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: Davis (Last) Jeremy (First) Wayne (Middle) Male ☑ Female ☐

Date of Birth: 08 / 03 / 1979 Telephone#(330) 993-7800

Home Address: 2942 Malibu dr sw

City: Warren State: Ohio Zip Code: 44481

Name if Company: Latrobe specialty steel Job Title: Warehouse worker

Social security No: 280-84-8375 Rate of Pay: 9.50

Location of Accident: 1551 Vienna Parkway Vienna, OH 44473
(Name of building) (Area(loading dock))

Date of accident: 04/11/2016 Time of accident: 5:45pm

Please describe fully how the accident occurred:

I was moving a pallet to be loaded on to a trailer. I ran over a piece of steel I didn't see. I was told the steel then bounced up and hit me in the face.

I don't remember getting hit a was knocked unconscious. I came to with my head on the steering wheel and people standing around me.

(Continue on the back side, if necessary)

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

From the flat steel bar hitting me in the side of mouth. I have serious injuries to my lower left jaw. My teeth and inside my mouth.

I also had stitches on the outside of mouth left side.

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

St Elizabeth Hospital 1044 Belmont Ave, Youngstown, OH 44504 (330)-746-7211

Name of your Supervisor: Chuck Klempey

Name(s) of witness(es): A driver from Pitt-Ohio trucking company seen this happen.

(attach witness(es) report(s)

When did you report the accident to your Supervisor? 04/11/2016

Signature of Employee: Jeremy Wayne Davis (Apr 13, 2016) Date: Apr 13, 2016

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Leveraging Resources in a Changing Market

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Email Address: wc@employersolutionsgroup.com

Employee's name: Jeremy Wayne Davis Phone Number (330)993-7800

Date of injury: 4/11/2016 Date Reported 4/11/2016

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...)
I have a fractured lower left jaw broken teeth cuts and abrasions. The pain is in my left side of face my jaw my teeth lips chick and gums.

Have you experienced an injury like this before?
No

Please tell me what you were doing when the injury occurred?
I was driving a forklift to load a customer order onto a trailer

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?
Lp powered forklift

Please describe the training you received prior to using this equipment.
I have had training before on a forklift. Just very little a this new facility.

Is there anything else you can tell us about how the injury occurred?
I was doing what my supervisor told me to do.

Jeremy Wayne Davis (Apr 13, 2016)
Signature of Employee

Apr 13, 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)_____ I have read, understand; and agree to the above responsibilities

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

Jeremy Wayne Davis (Apr 13, 2016)

Employees Signature

Apr 13, 2016

Date

Jeremy Wayne Davis

Employee please print your name here

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Re: Jeremy Davis
Address: 2942 malibu dr sw warren ohio 44481

Birthdate: 08/03/1979
S.S.N.: 280-84-8375

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:

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: Apr 13, 2016

Jeremy Davis (Apr 13, 2016)
(Signature of Patient or Guardian)

(Relationship to Patient if signed by Guardian)

(Reason Patient is unable to sign)