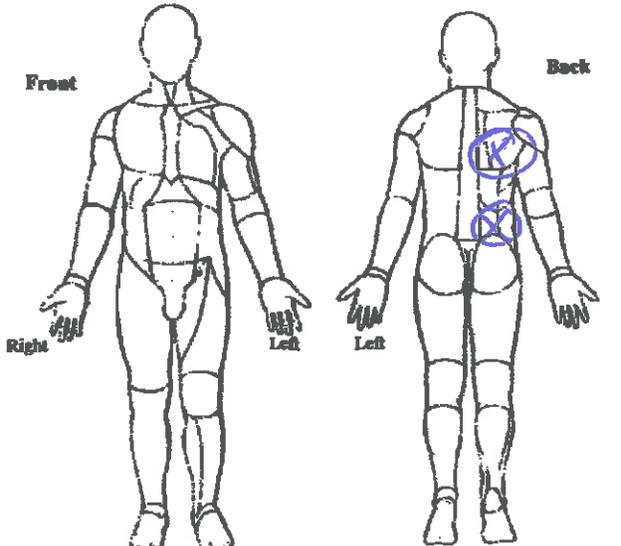


Purpose: To prevent future accidents

Employee Information

Employee's last name: Rathbun First name: John Middle: W
Phone Number: (906) 236-0094
Gender: Male Female
Date of hire: _____
Date of birth: 6/17/99
Home Address: 100 W Diamond Lake Road
City: Minneapolis State: MN Zip: 55409
Department: Tube Weld
Supervisor name: Toby Langiewicz

<p>Cause</p> <p><input type="checkbox"/> Slip and fall <input type="checkbox"/> Struck by equipment <input checked="" type="checkbox"/> Lifting or moving <input type="checkbox"/> Caught (in, on or between) <input type="checkbox"/> Needle puncture <input type="checkbox"/> Object in eye (Right <input type="checkbox"/> Left <input type="checkbox"/> <input type="checkbox"/> Repetitive/overuse <input type="checkbox"/> Other: _____</p>	<p>Mark Areas Of Injury Below</p> 
<p>Type of Injury</p> <p><input type="checkbox"/> Scrape/bruise <input checked="" type="checkbox"/> Sprain/strain <input type="checkbox"/> Puncture wound <input type="checkbox"/> Cut/laceration <input type="checkbox"/> Concussion <input type="checkbox"/> Bite <input type="checkbox"/> Chemical burn/rash/breathing difficulties <input type="checkbox"/> No apparent injury <input type="checkbox"/> Other</p>	



SUPERVISOR'S ACCIDENT REPORT

Employee Name: John Rathbun

Date of Incident: 11/5/2018 Date Reported: 11/5/2018

Time of Incident: ~~7:10 AM~~ 7:10 AM Time Reported: 7:13 AM

Location and brief description of incident:

He was pulling down on a clamped bracket to weld it to the tube.

Did the employee report the incident immediately? YES NO

Did you or someone else witness the incident? YES NO

If someone else did, who? _____

Do you have any reason to question the legitimacy of the incident? YES NO

If Yes, please explain: He told Ron Hanson that he had an injury to his shoulder from football

Indicate the conditions that led to the incident:

<input type="checkbox"/>	Unused/Unavailable lifting equipment	<input type="checkbox"/>	Wet/Slippery Floor
<input type="checkbox"/>	Unused/Unavailable PPE (gloves, etc)	<input type="checkbox"/>	Poor Housekeeping
<input type="checkbox"/>	Unused/Unavailable Sharps Container	<input type="checkbox"/>	Interaction with co-worker
<input type="checkbox"/>	Unguarded Equipment	<input type="checkbox"/>	Interaction with resident
<input type="checkbox"/>	Electrical	<input type="checkbox"/>	Chemical Exposure
<input type="checkbox"/>	Obstructed View	<input type="checkbox"/>	Airborne Contaminants/Smoke
<input type="checkbox"/>	Lack of Training	<input checked="" type="checkbox"/>	Other
<input type="checkbox"/>	Defective Tools or Equipment	<input type="checkbox"/>	

What changes could be made to eliminate or reduce the hazard(s) identified above?

