employer solutions staffing group
Leveraging Resources in a Changing Market

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First Report of Accident or Injury

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

Last Name: Chavez	First and Other Names: Keyri
Date of Birth: 11-11-1993	Length of time on this assignment: 7 days
Sex: Female / Social Security #: 109-98-0999	Jobsite: Supermoms Position: Commissary
Employee's Phone: (Home): 651-248-9581	Employee's Phone (Cell or Emergency Contact: NA
Date of incident: 12/15/2015	Time of incident: 9-10 AM ☑ PM ☐
Name(s) of witness: NA	Witness Phone: NA

Name of Supervisor: Denise Braucks	Date and time notified: 12/16/2015 8:56am

How did the incident occur? Keyri was cleaning her machine

Cause of Injury/Source (please select one)

Cut, Puncture or Scrape

Type of Injury/Illness (please select one)

All Other cumulative injuries

☐ No Physical Injury ☐ Not Reported ☑ Other specific injury: Cut/nail pulled up

Affected Body Part (please select one)

(Head) (Lower extremities) (Neck) (Trunk) Thumb

☐ Insufficient info to properly identify ☐ Not Reported ☑ Other specific injury: Right Thumb

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): Keyri said she was cleaning her line and did not see a screw and cut her right thumb by her nail. She said that the corner of her nail pops up a bit. She got a band-aid and returned to work.

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

Signed:	Print Name & Position: Kate Ritter On-Site Rep	Phone: 952-277-5227

Email form