employer solutions staffing group
Leveraging Resources in a Changing Market

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First Report of Accident or Injury

NEED TO COMPLETE THIS FORM ASAP AFTER INJURY—FAX TO ESSG AT 952-767-0740

Last Name: Kopacz		First and Other Names: Michael	
Date of Birth: 12/13/1988		Length of time on this assignment: 8 weeks	
Sex: Male	Social Security #: 106-88-4721	Jobsite: Orchard Park	Position: Material Handler
Employee's Phone: (Home):		Employee's Phone (Cell or Emergency Contact: 716-391-7863 Amanda Kopacz(wife)	
Date of incident: 7/24/15		Time of incident: 12.33	AM ☐ PM ☑
Name(s) of witness: Rose Pierce, Mark Passon, Kim Laettner		Witness Phone: work 716-662-5025	

Name of Supervisor: Mark Passon Date and time notified: 7/24/15 12:33pm

How did the incident occur? was lifting pallets and the one slid and he tried to catch it and twisted his back

Cause of Injury/Source (please select one)

Lifting and Lowering

Type of Injury/Illness (please select one)

Select Applicable

☐ No Physical Injury ☐ Not Reported ☑ Other specific injury: Sprain/Strain Lumbar

Affected Body Part (please select one)

(Head) (Lower extremities) (Neck) (Trunk) (Upper extermities)

☐ Insufficient info to properly identify ☐ Not Reported ☑ Other specific injury: lower back

Please let us know what shift does EE work, Please select one: 1st

What day of the week/weekends is the Employee scheduled to work: ☑ Monday: ☑ Tuesday ☑ Wednesday ☑ Thursday ☑ Friday ☐ Saturday ☐ Sunday

o WAS THE EMPLOYEE PAID THE FULL DAY FOR THE DOI: ☐ Yes ☑ No

o Can Site Location Accommodate, please select one: ☐ Yes ☑ No

o Accommodating POSITION: _____ (EX. FILING, OFFICE ASSISTANT, ETC.)

o If you are able to accommodate, what type of work is being offered? (Please select one)

o If you are not able to Accommodate, Which date was the Employee last work day: 7/24/15

INJURY DETAILS: (Include if it is a part of his job duties and the object that cause it ex: welding tube, hoist, packing carrots, etc.)

Description of Injury(s): lifted up the bar stock pallets and as one slid he tried to catch it and twisted his back.

Hospital / Clinic: ☑ Yes ☐ No
If Yes, Name and Address of Hospital / Clinic where taken for treatment: Healthworks 1900 Ridge Road, West Seneca
Phone: 716-712-0670

Signed:	Print Name & Position:	Phone:

Work Status Report

Treatment Date: 07/24/2015	Time In:	☒ Work Injury
Date of Injury: 07/24/2015	Time Out: 14:23	☐ Return to Work

Patient Name Kopacz, Michael

Patient Phone Number (716) 391-7863

Employer Lake Region Medical

(Place Label Here If Available)

☒ HealthWorks Southtowns
1900 Ridge Road
West Seneca, NY 14224
Phone: 716-712-0670
Fax: 716-712-0674

☐ HealthWorks Ken-Ton
2075 Sheridan Drive
Kenmore, NY 14223
Phone: 716-447-6474
Fax: 716-447-6433

☐ HealthWorks Depew
6199 Transit Road
Depew, NY 14043
Phone: 716-206-0390
Fax: 716-206-0394

Work Status / Restrictions

Diagnosis Sprain/Strain, Lumbar

Medications toradol, tramadol

Work Restrictions

☐ Return to regular work duties: Date: _____

☐ Return to work with the following restrictions (Limited Duty): Date: _____

☒ Totally Disabled

Lifting, Pushing, Pulling
- ☐ No Restriction
- ☐ Restrict to ____ pounds.
- ☐ No overhead work
- ☐ Avoid lifting with:
  - ☐ Right Arm ☐ Left Arm

Bending, Twisting, Stooping
- ☐ No restriction
- ☐ Limit to occasional
- ☐ Avoid completely

Standing
- ☐ No restriction
- ☐ Limit to ____ % of shift

Walking
- ☐ No restriction
- ☐ Limit to ____ % of Shift

Degree of Partial Disability
- ☐ Mild
- ☐ Mild to Moderate
- ☐ Moderate
- ☐ Moderate to Marked
- ☐ Marked

No use of: ☐ LEFT ☐ RIGHT ☐ Hand ☐ Arm ☐ Foot ☐ Leg

Minimal use of: ☐ LEFT ☐ RIGHT ☐ Hand ☐ Arm ☐ Foot ☐ Leg

Is Patient Working?
- ☐ YES
- ☐ NO
- ☐ Pending

Climbing:
- ☐ No Ladders
- ☐ No stairs, ramps

Other Restrictions:

Follow-Up / Referrals

Physical Therapy	Specialist / Referral	Special Tests

Return to HealthWorks: Monday Date: 07/27/2015 Time: 11:00 AM ☐ As Needed

Patient Instructions

☒ I have received a copy of these instructions and I understand them clearly. I will provide a copy of this form to my employer.