We will investigate the bracket tack process to make sure its safe

Toby Langicwitz Prod. Manager 11/5/2018
Prepared by Title Date



EMPLOYEE ACCIDENT REPORT
(To be completed by the injured employee)

Employer: Premier

Employee Name: Jonathan Robinson

Date of Accident: 11-5-18

Location of Accident: Tube Weld

What happened? (Please describe accident in your own words):

Pulling down a bracket to weld on and
strained lower back. When Dave got done welding
he said I was in pain

How were you injured? ~~pulling~~ straining muscles in back

What part(s) of your body was/were hurt? (Indicate Right or Left)

lower and upper back Right side

Have you ever injured this part of your body before? (Yes/No) If so, please describe:

Lower back No / upper back yes

Who was present when the accident happened?

John, Dave

The above report is true and correct:


Signature

11-5-18
Date

Accident Reports must be handed in to your supervisor or acting supervisor immediately after any incident. Failure to promptly report accidents will result in discipline up to and including discharge.



WITNESS STATEMENT
(To be completed by the witness)

Name of Injured Employee: _____ Date of Injury: _____

Name of Witness: _____ Phone Number: _____

Address of Witness: _____

Witness to accident or injury to answer all of the following questions:

1. Did you witness the accident or injury? YES NO
2. What part(s) of the body was injured? (head, neck, back)

3. Describe the type injury (strain, bruise, laceration)

4. What did the injured employee say at the time of the injury?

5. Did the injured employee complain of pain? If so, where?

6. Explain what the employee was doing at the time of the accident or injury occurred:

The above statement is true and correct:

Signature of Witness

Date

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties to penalties.



FAIRVIEW LAKES EMERGENCY DEPARTMENT
5200 Fairview Blvd
Wyoming MN 55092-8013
Phone: 651-982-7300
Fax: 651-982-7301

FAIRVIEW LAKES EMERGENCY DEPARTMENT
5200 Fairview Blvd
Wyoming MN 55092-8013
651-982-7000

November 5, 2018

Jonathan W Rathbun
No address on file.
906-236-0094 (home)

DOB: 6/12/1999

To Whom it may concern:

Jonathan Rathbun was seen in our Emergency Department today, November 5, 2018 for an injury that was reported to be work related.

The patient should not work over the next 48 hours. He should not lift, push, pull, anything greater than 10 pounds over the next 48 hours after that.

Sincerely,

Jason M. Devries, MD

A handwritten signature in black ink, appearing to read "J. Devries", with a long horizontal line extending to the right.

Fairview Accident or Injury Form

In order to process your hospital or clinic claim:

1. You must first call your insurance company to file a claim, if you have not already done so.
2. We need your worker's compensation, motor vehicle insurance, or third-party liability information. After this visit, please call 612-672-6724 or fax to 612-672-6707 within 48 hours. Provide the information on this form, so we can bill the proper insurance or party. If this information is not provided, you will be billed and will need to pay the amount due.

Patient information

Patient Rathbun, Jonathan W
CSN: 186435319 MRN: 0060686248 Medical record number: _____
Parent/ DOB: 6/12/1999 (19 yrs) Sex: M _____
Date of 11/5/2018 0718 Location: WY _____
Current  _____
City: _____ State: _____ ZIP code: _____

Accident information

Date of injury: _____

Motor vehicle

Do you have individual auto insurance? Yes No

If yes, your auto insurance will be billed as the primary insurance. If you do not have auto insurance, would you like your personal health insurance to be billed? Yes No

If you do not have auto or personal health insurance, you will be billed directly.

Workers' Compensation

All claims must first be billed to your employers' Workers' Compensation Insurance.

Has the first report of injury been filed with your employer? Yes No

If no, please do so within the next 3 business days to ensure that your claim will be paid.

Is the injury with your current or past employer? _____

Employer Name: _____ Phone: _____

Employer Address: _____

Personal Injury/Third Party

Are you currently on Medicare? Yes No

If yes, will you be submitting a liability claim? Yes No

(If no, Fairview will bill Medicare and any additional personal insurance).

If you aren't a Medicare Recipient, would you like your health insurance billed? Yes No
(If no, you will be billed directly.)

Accident/Insurance Information

Name of insurance carrier: _____

ID/Claim Number: _____

Billing address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Contact Person/Claim Adjuster: _____