CMG
CORPORATE MANAGEMENT GROUP

Angie Gonzales
Office 303-920-1425
Fax 303-736-7767
angie@corpmgmtgroup.com

Fax

To: ESG **From:** Angelica Gonzales

Fax: **Pages:** 10 including cover

Phone: 303-920-1425 **Date:** 2/12/2013

Re: Terrence McCarthy Workman's Comp **CC:**

X **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

- **Comments:**

Please provide me with a Case Number for Terrence McCarthy so he can follow up with ESG.

Thank you for your help!

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: MC CARTHY		First and Other Names: Terrence	
Date of Birth: 10-28-48		Length of time on this assignment:	
Sex: M	Social Security #: 011-40-0978		Assigned at: Byers industries
Phone: (Home): 303-444-5859		Phone: (Message):	
Date of Incident: 2-9-13		Time of incident: EVENING	
How did the incident occur? repetative motion			
Name(s) of witness:			Phone:

Supervisor Notification

Name of Supervisor: HAROLD BYERS Date and time notified: NONE / Notified Coworker only GARY Williams

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 injuries 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	Vascular
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 ✓ LEFT 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): Remove molding part by hand from molding machine.

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:

information given via phone call

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WORK STATUS REPORT/MEDICAL SERVICE FORM

EMPLOYEE INFORMATION

Name: Terrence MC CARTHY
Date of Birth: 10-28-1948
Social Security Number: 011-40-0978
Phone#: (303) 444-5859
Date Of Injury: 2-9-13
Time of Injury: ____ ☐ a.m. ☒ p.m.
Job Description: Machine Operator

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: 2-11-13 to Angelica Gonzales
Authorized Employer Signature:

EMPLOYER HAS LIGHT DUTY WORK AVAILABLE

TO BE COMPLETED BY PROVIDER

Diagnosis: Arthritis Flare up
Date of Examination: 2 / 11 / 13 Time: 5:08 ☐ 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:
- X May work full duty now (no restrictions) 2 / 11 / 13 (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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ACCOMMODATION CHECK LIST:

- Do you question the EE `s injury? NO
  (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: 2-9-13

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	X	X	X	X	X	X

- Can Site Location Accommodate: NO

  - If you are not able to Accommodate,

    Which date was the Employee last work day: 2-9-13
    (Include dates he/she has been off due to his/her injury):
    _____, _____, _____, _____, _____, _____

- Have you discussed any questions regarding the injury with the Site Location?
  X If Yes, why?
  Ask to speak with the Supervisor Terrence Reported his injury to. Per Ron & Byers + Harold & Byers, Terence did not report such incidint to any Supervisors They were not aware of anything.
  __ No If No, will you be? _____

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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 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

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT To X ray Time In: 438
DIVISION OF WORKERS' COMPENSATION Back From X ray Time Out: 522

PHYSICIAN'S REPORT OF WORKER'S COMPENSATION INJURY

A COPY OF THIS REPORT MUST BE SENT TO THE INJURED WORKER AND THE INSURER.

1. REPORT TYPE ☒ Initial ☐ Progress ☒ Closing

2. CASE CONFORMATION
Date of Injury 2-9-13
Injured Worker's Name Terrence McCarthy
Social Security # 011-40-0978
Date of Birth 10-28-48
Exam Date 2/11/13
Acct # 8x3007980118
Workers' Comp #
Insurer Claim #
Insurer Name
Insurer Phone/Fax
Employer Name CMG
Employer Phone/Fax 3037367767

3. INITIAL VISIT (only)
Injured worker's description of accident/injury

Are your objective findings consistent with history and/or work related mechanism of injury/illness? ☐ Yes ☒ No

4 CURRENT WORK STATUS ☒ Is Working ☐ Not Working

5. WORK RELATED MEDICAL DIAGNOSIS (ES) (4) thumb pain. 1ST CMC joint ARTHRITIS FLARE UP

6. PLAN OF CARE
a. TREATMENT PLAN
☐ Diagnostic tools/tests EVALUATION
☐ Procedures
☐ Therapy
☐ Medications
☐ Supplies
☐ Other THUMB - SPLINT ACETOMINOPHEN

b. WORK STATUS
☒ Able to return to full duty on 2/11/13
☐ Able to return to modified duty from ____ to ____
☐ Unable to work from ____ to ____
☐ Able to return to part time work on ____ for ____ hrs per day

c. LIMITATIONS/RESTRICTIONS ☒ No Restrictions ☐ Temporary Restrictions ☐ Permanent Restrictions

☐ Lifting (maximum weight in pounds) ____ lbs.		☐ Walking ____	hours per day
☐ Repetitive lifting ____ lbs.		☐ Standing ____	hours per day
☐ Carrying ____ lbs.		☐ Sitting ____	hours per day
☐ Pushing / Pulling ____ lbs.		☐ Crawling ____	hours per day
☐ Pinching / Gripping ____		☐ Kneeling ____	hours per day
☐ Reaching over head		☐ Squatting ____	hours per day
☐ Reaching away from body		☐ Climbing ____	hours per day
☐ Repetitive Motion Restrictions			

☐ Other

7. FOLLOW UP CARE AND REFERRALS
a. ☐ Return Appointment Date
b. ☐ Referral for ☐ Treatment (specify) ☐ Evaluation (specify)
☐ Impairment Rating ☐ Other (specify)
Referral Appointment to be made by ☐ Injured Worker ☐ Referring physician's office
Referred Provider's Name and Address Phone Number
c. ☐ Discharged from care (explain) ☐ Discharged for non compliance

Follow up w/ PCP.

