: Apr 5, 2018
John A. Dochterman (Apr 5, 2018)



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Injured Employee Questionnaire

Employee's Name: John A. Dochterman Phone Number 720-829-1834

Date of Injury: 04/03/2018 Date Reported 5 minutes after fall

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?


John A. Dochterman (Apr 5, 2018)
Employee Signature

Apr 5, 2018
Date

AUTHORIZATION FOR THE RELEASE OF INFORMATION

RE Employee: John A. Dochterman Birth Date: 06/28/1980

Address: 8982 Kent St. Westminster, CO. 80031 SSN: 523-43-4883

This will authorize: Chosen medical Provider
(Medical Provider/Facility)

To release to an authorized representative of CMG 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.

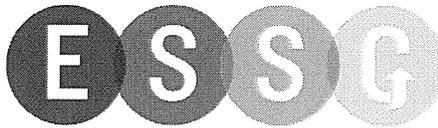
I understand that I may revoke this consent at any time by notifying, in writing, the healthcare facility listed above. Revoking this authorization does not apply to information that has already been released under this authorization. Upon fulfillment of the above stated purposes, this consent will automatically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

Date: Apr 5, 2018 Patient Signature 
John A. Dochterman (Apr 5, 2018)

Self (Patient or Guardian Signature)

(Relationship to patient IF guardian signs)

(Reason patient is unable to sign)



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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) JD I have read, understand; and agree to the above responsibilities

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


John A. Dochterman (Apr 5, 2018)
Employee Signature

Apr 5, 2018
Date

John A. Dochterman
Employee Printed Name



Employee Injury Report Forms

Adobe Sign Document History

04/05/2018

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