employer solutions staffing group

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: DePiero (Last) John (First) A (Middle) Male ☐ Female ☐

Date of Birth: 04 / 03 / 1957 Telephone#(720) 6958937

Home Address: 10464 Independence Cir

City: Westminster State: CO Zip Code: 80021

Name if Company: Prescient Job Title: PSB

Social security No: 289-50-4025 Rate of Pay: $12.00

Location of Accident: Main Bldg (Name of building) Truss bundling (Area(loading dock))

Date of accident: September 8, 2016 Time of accident: 7:00 pm

Please describe fully how the accident occurred:
handling a truss and one slip down my arm.

(Continue on the back side, if necessary)

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

If medical treatment was provided, please include name, address, and phone # of Facility:
none

Name of your Supervisor: Jimmy G

Name(s) of witness(es): Mike

(attach witness(es) report(s)

When did you report the accident to your Supervisor? immediately

Signature of Employee: John DePiero John DePiero (Sep 11, 2016) Date: Sep 11, 2016

Employee's Form

employer solutions staffing group LLC
Leveraging Resources in a Changing Market

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Email Address: wc@employersolutionsgroup.com

Employee's name: JOHN DEPIERO Phone Number 720-695-8937

Date of injury: SEPTEMBER 8TH Date Reported SEPTEMBER 8TH

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…)
SMALL LACERATION, LESS THAN 1".

Have you experienced an injury like this before?
YES

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

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?
NONE

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

Is there anything else you can tell us about how the injury occurred?
NO

John DePiero
John DePiero (Sep 11, 2016)
Signature of Employee

Sep 11, 2016
Date

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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). N/A I have read, understand; and agree to the above responsibilities

(initial) N/A I acknowledge that I have received a separate copy of this form.

John DePiero
John DePiero (Sep 11, 2016)
Employees Signature

Sep 11, 2016
Date

John DePiero
Employee please print your name here

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Re: JOHN DEPIERO
Address: 10464 INDEPENDENCE CIR

Birthdate: APRIL 4, 1957
S.S.N.: 289-50-4025

This will authorize employee's chosen medical provider
(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:

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)_____		

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.

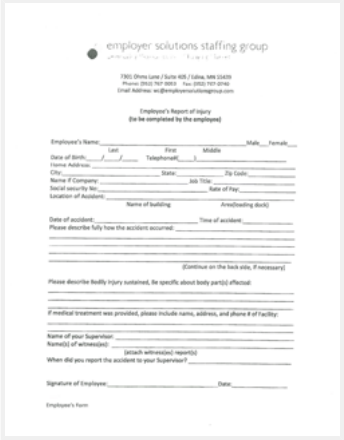
I understand that I may revoke this consent at any time by notifying, in writing, the healthcare facility listed above. Revoking this authorization does not apply to information that has already been released under this authorization. Upon fulfillment of the above-stated purposes, this consent will automatically expire. A photocopy or fax of this authorization is as valid as the original bearing my signature.

Dated: Sep 11, 2016

John DePiero
John DePiero (Sep 11, 2016)
(Signature of Patient or Guardian)

_____
(Relationship to Patient if signed by Guardian)

_____
(Reason Patient is unable to sign)



employer solutions staffing group

Injury Report forms: For Employee

Adobe Sign Document History 09/11/2016

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