employer solutions staffing group
Leveraging Resources in a Changing Market

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: Valdez		First and Other Names: David	
Date of Birth: 11/04/1975		Length of time on this assignment:	
Sex: M	Social Security #: 585-35-9065	Jobsite: CO Lighting	Position: Field Tech
Employee's Phone: (Home): 505-304-8942		Employee's Phone (Cell or Emergency Contact: 505-304-8942	
Date of incident: 12/14/2015		Time of incident: 10:30	AM ☑ PM ☐
Name(s) of witness:		Witness Phone: n/a	

Name of Supervisor: Carola Atkins	Date and time notified: 12/14/2015 10:30 am

How did the incident occur? While changing a light bulb the fixture fell down and the sheet metal cut his hand

Cause of Injury/Source (please select one)

Cut, Puncture or Scrape

Type of Injury/Illness (please select one)

Laceration

☐ No Physical Injury ☐ Not Reported ☐ Other specific injury: _____

Affected Body Part (please select one)

(Head) (Lower extremities) (Neck) (Trunk) Hand

☐ 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)

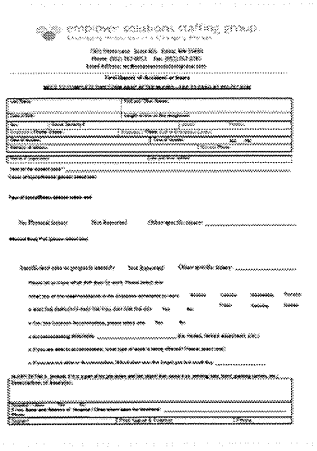
o If you are not able to Accommodate, Which date was the Employee last work day: _____

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): David was replacing light bulb in canopy fixture. He says "the lense door has to be pulled down to open, and slammed shut to close". When he shut the fixture the entire fixture came down and he was cut on the hand by the sheet metal that the fixture was held up by.

Hospital / Clinic: ☑ Yes ☐ No
If Yes, Name and Address of Hospital / Clinic where taken for treatment: Presbyterian RMC ER (Rio Rancho, NM)
Phone: 505-253-1539

Signed: Caitlin Scholl	Print Name & Position: Administrative Assistant	Phone: 303.920.1425



First Report of Injury

Adobe Document Cloud Document History

December 21, 2015

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"First Report of Injury" History

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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: David Valdez Paul (Last / First / Middle) Male ☒ Female ☐

Date of Birth: 11/09/1975 Telephone#(505) 304-8942

Home Address: 7008 Clark Hills Dr

City: Rio Rancho State: NM Zip Code: 87144

Name if Company: CLI Job Title: Field tech

Social security No: 585-35-9015 Rate of Pay:

Location of Accident: Valero (Name of building) Gas pump area (Area/loading dock)

Date of accident: 12/14/15 Time of accident: 10:30 am

Please describe fully how the accident occurred: I was replacing light bulb in canopy fixture. The lense door has to be pulled down to open, and slammed shut to close. When I went to close shut fixture the entire fixture came down, and to avoid getting hit in face or neck I grabbed sheet metal the fixture is held up with, and grab with left hand therefore slicing my hand. (Continue on the back side, if necessary)

Please describe Bodily injury sustained, Be specific about body part(s) affected:
Multiple Cuts on left hand. Cut from tip of index finger down to the 2 middle fingures down to right side of palm.

If medical treatment was provided, please include name, address, and phone # of Facility:
Presbyterian West Medical Center
2400 Unser Blvd Rio Rancho NM

Name of your Supervisor: Carola Atkins

Name(s) of witness(es):

(attach witness(es) report(s) 12/14/15 10:30 am

When did you report the accident to your Supervisor? Day of Incident, released from Hosp. to

Signature of Employee: [signature] Date: 12.21.15

Employee's Form

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Phone: (952) 767-0053 Fax: (952) 767-0740
Email Address: wc@employersolutionsgroup.com

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) D.V I have read, understand; and agree to the above responsibilities

(initial) D.V I acknowledge that I have received a separate copy of this form.

David P Valdez 12-21-05

Employees Signature Date

David P. Valdez

Employee please print your name here

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

Employee's name: David P. Valdez Phone Number (505) 304-8942

Date of injury: 12-14-15 Date Reported 12-14-15

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? Better, Just letting hand heal. Cleaning hand regularly and trying not to use left hand too much.

Please tell me the nature of your injury. Where does it hurt? What type of injury? (strain, sprain, cut, bruise, ect...) Cut from Index finger to Palm.

Have you experienced an injury like this before? Never!!

Please tell me what you were doing when the injury occurred? Changing out burnt out bulb in fixture.