8. MAXIMUM MEDICAL IMPROVEMENT (MMI)
☐ Injured Worker has reached MMI Date
Maintenance care after MMI required? ☐ No ☐ Yes If yes, specify care
☐ Injured Worker is not at MMI, but is anticipated to be at MMI in/on
☐ MMI date unknown at this time

9. PERMANENT MEDICAL IMPAIRMENT
☐ No permanent impairment
☐ Anticipate permanent impairment
☐ Permanent Impairment (attach required worksheets and narrative)
☐ Needs referral to Level II physician for impairment rating (see b above)

10. PHYSICIAN'S SIGNATURE
Date of Report 2/11/13
Print Name DR. HAWKE, DR KUPER
License number 23964 HAWKE/ 30722 KUPER
Address 9195 Grant # 100 Thornton, CO 80229
Telephone Number 303-292-0[illegible]4

WC M164 11/00

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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.)

CMG
CORPORATE MANAGEMENT GROUP

Angie Gonzales
Office 303-920-1425
Fax 303-736-7767
angie@corpmgmtgroup.com

Fax

To: Veronica **From:** Angie Gonzales

Fax: **Pages:** 2

Phone: **Date:** 2/11/2013

Re: Post Accident **CC:**

☒ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

- **Comments:**

Thank you for your help!

Angie Gonzales :)

Health ONE Occupational Medicine and Rehabilitation

MEDICAL SERVICES AUTHORIZATION

Employer Corporate Management Group Date 2/11/13

Address 333 Jackson Ave Phone Number 303-444-5859

Patient's Name Terrence McCarthy Supervisor's Name _____

EMPLOYMENT PHYSICALS

- ☐ DOT Physical
- ☐ History & Physical
- ☐ Back Assessment (Schedule w/Rehab)
- ☐ Respirator Physical
- ☐ Hazmat Physical
- ☐ Guard Physical
- ☒ Other Services _____

DRUG & ALCOHOL TESTS (please mark test type and reason for test)

☐ NIDA/DOT
Reason: ☐ Post-Offer ☐ Random ☐ Post-Accident ☐ Reasonable Suspicion

☐ 5 Panel to Quest
Reason: ☐ Post-Offer ☐ Random ☐ Post-Accident ☐ Reasonable Suspicion

☒ Rapid
Reason: ☐ Post-Offer ☐ Random ☒ Post-Accident ☐ Reasonable Suspicion

☐ Drug Screen Collection Only
Reason: ☐ Post-Offer ☐ Random ☐ Post-Accident ☐ Reasonable Suspicion

☐ Breath Alcohol Test
Reason: ☐ Post-Offer ☐ Random ☐ Post-Accident ☐ Reasonable Suspicion

☐ Other _____
Reason: ☐ Post-Offer ☐ Random ☐ Post-Accident ☐ Reasonable Suspicion

MEDICAL TREATMENT

On the Job Injury? ☒ **Yes** ☐ **No**

Date of Injury 2-9-13 Area of Body Injured hand

Workers' Compensation Insurance Carrier: _____ Ph # _____

WC Insurance Carrier Address: _____

Comments _____

Authorized By: Angelica M Gonzales Title: Acct Manager CMG

North Suburban Occupational Medicine
9195 Grant Street, Suite 100
Thornton, CO 80229
303-292-0034

RAPID DRUG SCREEN COLLECTION RECORD

DONOR NAME Terrence McCarthy DATE 2/11/13

COMPANY NAME Corporate Mgmt Group ID 011-40-0978

Test Information: LOT# DOA1105100 Expiration Date 10/2013

__: Dip 10 (COC, AMP/THC/MHC/MTD/MOMA/OPI/OXY/PCP/BARIB20)

X: Dip 5 (THC,OPI,COC,AMP,METH)

Reason for Test _____Post Offer X Post Accident _____Follow Up

_____Random _____Follow up _____Reasonable Cause _____Other

Temperature of sample within range (90-100 degrees F) _____Yes _____No

Time Of Application 5:05pm Time Of Reading 5:08pm (Reading within 4 min.)

Results: X Negative _____Non-Negative sent for confirmation_____

Donor Refuses

Further Testing: YES or NO Specimen ID#_____

(If yes, Please send to MRO with long sheet)

I certify that I have conducted the test(s) indicated on this form on specimen(s) provided By the above named donor. I am qualified to conduct this test and the results are as recorded on this form.

Signature of Collector _____ Date 2/11/13

I have provided my urine specimen to the collector. I have not adulterated it in any manner.

Signature of Donor Terrence D. McCarthy Date 2/11/13

I understand that I can send out this specimen to a lab for further testing if needed.

The cost is at my own expense.

Signature of Donor _____ Date_____

HealthONE Occupational Medicine/Rehabilitation at North Suburban

9195 Grant Street, Suite 100
Thornton, CO 80229

FAX COVER SHEET

Date: ___/___/___ Time: _____AM / PM

To:

Corporate Management Group Fax: 303-736-7767

Fax: _____

From: _____ Phone: 303-292-0034
303-451-7700
Fax: 303-292-0097
303-252-9474

Re: _____

Number of pages including cover sheet: _____

Notes: _____

_____

_____