



February 08, 2008

JOHN HEMMINGER
1600 NORTH DR.
SIOUX FALLSSD 57117,

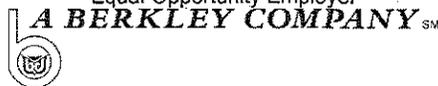
Claim No: 1000026635
Employee: JOHN HEMMINGER
Employer: Employer Solutions Staffing
Group LLC
Date of Injury: 01/30/2008
Social Security No: 503984292

We have received a First Report of Injury from your employer indicating that you may have received a work-related injury and may be eligible for workers' compensation benefits.

Please **thoroughly** complete the reverse side of this form, being as specific as possible, and return it promptly. In doing so, you will have provided information to aid in processing your claim.

MANDATORY FRAUD NOTICE

A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. Minnesota Statute 60A.955.



Statement of Facts

EMPLOYEE	Name JOHN HEMMINGER	Address 1600 NORTH DR. SIOUX FALLS SD 57117	Phone
	Date of Birth 10/23/1981	Marital Status <i>Single</i>	Social Security No. 503984292

EMPLOYMENT	Name of Employer Employer Solutions Staffing Group LLC	Name of Foreman/Supervisor <i>Ken Klasterman</i>
	Number of hours worked per day: <i>8</i> Wage per hour: <i>\$10.22</i> Earnings from another source or employer? <i>None</i>	Number of days worked per week: <i>5</i> What hours do you normally work? <i>7-3:30 PM</i> Are you self-employed? <i>No</i>

INJURY	What is the nature of your present trouble, and what parts of your body are involved? If applicable, left or right? <i>Both Arms It was just an allergic reaction to the chemicals that we use.</i>	
	When did the trouble first start? Give the specific date and hour. Explain fully and exactly what you were doing, what happened to you at the time your trouble started, and where you were when it occurred. <i>putting resin on MSW's</i>	
	When did you notify your employer? <i>Some day</i>	Where and to whom did you report? <i>Teeh (Kenny)</i>
	Give names of witnesses: <i>Kenny, Tainie</i>	

DISABILITY	Give specific time lost from work due to this injury. Also, indicate on line below the name of the physician who authorized restrictions and/or time lost from work. <i>3 hr.</i>	DATE <i>1/3/08</i>	# OF HOURS <i>3hr</i>	WILL EMPLOYER PAY THIS TIME LOSS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	REASON FOR TIME LOSS <i>Doctor visit</i>
	When did you return to work or when do you expect to return to work? <i>1/30/08</i>				

MEDICAL	Where did you receive treatment? <i>Pipestone Minn. Medical hospital</i>	
	Date you first saw doctor?	Who sent you to a doctor? <i>Kenny</i>
	How many times did you treat? <i>6 days</i>	Are you still treating? <i>No</i>
	Are you fully recovered now? <i>Yes</i>	Did you hurt any other part of your body?
	Give names and address of doctors who treated you:	
	Name: <i>Pipestone Medical Group</i>	Address: <i>Pipestone, MN 56464</i>

PAST MEDICAL	Have you had similar trouble to the same body part(s) in the past? <i>No</i>	Date of injury: <i>1/30/08</i>
	When did you last treat for this past condition? <i>1-7-08</i>	Were you given permanent restrictions? <i>-</i>
	Were you given a permanent partial disability rating? <i>-</i>	If so, what percentage? <i>-</i>
	Give names and address of doctors who treated you:	
	Name: <i>Avera</i>	Address: <i>Sioux Falls, SD</i>
	Name: _____ Address: _____	

EQUIPMENT	Was a machine involved with this injury? <i>No</i>	If so, what type of machine?
	Does your employer own this machine? <i>No</i>	Is the machine defective in any way?

HOBBIES	What hobbies, sports or leagues do you participate in? <i>Basketball</i>
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SIGNATURE	Signature of Employee <i>John Hemminger</i>	Date Signed
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