



7301 Ohms Lane Suite 405 Edina, MN 55439
Phone: (952) 767-0053 Fax: (952) 767-0740
Email Address: wc@employersolutionsgroup.com

First Report of Accident or Injury

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

Last Name: <u>Kappius</u>		First and Other Names: <u>Barry</u>	
Date of Birth: <u>09/24/1985</u>		Length of time on this assignment:	
Sex: <u>M</u>	Social Security #: <u>521-73-7010</u>	Jobsite: <u>colighting</u>	Position: <u>lighting Tech</u>
Employee's Phone: (Home): <u>720.938.1772</u>		Employee's Phone (Cell or Emergency Contact):	
Date of incident: <u>9/21/2015</u>		Time of incident: <u>9:30 AM</u> AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>	
Name(s) of witness: <u>Barry Jason Trujillo</u>		Witness Phone:	

Name of Supervisor: <u>Brian Fisher</u>	Date and time notified: <u>9/21 9:30 AM</u>
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How did the incident occur? Hurt finger while rotating a 2x4 figure

Cause of Injury/Source (please select one)

Select Applicable

Type of Injury/Illness (please select one)

Select Applicable

No Physical Injury Not Reported Other specific injury: "Avulsion on tip of left pinky finger"

Affected Body Part (please select one)

(Head) (Lower extremities) (Neck) (Trunk) (Upper extremities)

Insufficient info to properly identify Not Reported Other specific injury: _____

Please let us know what shift does EE work, Please select one:

What day of the week/weekends is the Employee scheduled to work: Monday: Tuesday Wednesday Thursday

Friday Saturday Sunday

o WAS THE EMPLOYEE PAID THE FULL DAY FOR THE DOI: Yes No

o Can Site Location Accommodate, please select one: Yes No

o Accommodating POSITION: _____ (EX. FILING, OFFICE ASSISTANT, ETC.)

o If you are able to accommodate, what type of work is being offered? (Please select one)

o If you are not able to Accommodate, Which date was the Employee last work day: _____

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):

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

Signed: _____ Print Name & Position: _____ Phone: _____



employer solutions staffing group

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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 Solution Staffing Group, LLC is willing to accommodate modified job duties.

Complete an Attending Physician's Return to Work Recommendations Record after each visit, and 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.

The medical restrictions are in effect 24 hours per day. Exercise 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, are subject to disciplinary actions.

(initial) BF ^{BK} I have read, understand; and agree to the above responsibilities

(initial) BF ^{BK} I acknowledge that I have received a separate copy of this form.

BF ^{BK}
Barry Kappius (Sep 23, 2015)

Employee's Signature

Sep 23, 2015

Date

Barry Kappius

Employee please print your name here



employer solutions staffing group

Employment Solutions Group, Inc. 10000 E. Hampden Ave. Suite 1000 Denver, CO 80231

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Email Address: wc@employersolutionsgroup.com

Employee's Report of Injury (to be completed by the employee)

Employee's Name: Barry Dean Kappius Male Female

Date of Birth: 09 / 24 / 1985 Telephone#(720) 938-1772

Home Address: 10887 grange creek dr

City: Thornton State: Co Zip Code: 80233

Name of Company: Colorado lighting Job Title: Lighting tech

Social security No: 521-73-7016 Rate of Pay: 18.00

Location of Accident: Boulder

Name of building Area (loading dock)

Date of accident: 09/21/2015 Time of accident: 9:30 am

Please describe fully how the accident occurred: _____

I was rotating a 2x4 fixture and it had slipped. I reached to grab it and somehow had my left pinky finger caught and ripped a portion off.

(Continue on the back side, if necessary)

Please describe Bodily injury sustained, Be specific about body part(s) affected:

Avulsion on the tip of my left pinky finger

If medical treatment was provided, please include name, address, and phone # of Facility:

Boulder community health, Emergency department
4747 Arapahoe Ave. Boulder, CO 80303

Name of your Supervisor: Jason Trujillo

Name(s) of witness(es): Brian Fisher

(attach witness(es) report(s))

When did you report the accident to your Supervisor? Immediately

Signature of Employee: 

Date: Sep 23, 2015

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Re: _____
Address: _____

Birthdate: _____
S.S.N.: _____

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:

- | | |
|---|--|
| <input checked="" type="checkbox"/> Entire Medical Record for All Dates | <input checked="" type="checkbox"/> Operative Reports |
| <input checked="" type="checkbox"/> History/Physical | <input checked="" type="checkbox"/> Psychological Tests/Reports |
| <input checked="" type="checkbox"/> AIDS/HIV Records | <input checked="" type="checkbox"/> Correspondence |
| <input checked="" type="checkbox"/> Consultation Reports | <input checked="" type="checkbox"/> Discharge Summaries |
| <input checked="" type="checkbox"/> X-Ray/Scan Reports and Films | <input checked="" type="checkbox"/> Diagnostic Testing Reports and Films |
| <input checked="" type="checkbox"/> Pathology Reports | <input checked="" type="checkbox"/> Any and all chart notes, narrative reports, billings and medical records |
| <input checked="" type="checkbox"/> Laboratory Reports | <input checked="" type="checkbox"/> Mental Illness/Chemical Dependency, and/or alcohol abuse records |
| <input checked="" type="checkbox"/> Other (Specify) _____ | |

The information is needed for the following purpose: workers' compensation.

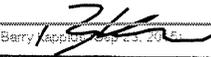
I authorize the use and disclosure of my individually identifiable health information as described above.

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 regulations 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.

Dated: Sep 23, 2015



(Signature of Patient or Guardian)

(Relationship to Patient if signed by Guardian)

(Reason Patient is unable to sign)

Incident Report Forms

Adobe Document Cloud Document
History

September 23, 2015

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