employer solutions staffing group
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: McArthur	First and Other Names: Monique	
Date of Birth: 03/19/1995	Jobsite: Supermom's	Start Date at Jobsite: 11/09/2018
Social Security #: 474-29-6578	Position: FT Shipping	
Employee's Phone (Home): N/A	Employee's Phone (Mobile): 651-274-1098	
Date of Incident: 02/04/2019	Time of Incident: 5:45 AM ☑ PM ☐	
Name of witness(es): Maria Villeda (Mother)	Witness(es) phone #(s): 651-403-9308	
Name of Supervisor: Miguel Quintanilla	Date and time notified: 02/04/2019 at 1:25 PM	

Cause of Injury/Source (please select one)

Select Applicable — Slipped on ice

Type of Injury/Illness (please select one)

Select Applicable — N/A

- 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:

Monique was getting out of her mother's car around 5:45am on 02/04/2019 when she slipped on ice at the beginning of the sidewalk by the main entrance of her work, Supermom's. Monique fell onto the right side of her body. She hit her right shoulder/shoulder blade, right upper thigh, lower back, and right arm. Monique felt as if she hit her head, but she did not.

Name and Address of Hospital/Clinic where taken for treatment: Allina Health - Cottage Grove, MN	
Hospital/Clinic Phone: 651-458-1884	
Recruiter/Supervisor Signature:	Recruiter/Supervisor Phone: 651-666-3883
Recruiter/Supervisor Print Name: Mari Anderson	

employer solutions staffing group

PO Box 46270 Minneapolis, MN 55344-9956
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: McArthur (Last) Monique (First) (Middle) **Male** ☐ **Female** ☒

Date of Birth: 03/19/1995 **Home Telephone:**
Home Address: 9024 Jensen Ave S
City: Cottage Grove **State:** MN **Zip Code:** 55016
Name of Company: Supermoms **Job Title:** Recruiter
Social Security #: 474-29-6578 **Rate of Pay:** $11 / hr
Location of Accident: Supermoms (Name of building) sidewalk of entrance (Area (loading dock))

Date of accident: 02/04/19 **Time of accident:** 5:45 am
Please describe fully how the accident occurred:
I was getting out of mother's vechicle, As I stepped out of the car, I slipped on my right side of my body. I felt as I hit my head as well, so I asked to leave early
(Continue on the back side, if necessary)

What body part(s) are affected? (be specific):
right shoulder, right arm, right upper thigh, and lower back

Name of your Supervisor: Miguel Quintanilla
Name(s) of witness(es): Marita Villeda
[attach witness(es) report(s)]

When did you report the accident to your Supervisor? Later in the day

Employee Signature: Monique McArthur **Date:** 02/07/19

AUTHORIZATION FOR THE RELEASE OF INFORMATION

RE Employee: Monique McArthur Birth Date: 03/19/1995

Address: 9024 Jensen Ave S., Cottage Grove, MN 55016 SSN: 474-29-6578

This will authorize: Allina Health - Cottage Grove
(Medical Provider/Facility)

To release to an authorized representative of Monique McArthur 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: 02/07/19 Patient Signature Monique McArthur
(Patient or Guardian Signature)

Self
(Relationship to patient IF guardian signs)

X
(Reason patient is unable to sign)

employer solutions staffing group

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

X

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, Monique McArthur, 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.

Monique McArthur 02/07/19
Employee Signature **Date**

Megan Anderson 2/7/2019
Recruiter/Supervisor Signature **Date**

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

X

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

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

Monique McArthur 02/07/19

Employee Signature Date

Monique McArthur

Employee Printed Name

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

WORK STATUS REPORT/MEDICAL SERVICE FORM

EMPLOYEE INFORMATION:

Name: Monique McArthur
Date of Birth: 03/19/1995
Social Security Number: 474-29-6578
Phone#: 651-458-1884
Date Of Injury: 02/04/2019
Time of Injury: 5:45 ☑ a.m. ☐ p.m.
Job Description: FT Shipping - 1st Shift

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.

employer solutions staffing group.

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

Injured Employee Questionnaire

Employee's Name: Monique McArthur Phone Number 651-274-1098

Date of Injury: 02/04/2019 Date Reported 02/04/2019

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? Still sore, but did feel better.

Please tell me the nature of your injury. Where does it hurt? What type of injury? (strain, sprain, cut, bruise, etc...) Just bruised right side of body right shoulder, arm, upper thigh, and lower back

Have you experienced an injury like this before?
Yes, but not at a work place.

Please tell me what you were doing when the injury occurred?
Getting out of mother's vechicle

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

What tools and equipment were you using at the time of injury?
I was holding on to the door handle

Please describe the training you received prior to using this equipment.
no training needed

Is there anything else you can tell us about how the injury occurred?
not at this moment

Monique McArthur
Employee Signature

02/07/19
Date

Employee Form

0710WC

Job Description
Recruiter/Supervisor Statement

Employee Name: Monique McArthur **Job Title:** Recruiter

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:

Monique works in the shipping dept.

Recruiter/Supervisor Signature **Date** 02/01/2019