☒ Other Instructions:

ice, heat, gentle range of motion/ stretching

☐ X-Rays done – I understand that x-rays do not always show injury or disease. Fractures may not be seen on an initial x-ray. If my problem persists or worsens, I will contact HealthWorks or go to the nearest Emergency Department.

Provider Signature: _____ Patient Signature: _____

Work Status Report

Treatment Date: 07/27/2015	Time In:	☒ Work Injury
Date of Injury: 07/24/2015	Time Out:	☐ Return to Work

Patient Name Kopacz, Michael

Patient Phone Number (716) 391-7863

Employer Lake Region Medical
(Place Label Here if Available)

☒ HealthWorks Southtowns
1900 Ridge Road
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6199 Transit Road
Depew, NY 14043
Phone: 716-206-0390
Fax: 716-206-0394

Work Status / Restrictions

Diagnosis Thoraco-Lumbar Strain

Medications Cyclobenzaprine, Medrol as directed

Work Restrictions

☐ Return to regular work duties: Date: _____

☐ Return to work with the following restrictions (Limited Duty): Date: _____

☒ Totally Disabled

Lifting, Pushing, Pulling
- ☐ No Restriction
- ☐ Restrict to ____ pounds.
- ☐ No overhead work
- ☐ Avoid lifting with:
  - ☐ Right Arm ☐ Left Arm

Bending, Twisting, Stooping
- ☐ No restriction
- ☐ Limit to occasional
- ☐ Avoid completely

Standing
- ☐ No restriction
- ☐ Limit to ____ % of shift

Walking
- ☐ No restriction
- ☐ Limit to ____ % of Shift

Degree of Partial Disability
- ☐ Mild
- ☐ Mild to Moderate
- ☐ Moderate
- ☐ Moderate to Marked
- ☐ Marked

No use of: ☐ LEFT ☐ RIGHT ☐ Hand ☐ Arm ☐ Foot ☐ Leg

Minimal use of: ☐ LEFT ☐ RIGHT ☐ Hand ☐ Arm ☐ Foot ☐ Leg

Is Patient Working?
- ☐ YES
- ☐ NO
- ☐ Pending

Climbing:
- ☐ No Ladders
- ☐ No stairs, ramps

Other Restrictions:

Follow-Up / Referrals

Physical Therapy	Specialist / Referral	Special Tests
	Dr. David Bagnall - Rehab NY	
	HealthWorks - W. Seneca Office	
	Friday, 7/31/2015 - 9:20 AM	
	Complete the information packet for visit.	

Return to HealthWorks: _____ Date: _____ Time: _____ ☒ As Needed

Patient Instructions

☒ I have received a copy of these instructions and I understand them clearly. I will provide a copy of this form to my employer.

☒ Other Instructions:

While taking Medrol, avoid all over the counter anti-inflammatory medicines (Ibuprofen, Naproxen, Aspirin) and avoid ALL Alcohol. Take this medicine with food. You MAY take Tylenol (Acetaminophen) if needed.

☐ X-Rays done – I understand that x-rays do not always show injury or disease. Fractures may not be seen on an initial x-ray. If my problem persists or worsens, I will contact HealthWorks or go to the nearest Emergency Department.

Provider Signature: _____ MD Patient Signature: _____

CONFIRMATION: INJURY OR ILLNESS FORM SUBMITTED

ID # 4897

Date and Time Reported:	7/24/2015 12:33 PM
Was this a non-occupational injury or illness?:	
Organization:	Lake Region Medical>Operations>Advanced Surgical>Orchard Park>OPK Support>
Report Type :	Injury or Illness

REPORTED BY

First Name:	Lisa
Last Name:	Nichols
Job Title:	HR
Phone:	
Email Address:	

SUBJECT IDENTITY

First Name:	Michael
Last Name:	Kopacz
Department:	Supply Chain
Was employee working within the scope of the job when the incident occurred?:	Yes

DESCRIPTION

Date and Time of injury, onset of illness or incident:	7/24/2015 7:33 AM
Date and Time employee began work:	
Did the event occur offsite?:	No
Place where incident occurred (department or physical location):	Bar stock area
What was the employee doing before the incident occurred?:	just signed in and ready to start his orders
Detailed description of incident and any relevant circumstances & conditions that preceeded incident:	lifted up the pallets and as the one slid he tried to catch it and twisted his back
Select injury or type of illness:	Injury
Injury Category:	Other
Other Injury Category:	twisted back
Illness Category:	Other
Other Illness Category:	n/a
Describe the injury or illness:	lower back pain
What object or substance directly harmed the employee or impacted the environment?:	lifting bar stock
Details of the injury - Type:	Other
Details of the Injury - Other Type:	lower back
Details of the Injury - Body Part:	Back
Details of the injury - Severity:	back feels like its burning and throbbing

CONFIRMATION: INJURY OR ILLNESS FORM SUBMITTED

Witness 1: Mike Hoffman

Witness 1 Comments:

Would you like to add a second witness?:

Was this a potentially serious incident?: