



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

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

Employee's Name: Gordon Brandon Kyle Male Female
 Last First Middle
 Date of Birth: 11 / 25 / 1987 Telephone#(620) 510-9024
 Home Address: 314.N. Sullivan st
 City: Ulysses State: Kansas Zip Code: 67880
 Name if Company: CLI Servicea Job Title: Lighting Tech
 Social security No: 513-96-0431 Rate of Pay: 16.00
 Location of Accident: CLI Shop (Garden City, Kansas) Around the trash dumpster
 Name of building Area(loading dock)

Date of accident: February 24 Time of accident: 12:15p.m

Please describe fully how the accident occurred: _____
 I just came back from my lunch break, throwing out some debri that I collected from my morning. while I was putting the debri in the trash
 a piece of glass was exposed, and I did not see it. That is when my left for arm was caught on the exposed glass. I contacted the project manager
 And he tried to contact the appropriate parties but no answer. that is when he took me to the hospital in Garden City Kansas

(Continue on the back side, if necessary)

Please describe Bodily injury sustained, Be specific about body part(s) affected:
Left for arm above the wrist, about five inches from the wrist

If medical treatment was provided, please include name, address, and phone # of Facility:
St.Caterine's Hospital, 410 spruce st garden city kansas 67846

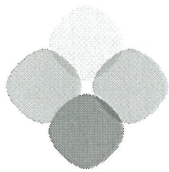
Name of your Supervisor: Jason Fritz

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

(attach witness(es) report(s))

When did you report the accident to your Supervisor? ASAP

Signature of Employee: *Brandon Gordon* Date: Feb 24, 2016
BrandonGordon (Feb 24, 2016)



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Employee's name: Brandon Gordon Phone Number (620)-510-9024

Date of injury: 2/24/2016 Date Reported 2/24/2016

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, ect...)
it didn't hurt when i was cut, or getting stiches and as the day goes by no pain what so ever

Have you experienced an injury like this before?

No I have not

Please tell me what you were doing when the injury occurred?

I was throwing out some old debri from my morning task getting ready to go back to locario

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

Yes it is part of my job duties, getting cut, no it is not part of my my job duties

What tools and equipment were you using at the time of injury?

the trash can

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

I don't know how to answer, just childhood experience of taking out the trash

Is there anything else you can tell us about how the injury occurred?

I just need to pay a little more attention to my surroundings

Brandon Gordon
BrandonGordon (Feb 24, 2016)

Signature of Employee

Feb 24, 2016

Date



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Maximizing Productivity Through Staffing Solutions

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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) B.G.
B.G. I have read, understand; and agree to the above responsibilities

(initial) B.G.
B.G. I acknowledge that I have received a separate copy of this form.

Brandon Gordon

BrandonGordon (Feb 24, 2016)

Employee Signature

BrandonGordon

Employee please print your name here

Feb 24, 2016

Date

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Re: Brandon Gordon
Address: 314.N.Sullivan st

Birthdate: 11/25/1987
S.S.N.: 513-96-0431

This will authorize employee's chosen medical provider/facility
(Medical Provider/Facility)

to release to an authorized representative of Corporate Management Group 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.

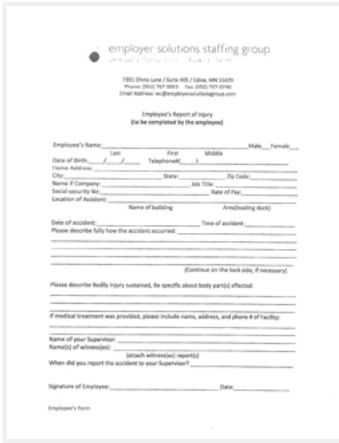
Dated: Feb 24, 2016

Brandon Gordon
BrandonGordon (Feb 24, 2016)

(Signature of Patient or Guardian)

(Relationship to Patient if signed by Guardian)

(Reason Patient is unable to sign)








Injury Report forms: For Employee

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2/24/16

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