employer solutions staffing group LLC
PO Box 46270 Minneapolis, MN 55344-9956
Phone: (952) 767-0053 Fax: (952) 767-0740
Email Address: wc@employersolutionsgroup.com

First Report of Accident or Injury

RECRUITER/SUPERVISOR NEEDS TO COMPLETE THIS FORM ASAP AFTER INJURY
Email: wc@employersolutionsgroup.com

Last Name: Schade	First and Other Names: Karen	
Date of Birth: 08-07-1965	Jobsite: Premier Marine	Start Date at Jobsite: 10/31/2018
Social Security #: 472-84-7407	Position: Final Assembly	
Employee's Phone (Home):	Employee's Phone (Mobile): 651-247-0189	
Date of incident: 11/29/2018	Time of incident: 2:30 AM ☐ PM ☑	
Name of witness(es): Dollanne & Eric	Witness(es) phone #(s): N/A	

Name of Supervisor: Dan	Date and time notified: 2:30pm

Cause of Injury/Source (please select one)

Struck by/Against Object

Metal component of air hose

Type of Injury/Illness (please select one)

Contusion

Left side of temple

- o Was the employee paid for 4+ hours the date of injury? ☑ **Yes** ☐ **No**
- o What shift does the employee work? 1ST ☑ 2ND ☐ 3RD ☐
- o Is the employee missing time from work? ☑ Yes ☐ No
- o Does the site location offer light duty work? ☐ Yes ☐ No
- o Is there surveillance footage of the incident? ☐ Yes ☐ No
- o Did employee go to the E.R. or Clinic? ☐ Yes ☑ No
- o Does the employee need a translator? ☐ Yes ☑ No Language: _____

INJURY DETAILS: (Describe the incident in detail and which body part(s) that are affected. Please be specific).

Describe how injury(s) occurred - please be specific:

Karen was working in the warehouse where there were 2 aisles of pontoons, each side consisting of 5 boats per side. Karen was working on the right-side aisle. Karen was bending over working on a boat, the employee on the left side of the aisle directly across from her, released the clamp to the air gun, which released the air hose, that swung 15-20 feet across the aisle contacting Karen on the left side of her temple. Karen instantly seen "stars" holding on to the pontoon for support while standing. Swelling was instant to her left temple, an employee by the name of Dollanne applied and ointment to the injury. Eric, who is a welder witnesses the incident take place.
Dan, the assistant manager, was near Karen during the time of the injury when it had happened. Karen informed Dan what happened and how she seen stars after the object made contacted with her head. Dan noticed the swelling to her temple making a comment of "holy crap"!
First aid was not offered, a report was not made, Karen was not sent to the hospital for observation.

Name and Address of Hospital/Clinic where taken for treatment: N/A

Hospital/Clinic Phone: N/A

Recruiter/Supervisor Signature: Rachel Prickett Digitally signed by Rachel Prickett Date: 2018.11.29 10:15:00 -06'00' Recruiter/Supervisor Phone: 651-666-3883

Recruiter/Supervisor Print Name: Rachel Prickett

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Employee's Report of Injury

(to be completed by the employee)

Employee's Name: Schade Karen Grace (Last / First / Middle) Male ☐ Female ☑

Date of Birth: 08-07-1965 Home Telephone: 651-247-0189

Home Address: 46443 Cambridge Drive

City: Stanchfield State: MN Zip Code: 55080

Name of Company: Premier Marine Job Title: Final Assembly

Social Security #: 472-84-7407 Rate of Pay: $15.00

Location of Accident: Inside of the warehouse
(Name of building / Area (loading dock))

Date of accident: 11/28/2018 Time of accident: 2:30pm

Please describe fully how the accident occurred:

Karen was working in the warehouse where there were 2 aisles of pontoons, each side consisting of 5 boats per side. Karen was working on the right-side aisle. Karen was bending over working on a boat, the employee on the left side of the aisle directly across from her, released the clamp to the air gun, which released the air hose, that swung 15-20 feet across the aisle contacting Karen on the left side of her temple. ~~Karen instantly seen "stars" holding on to the pontoon for support while standing. Swelling was instant to her left temple, an employee by the name of Dollanne applied and ointment to the injury. Eric, who is a welder~~ witnesses the incident take place.
Dan, the assistant manager, was near Karen during the time of the injury when it had happened. Karen informed Dan what happened and how she seen stars after the object made contacted with her head. Dan noticed the swelling to her temple making a comment of "holy crap"!
First aid was not offered, a report was not made, Karen was not sent to the hospital for observation.

