



employer solutions staffing group
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, Letera Peterson, 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.

Letera Peterson 12/1/16
Employee Date

[Signature] 12-1-16
Supervisor Date

Employee Incident Report

PLEASE COMPLETE ALL INFORMATION (To be completed by Supervisor with employee)

Your Name (please print): Letera Peterson Today's Date: 11-30-16

Date Accident Occurred: 11-29-16 Time Accident Occurred: _____ a.m. 8³⁰ p.m.

Time you started working: _____ a.m. 3³⁰ p.m. Were you working overtime? Yes No

Your regular department: YES Shift: _____ 1st 2nd _____ 3rd

Date of birth: 2-18-89 Date of hire: 11-21-16

Were you performing your regular job? Yes _____ No If not, where were you working? _____

Please describe in complete detail what happened and list equipment, tools, or machines that were involved.

Employee/Witness Statement:

while packing patty on line 1, and carrying a box to the conveyor, her shoulder popped/cracked. At the time it felt good and relieved pressure in shoulder. Later in the day it started to get irritated and sore. The next morning it was very stiff and sore. Unable to move with out pain.

Please check all appropriate boxes below: Part of Body Affected

Head	Upper Extremities	Trunk	Lower Extremities
<input type="checkbox"/> Ear <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/> Elbow <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/> Back (Middle)	<input type="checkbox"/> Ankle <input type="checkbox"/> right <input type="checkbox"/> left
<input type="checkbox"/> Eye <input type="checkbox"/> right <input type="checkbox"/> left	<input checked="" type="checkbox"/> Upper arm <input checked="" type="checkbox"/> right <input checked="" type="checkbox"/> left	<input type="checkbox"/> Back (Lower)	<input type="checkbox"/> Hip <input type="checkbox"/> right <input type="checkbox"/> left
<input type="checkbox"/> Nose	<input type="checkbox"/> Wrist <input type="checkbox"/> right <input type="checkbox"/> left	<input checked="" type="checkbox"/> Back (Upper)	<input type="checkbox"/> Knee <input type="checkbox"/> right <input type="checkbox"/> left
<input type="checkbox"/> Skull	<input type="checkbox"/> Hand <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/> Tailbone	<input type="checkbox"/> Upper leg <input type="checkbox"/> right <input type="checkbox"/> left
<input type="checkbox"/> Teeth	<input checked="" type="checkbox"/> Shoulder <input checked="" type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/> Chest	<input type="checkbox"/> Lower leg <input type="checkbox"/> right <input type="checkbox"/> left
<input type="checkbox"/> Face	<input type="checkbox"/> Forearm <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/> Other	<input type="checkbox"/> Foot <input type="checkbox"/> right <input type="checkbox"/> left
	<input type="checkbox"/> Thumb <input type="checkbox"/> right <input type="checkbox"/> left		<input type="checkbox"/> Toe(s) <input type="checkbox"/> right <input type="checkbox"/> left
	<input type="checkbox"/> Fingers <input type="checkbox"/> right <input type="checkbox"/> left		

Nature of Specific Injury

- Abrasion (scratch) Burn (thermal) Laceration (cut)
 Burn (chemical) Contusion (bruise) Puncture
 Electrical shock Strain, Sprain Foreign body in eye

Type of Accident

- Caught in/on/between Fall (different level) Cumulative trauma (repetitive)
 Contact w/electric current Inhalation, absorption Struck against or struck by object
 Collision (vehicle) Ingestion Other (please explain)
 Fall (floor level) Infection

Did anyone else see this happen? Yes* _____ No *If yes, indicate names: AKgh / French / Jenny
 Did you see the Company nurse? _____ Yes No (nobody else was sore but did not see)
 Did you go to the Emergency Room? _____ Yes No Name of Hospital: anything happen
 Did you see a Physician? _____ Yes No Physician Name and Phone: _____

*request statement/incident report from witnesses

This is an accurate report of my injury or near miss.

