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: Smithers (Last) Jessica (First) May (Middle) Male ☐ Female ☑

Date of Birth: 07 / 05 / 1990 Telephone#(716) 9012148

Home Address: 77. Fairelm ln upper

City: Cheektowaga State: Ny Zip Code: 14227

Name if Company: Lake region Job Title: Finisher

Social security No: 252-77-0556 Rate of Pay: 12.08

Location of Accident: Main building (Name of building) Polish area (Area(loading dock))

Date of accident: 10-31-16 Time of accident: 12

Please describe fully how the accident occurred:

Went to polish hook blades and the wing nut on a grinder we use caught my glove on my left hand and pulled it to the device. My hand hit it until I could untangle the glove from the nut.

(Continue on the back side, if necessary)

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

Left hand side of hand near joint on pinky finger bruised.

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

None

Name of your Supervisor: Steve

Name(s) of witness(es): None

(attach witness(es) report(s)

When did you report the accident to your Supervisor? No

Signature of Employee: J Smithers Jessica smithers (Nov 9, 2016) Date: Nov 9, 2016

employer solutions staffing group LLC
Leveraging Resources in a Changing Market

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Email Address: wc@employersolutionsgroup.com

Employee's name: Jessica smithers Phone Number 716-901-2148

Date of injury: 10-31-16 Date Reported 10-31-16

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…)
Bruised hand

Have you experienced an injury like this before?
No

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

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?
Grinder

Please describe the training you received prior to using this equipment.
Supervised training for over two weeks

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

J Smithers
Jessica smithers (Nov 9, 2016)
Signature of Employee

Nov 9, 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.

J Smithers
Jessica smithers (Nov 9, 2016)

Employees Signature

Nov 9, 2016

Date

Jessica smithers

Employee please print your name here

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Re: Jessica smithers
Address: 77 fairelm ln cheektowaga ny 14227

Birthdate: 07-05-1990
S.S.N.: 252-77-0556

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.

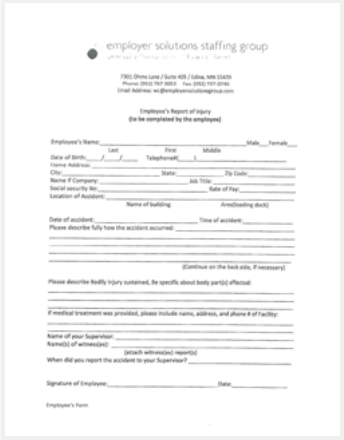
I understand that I may revoke this consent at any time by notifying, in writing, the healthcare facility listed above. Revoking this authorization does not apply to information that has already been released under this authorization. Upon fulfillment of the above-stated purposes, this consent will automatically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

Dated: Nov 9, 2016

J Smithers
Jessica smithers (Nov 9, 2016)
(Signature of Patient or Guardian)

_____
(Relationship to Patient if signed by Guardian)

_____
(Reason Patient is unable to sign)



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Injury Report forms: For Employee

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