(Continue on the back side, if necessary)

What body part(s) are affected? (be specific):

Left side of temple.

Name of your Supervisor: Dan

Name(s) of witness(es): Eric,Dollanne
[attach witness(es) report(s)]

When did you report the accident to your Supervisor? 2:30pm

Employee Signature: _____ Date: 11/29/2018

AUTHORIZATION FOR THE RELEASE OF INFORMATION

RE Employee: Karen Schade Birth Date: 08-07-1965

Address: 46443 Cambridge Drive Stanchfield, MN 55080 SSN: 472-84-7407

This will authorize: _____
(Medical Provider/Facility)

To release to an authorized representative of _____ 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** History/Physical
- **X** AIDS/HIV Records
- **X** Consultation Reports
- **X** X-Ray/Scan reports and Films
- **X** Pathology Reports
- **X** Laboratory Reports
- **X** Other (Specify): _____
- **X** Operative Reports
- **X** Psychological Tests/Reports
- **X** Correspondence
- **X** Discharge Summaries
- **X** Diagnostic Testing Reports and Films
- **X** Any and all Chart Notes, Narrative Reports, Billings and Medical Records
- **X** Mental Illness/Chemical Dependency, and/or Alcohol Abuse records

This 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 regulation 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.

Date: _____ Patient Signature_____
(Patient or Guardian Signature)

_____
(Relationship to patient IF guardian signs)

_____
(Reason patient is unable to sign)

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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, _____, acknowledge that I have reported an on the job incident. My employer and/or worksite has offered me medical attention. 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 myself or others. I understand that if my condition changes in relation to this work related incident that I must notify my supervisor and/or employer representative before seeking any medical attention.

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

	11/29/2018	Rachel Prickett Digitally signed by Rachel Prickett Date: 2018.11.29 10:37:43 -06'00'	11/29/2018
Employee Signature	Date	Recruiter/Supervisor Signature	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 Solutions Staffing Group, LLC is willing to accommodate modified job duties.

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. If you feel you are being required to do tasks outside of your restrictions, please call 952-767-0053.

The medical restrictions are in effect 24 hours per day. Exercise good judgement 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, may affect your entitlement to benefits.

(initial)_____ I have read, understand; and agree to the above responsibilities

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

_____ 11/29/2018

Employee Signature Date

_____

Employee Printed Name

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WORK STATUS REPORT/MEDICAL SERVICE FORM

EMPLOYEE INFORMATION:

Name: Karen Schade
Date of Birth: 08-07-1965
Social Security Number: 472-84-7407
Phone#: N/A
Date Of Injury: 11/28/2018
Time of Injury: 2:30 ☐ a.m. ☑ p.m.
Job Description: Final Assembly

Drug/Alcohol Test: Yes or No **(FOR ALL WORK RELATED INJURIES)**

EMPLOYER INFORMATION:

Company: Employer Solutions Staffing Group, LLC
Phone #: 952-767-0053 Fax #: 952-767-0740 Date Notified: _____
Authorized Employer Signature: _____

EMPLOYER HAS LIGHT DUTY WORK AVAILABLE

TO BE COMPLETED BY PROVIDER:

Diagnosis: _____

Date of Examination: _____/_____/_____ Time: _____ ☐ a.m. ☐ p.m.