Employee Signature: Letera Peterson Date: 11-30-16

Investigating Supervisor Signature: [Signature] Date: 11-30-16

Supervisor's Incident Reporting and Investigation Form

Employee's Name <i>Letera Peterson</i>		Supervisor's Name <i>Matt Heaton</i>	
Job Title and Department <i>pack out</i>			
Work Location <i>Dimension</i>		Reporting Supervisor <i>Matt - Jenny</i>	
Type of Incident: (check one) <input type="checkbox"/> Incident/Near Miss <input checked="" type="checkbox"/> Injury			
Incident Date <i>11-29</i>		Time <i>8:30</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	Date Reported <i>11-30</i>
			Last Day Worked

Describe what the employee was doing just before the accident/incident occurred.
packing patty to a box.

Describe how the accident/incident occurred (be specific about body part injured):
while carrying a box of patties to the conveyor her shoulder cracked. At first felt good and relieved pressure but later became sore. Letera told no one until the next day.

When and to whom did the employee first report the incident: *M. Les Gilbert / Matt Heaton*

Witnesses: *no witnesses to the incident but she said Jenny-Akela-French asked about*

To be completed within 24 hours by the Supervisor / Department Manager
 Describe in detail the task the employee was doing at the time of injury (include vehicle, equipment or tools used):

Describe your findings of the incident, what was employee doing when injured, how and where did it specifically occur:
being sore

Letera informed me on 11-30 that on 11-29 she strained her shoulder. she did not inform any one until asked. she said it was most likely just sore from a new job. Continued work if any kind seemed to irritate it. I let her go home

Interview witnesses or co-workers for additional insights. Attach sheet for additional info/comments. *Her choice.*

Was this the employee's regular work assignment? Yes No If no, was person trained for assignment? Yes No

Causal Factors	Yes	No	Comments	Corrective Action
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- Environment**
- 1.1 Did the work area design contribute to the injury? Yes No
 - 1.2 Was the area cluttered? Yes No
 - 1.3 Did the employee have to be in this area to complete the job? Yes No
 - 1.4 Were other conditions (noise, air contaminants, extreme temperatures, etc.) a contributing factor? Yes No
 - 1.5 Other Yes No

- Equipment/Tools**
- 2.1 Was the correct equipment being used? Yes No
 - 2.2 Was the correct equipment readily available? Yes No
 - 2.3 Did any defects or change in equipment/material contribute to hazardous conditions? Yes No
 - 2.4 Is regular maintenance done on machinery/equipment? Yes No
 - 2.5 Are there any maintenance logs? Yes No
 - 2.6 Was the employee using PPE (Shoes, apron, goggles)? Yes No

- Method**
- 3.1 Was the employee performing according to SOP? Yes No
 - 3.2 Was there a better method to perform task? Yes No

- Employee**
- 4.1 Was safety equipment specified for this job? (List all) Yes No
 - 4.2 Was this equipment being used? Yes No
 - 4.3 Have safety procedures been established for this task? Yes No
 - 4.4 Were safety procedures being followed? If no, why? Yes No
 - 4.5 Was the employee trained on necessary equipment? Yes No

Witness Incident Report

PLEASE COMPLETE ALL INFORMATION (To be completed by Supervisor with employee)

Your Name (please print): Miles Gilbert Today's Date: 11-30-16

Date Accident Occurred: 11-30-16 Time Accident Occurred: _____ a.m. 4:30 p.m.
witnessed on

Time you started working: _____ a.m. 2:30 p.m. Were you working overtime? ___ Yes No

Your regular department: pack out Shift: ___ 1st 2nd ___ 3rd

Were you performing your regular job? Yes ___ No If not, where were you working? _____

Did you see this happen? ___ Yes* No

Who was involved in the incident? Letera Peterson

What date did this occur? 11-29-16

Are you aware of anyone else that witnessed this incident? ___ Yes No *if yes, indicate names

**request statement/incident report from witnesses*

Please describe in complete detail what happened and list equipment, tools, or machines that were involved.

Employee/Witness Statement:

I noticed Letera was sore and having trouble packing boxes so I asked her about it. After her telling me she was in pain I moved her to a job that would be easier for her and then told Matt.

This is an accurate report of my injury or near miss.

Employee Signature: Miles Gilbert Date: 11-30-16

Investigating Supervisor Signature: [Signature] Date: 11-30-16

RETURN THIS ORIGINAL TO THE HR MANAGER IMMEDIATELY AFTER INCIDENT