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

What tools and equipment were you using at the time of injury? Harness, Flouresent vest, Gla

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

Is there anything else you can tell us about how the injury occurred?
This fixture was retro-fitted and the existing sheetmeta that is used to hold up entire fixture gave and fell.

Signature of Employee

12-21-15
Date

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Re: David P. Valdez
Address: 7008 Clark Hills Dr

Birthdate: 11/04/1975
S.S.N.: 585-35-9045

This will authorize Presbyterian (Rust Rust medical center)
(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:

X	Entire Medical Record for All Dates	X	Operative Reports
X	History/Physical	X	Psychological Tests/Reports
X	AIDS/HIV Records	X	Correspondence
X	Consultation Reports	X	Discharge Summaries
X	X-Ray/Scan Reports and Films	X	Diagnostic Testing Reports and Films
X	Pathology Reports	X	Any and all chart notes, narrative reports, billings and medical records
X	Laboratory Reports	X	Mental Illness/Chemical Dependency, and/or alcohol abuse records

X Other (Specify) Information needed for Incident only.

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: 12-21-15

David P. Valdez
(Signature of Patient or Guardian)

_____
(Relationship to Patient if signed by Guardian)

_____
(Reason Patient is unable to sign)

PRESBYTERIAN

PRESBYTERIAN RUST MEDICAL CENTER
RMC ER
2400 Unser Se
Rio Rancho NM 87124-4740
Dept: 505-253-1539
Loc: 505-253-6100

December 14, 2015

Patient: David Valdez
Date of Birth: 11/4/1975
Date of Visit: 12/14/2015

To Whom It May Concern:

David Valdez was seen and treated in our emergency department on 12/14/2015. He may return to work on (LIGHT DUTY UNTIL SUTURES OUT) 12/15/15.

Sincerely,

Lauren Buchanan, MD

- Be sure to update your list when medications are discontinued, changed or added (including over-the-counter products)

Printed information to patient

The patient was provided with a printed copy of this After Visit Summary and all references/attachments.

This is a summary of the care and treatment you received today and is provided as an easy way for you to reference information about your visit and to help remind you about any follow up instructions, appointments, test or procedures that were recommended. This document is not a part of your medical record. If you need a copy of your medical record, please contact the front desk.

Si necesita ayuda para traducir esta información, usted puede obtener asistencia de el área de recepción.

PRESBYTERIAN

After Visit Summary

RMC ER
2400 Unser SE
Rio Rancho NM 87124-4740
Phone: 505-253-1539

David Valdez
12/14/2015 9:40 AM ED

Description: **Male DOB: 11/4/1975**
Department: **RMC ER**

Patient Demographics

Patient Name	Sex	DOB	Address	Phone
Valdez, David	Male	11/4/1975	7008 Clark Hills Dr NE RIO RANCHO NM 87144	505-304-8942 (Home) 505-304-8942 (Mobile) *Preferred*

Diagnoses this visit

Your diagnosis was LACERATION OF HAND, LEFT, INITIAL ENCOUNTER.

You were seen by

You were seen by Lauren Buchanan, MD.

Follow-up Information

Follow up with Abhishek Ahuja, MD.
Specialty: Family Practice
Contact information:
3901 Atrisco Dr NW
Albuquerque NM 87120-1627
505-462-7575

Your Medication List

ASK your doctor about these medications

	Morning	Around Noon	Evening
hydrOXYzine hydrochloride 25 mg tablet Take 1 tablet by mouth every 4 hours as needed for Itching or Anxiety. May cause somnolence, if so, take every 6 hours Quantity: 30 tablet Dose: 25 mg Commonly known as: ATARAX			
omeprazole 20 mg tablet Dose: 20 mg Commonly known as: PRILOSEC OTC			

You are allergic to the following

No active allergies

Procedures and tests performed during your visit

Laceration repair (IP Procedure Navigator)

Medications Administered

acetaminophen (TYLENOL) tablet 650 mg

bupivacaine (MARCAINE) 0.5 % (5 mg/mL) injection 15 mg

neomycin-bacitracin zn-polymixin (NEOSPORIN (TRIPLE ANTIBIOTIC)) 1 packet

Results

None

Your Vital Signs Were

BP	Temp(Src)	Resp	SpO2	Smoking Status
139/91 mmHg	98.6 °F (37 °C) (Oral)	18	96%	Former Smoker

Discharge Instructions

SUTURES OUT IN APPROXIMATELY 7 DAYS, WOUND CARE AS INSTRUCTED, SPLINT AS NEEDED FOR COMFORT.
RETURN TO THE ED FOR ANY CONCERNS.

Discharge References/Attachments

LACERATION CARE, ADULT, EASY-TO-READ (ENGLISH)