Treatment Plan:
_____ Must Return for re-evaluation on: _____/_____/_____
_____ To received PT/OT Services Duration: _____ x week _____x weeks
Surgery Scheduled: _____/_____/_____
_____ Time:_____ ☐ a.m. ☐ p.m. ☐ Inpatient ☐ Outpatient
_____ No further care required Discharge Date: _____/_____/_____

Expected Healing Time:
_____ Days _____ Weeks _____ Months _____
_____ Other _____

Current Status:
_____ May work full duty now (no restrictions) _____/_____/_____ (Date)
_____ May work light duty now with identified restrictions through _____/_____/_____
_____ Presently working as of: _____/_____/_____
_____ Many not work until: _____/_____/_____ ☐ Full Duty ☐ Light Duty
_____ Lifting: Maximum Wight in Lbs.
_____ Pushing: ☐ 0 ☐ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 50 ☐ 60
_____ Pulling:
Bending: Maximum Times/Hour: ☐ 0-2 ☐ 2-6 ☐ 6-10 ☐ 10-20
Degree of bend: ☐ 10-20 ☐ 20-45 ☐ Full
_____ No Sitting _____ No Standing _____No Walking
_____ Sitting Job Only _____ No Climbing or Overhead Work
_____ May not use: ☐ Right Hand ☐ Left Hand
_____ Keep dressing/wound clean & dry
Medication may cause drowsiness.
_____ Use caution operating machinery or equipment.

Comments: _____

Next Follow Up Appointment:

PHYSICIAN INFORMATION:

Physician Name: _____ Phone: (_____) _____-_____
Physician Signature: _____ Date: _____/_____/_____

Employee: To expedite prompt claim handling, this complete form is to be returned to your employer either on the same day of the appointment or, should lost time be incurred, it is to be forwarded to your employer the day following the appointment.

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Injured Employee Questionnaire

Employee's Name: Karen Schade Phone Number 651-247-0189

Date of Injury: 11/28/2018 Date Reported 11/28/2018

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, etc…)

Have you experienced an injury like this before?

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

Is this part of your normal job functions? If not, what training did you receive prior to this job function?

What tools and equipment were you using at the time of injury?

Please describe the training you received prior to using this equipment.

Is there anything else you can tell us about how the injury occurred?

_____ 11/29/2018

Employee Signature Date

Employee Form

Job Description
Recruiter/Supervisor Statement

Employee Name: Karen Schade **Job Title:** Final Assembly

NOTE: In terms of an 8-hour workday.
Occasionally, equals 1% to 33%. Frequently, 34% to 66%. , or Continuously, 67% to 100%.

In an 8-hour workday, Employee does the following: (Check full capacity for each activity)

TOTAL AT ONE TIME										
Sit	☑ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	HRS
Stand	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☑ 8	HRS
Walk	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☑ 8	HRS
Drive	☑ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	HRS
TOTAL DURING ENTIRE 8-HOUR DAY										
Sit	☑ 0	☑ 1	☐ 2	☑ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	HRS
Stand	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☑ 8	HRS
Walk	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☑ 8	HRS

Lifting	**OCCASIONALLY**	**FREQUENTLY**	**CONTINUOUSLY**	**NONE**
Up to 10 lbs.	■	☐	☐	☐
11-20 lbs.	■	☐	☐	☐
21-25 lbs.	☐	☐	☐	■
26-50 lbs.	☐	☐	☐	■
51-100 lbs.	☐	☐	☐	■

Carrying:	**OCCASIONALLY**	**FREQUENTLY**	**CONTINUOUSLY**	**NONE**
Up to 10 lbs.	■	☐	☐	☐
11-20 lbs.	☐	☐	☐	■
21-25 lbs.	☐	☐	☐	■
26-50 lbs.	☐	☐	☐	■
51-100 lbs.	☐	☐	☐	■

Use of Hands	**SIMPLE GRASPING**	**FINE WORK**	**PUSHING PULLING**	**LOW SPEED ASSEMBLY**	**HIGH SPEED ASSEMBLY**
Left	■	■	■	■	☐
Right	■	■	■	■	☐

Comments:

Worker needs to:	**OCCASIONALLY**	**FREQUENTLY**	**CONTINUOUSLY**	**NONE**
Bend	■	☐	☐	☐
Squat	■	☐	☐	☐
Crawl	☐	☐	☐	■
Climb	☐	☐	☐	■
Reach	■	☐	☐	☐
Kneel	■	☐	☐	☐
Twist	■	☐	☐	☐

Please explain in detail what the employee does on a daily basis:

Rachel Prickett Digitally signed by Rachel Prickett Date: 2018.11.29 10:37:03 -06'00'

Recruiter/Supervisor Signature

11/29/2018

Date