



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: Cipponeri Russell John Male Female
Last First Middle
 Date of Birth: 12 / 01 / 1976 Telephone# (586) 855-1485
 Home Address: 10560 W 102nd PL.
 City: Westminster State: CO Zip Code: 80021
 Name of Company: Crating Technologies Job Title: _____
 Social security No: 377-82-0481 Rate of Pay: 14/hr
 Location of Accident: Crating Technologies Woodshop
Name of building Area (loading dock)

Date of accident: June 20th, 2017 Time of accident: 4:10pm

Please describe fully how the accident occurred: _____

(Continue on the back side, if necessary)

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

If medical treatment was provided, please include name, address, and phone # of Facility:

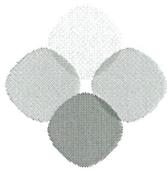
Name of your Supervisor: Justin

Name(s) of witness(es): Ralph? (Shop Supervisor)

(attach witness(es) report(s))

When did you report the accident to your Supervisor? Immediately

Signature of Employee: *Russell Cipponeri* Date: Jun 22, 2017
Russell Cipponeri (Jun 22, 2017)



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Employee's name: Russell Cipponeri Phone Number (586) 855-1485

Date of injury: June 20th, 2017 Date Reported June 20th, 2017

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...)

Have you experienced an injury like this before?

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

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

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

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

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

Russell Cipponeri
Russell Cipponeri (Jun 22, 2017)

Signature of Employee

Jun 22, 2017

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) RC I have read, understand; and agree to the above responsibilities

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

Russell Cipponeri
Russell Cipponeri (Jun 22, 2017)

Employee Signature

Russell Cipponeri

Employee please print your name here

Jun 22, 2017

Date

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Re: _____
Address: 10560 W 102nd Pl.

Birthdate: 12/01/1976
S.S.N.: 377-82-0481

This will authorize employee's choice of 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: Jun 22, 2017

Russell Cipponeri
Russell Cipponeri (Jun 22, 2017)

(Signature of Patient or Guardian)

(Relationship to Patient if signed by Guardian)

(Reason Patient is unable to sign)



Injury Report forms: For Employee

Adobe Sign Document History

06/22/2017

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