



employer solutions staffing group  
 Leveraging Resources in a Changing Market

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: Laird Laniel L Male  Female   
Last First Middle  
 Date of Birth: 01 / 09 / 1966 Telephone#( 719 ) 5537586  
 Home Address: 2500 W. Hampden Ave, #163  
 City: Englewood State: Co Zip Code: 80110  
 Name of Company: Kong Job Title: Machine Operator  
 Social security No: 483862396 Rate of Pay: 11.00  
 Location of Accident: Kong Manufacturing At the Machines  
Name of building Area (loading dock)

Date of accident: 9/29/2016 Time of accident: 0000

Please describe fully how the accident occurred: \_\_\_\_\_

This is a repetitive motion injury. After the very hot parts come out of the press by hand, the operator must quickly try to trim all extra material from the outer edges of the part and then puncture the small round end and push, twist, pull, repeat as ma

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(Continue on the back side, if necessary)

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

Bi Lateral wrist pain, hand pain, tingling and some numbness in both hands.

\_\_\_\_\_  
 \_\_\_\_\_

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

Health one occupational medicine 14000 E Arapahoe Rd., Ste 160 Centennial, CO 80112 Phone: 303-218-4250

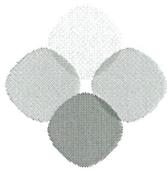
Name of your Supervisor: Clint

Name(s) of witness(es): \_\_\_\_\_

(attach witness(es) report(s))

When did you report the accident to your Supervisor? 9/28/2016, 9/29/2016

Signature of Employee: Laniel L Laird Date: Oct 4, 2016  
Laniel L Laird (Oct 4, 2016)



# employer solutions staffing group<sup>LLC</sup>

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Phone: (952) 767-0053 Fax: (952) 767-0740  
Email Address: wc@employersolutionsgroup.com

Employee's name: Laniel L Laird Phone Number 719-553-7586

Date of injury: 9/29/2016 Date Reported 9/29/2016

**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?

Please tell me the nature of your injury. Where does it hurt? What type of injury? ( strain, sprain, cut, bruise, ect...)

Both hands. Left hand, still cannot close all the way without pain. tingling, some numbness feeling sometimes, Right hand, Tingles and numbness feeling often, cannot use much before it starts to feel like my hand is asleep.

Have you experienced an injury like this before?

no

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

Working

Is this part of your normal job functions? , If not what training did you receive prior to this Job Function?  
yes, and very little training at this place

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

needle nose pliers, side cutter pliers

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

here is the part, trim this and open this end hole to look like this. about 4.5 days worked with a co worker.

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

repetitive motion.

Laniel L Laird  
Laniel L Laird (Oct 4, 2016)

Signature of Employee

Oct 4, 2016

Date



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Maximizing Productivity Through Staffing Solutions

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

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

Laniel L Laird  
Laniel L Laird (Oct 4, 2016)

\_\_\_\_\_  
Employee Signature

Oct 4, 2016

\_\_\_\_\_  
Date

Laniel L Laird

\_\_\_\_\_  
Employee please print your name here

**AUTHORIZATION FOR THE RELEASE OF INFORMATION**

Re: Laniel L Laird  
Address: 2500 w hampden ave, #163, Englewood, Co, 80110

Birthdate: 01/09/2016  
S.S.N.: 483-86-2396

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: Oct 4, 2016

Laniel L Laird  
Laniel L Laird (Oct 4, 2016)  
(Signature of Patient or Guardian)

\_\_\_\_\_  
(Relationship to Patient if signed by Guardian)

\_\_\_\_\_  
(Reason Patient is unable to sign)



# Injury Report forms: For Employee

Adobe Sign Document History

10/04/2016

|                 |  |
|-----------------|--|
| Created:        | 10/03/2016                                       |
| By:             | Caitlin Scholl (Caitlin@corpmanagementgroup.com) |
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## "Injury Report forms: For Employee" History

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Signature Date: 10/04/2016 - 11:51:29 AM MDT - Time Source: server- IP address: 71.211.252.121
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