



employer solutions staffing group

10000 W. Yale Avenue, Suite 405, Edina, MN 55439

7301 Dhms 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: Fraser Joyce Lynn Male Female
 Last First Middle
 Date of Birth: 4 / 5 / 1961 Telephone# (615) 630-8974 (Cell)
 Home Address: 8819 W. Yale Avenue
 City: Lakewood State: CO Zip Code: 80227
 Name of Company: _____ Job Title: Machine operator
 Social security No: 305-78-1488 Rate of Pay: \$12.80
 Location of Accident: Lake Region Medical (Centerless grind - Machine #3)
 Name of building Area (loading dock)

Date of accident: 1-28-2016 Time of accident: 5:50 pm

*Centerless
Grind
in Machine
#3*

Please describe fully how the accident occurred: I had just got done checking the water level of machine tank with dip stick and added more water to the tank. Was coming back to machine and noticed the tank lid was not sitting on tank correctly. Went to place the tank lid straight over the tank when my glove got hold under the lid went to remove my hand →
 (Continue on the back side, if necessary)

Please describe Bodily Injury sustained, Be specific about body part(s) affected:
Side of index finger (1st joint tip) on the left hand.

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

Name of your Supervisor: Paul
 Name(s) of witness(es): Todd Bobbie Finley & Photh
 (attach witness(es) report(s))

When did you report the accident to your Supervisor? 1st First Aid Responder - Pam Kelly (5:51)
(6:20 p.m.) then Team Leader Chris Lepski, then Paul when I found him (9:35)

Signature of Employee: Joyce Fraser Date: 2-3-2016

and realized the glove was stuck - went to lift the lid up was
when the lid came back down on my finger and pinched the
lid on my finger (left index finger).

Went to find 1st Aid person to inform them of the report - look after Salli
find Pam Kelley - she looked at my finger then we went back out
to first aid station together, NO supervisor was around at that time.
to report it. Pam said, "If she see one she will inform them to come
see me." Then I seen Chris Team Lead about what happen (bizq.)

I also checked for blood on gloves, tank lid, tank.
No blood was found.



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

(Initial) JF I acknowledge that I have received a separate copy of this form.

Joyce Frasin
Employees Signature

2-3-2016
Date

Joyce Frasin
Employee please print your name here

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Re: Joyce Frasier
Address: 8879 W. Yale Ave Lakewood CO 80227

Birthdate: 4/5/1961
S.S.N.: 305-78-1488

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:

- | | |
|---|--|
| <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.

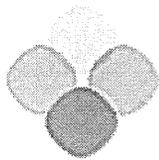
I understand that I may revoke this consent at any time by notifying, in writing, the healthcare facility listed above. Revoking this authorization does not apply to information that has already been released under this authorization. Upon fulfillment of the above-stated purposes, this consent will automatically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

Dated: 2-3-2016

Joyce Frasier
(Signature of Patient or Guardian)

N/A
(Relationship to Patient if signed by Guardian)

N/A
(Reason Patient is unable to sign)



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Leveraging Resources in a Changing Market

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DECLINE OF MEDICAL TREATMENT FORM

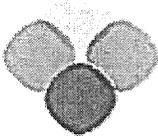
This form is only to be signed if you **do not** require medical attention in relation to your report of an on the job incident.

I, Joyce Frazier, acknowledge that I have reported on the job incident. The facility has offered me medical attention to be administered by the facility's designated workers' compensation physician. However, at this time I feel I **do not require** medical attention and by signing this form I am stating that I can safely complete the essential functions of my job without compromising the safety of my co-workers, residents, or myself. I understand that if my condition changes in relation to this work related incident that I must notify the facility's administrator before seeking any medical attention.

By signing this form I am declining medical attention by a physician at this time.

Joyce Frazier 2-3-2016
Employee Date

Myda Tolbet 2/4/2016
Supervisor Date



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Phone: (952) 767-0053 Fax: (952) 767-0740
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Employee's name: byce Lynn Frozier Phone Number 615-630-8974

Date of injury: 1-28-2016 Date Reported 1-28-2016

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? Good

Please tell me the nature of your injury. Where does it hurt? What type of injury? (strain, sprain, cut, bruise, ect...) Frest index finger on left hand (1st tip joint in firm) Blood blister, w/ swelling & bruising.

Have you experienced an injury like this before? NO

Please tell me what you were doing when the injury occurred? Just added more water to machine #3 the proper water level into machine tank to keep water coolant correct to run. When I noticed coming back from water closet noticed the tank lid not on correctly so I & Ryan noticed coming back from water closet noticed the tank lid not on correctly. (Centurion Hand Machine #3)
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?
Dipstick, gallon plastic jug (gloves, safety glasses on)

Please describe the training you received prior to using this equipment.
1. Use dipstick to check water level - add water into screen area (Chris)
2. Many - likes us to check by letting the tank lid to check the back tank level to see visual with flashlight.

Is there anything else you can tell us about how the injury occurred?
Like to know why the tank lid was not put back on correctly before I started my machine. The machine had been down prior before I got to it.

byce Lynn Frozier
Signature of Employee

2-3-2016
Date