employer solutions staffing group

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: Popoca (Last) Octavio (First) A (Middle) Male ☑ Female ☐

Date of Birth: 11 / 20 / 1967 Telephone#(224) 3214617

Home Address: 2312 8th parkway

City: waukegan State: il Zip Code: 60085

Name if Company: Lake Regiom Job Title: machine operator

Social security No: 603264947 Rate of Pay: 18.01

Location of Accident: Buildin 1 (Name of building) working area (Area(loading dock))

Date of accident: 10/07/2016 Time of accident: 5:10

Please describe fully how the accident occurred:

I was waiting for the smart-scope to be open and when i turned my head around to take a look, I felt very dizzy and I fell down.

(Continue on the back side, if necessary)

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

No bodily injuries. one of my arteries dissection.

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

GLENBROOK HOSTPITAL, 2100 pfingsten rd glenview, 847-657-5840

Name of your Supervisor: Tom C.

Name(s) of witness(es): Tom, the lady inspectioning the production.

(attach witness(es) report(s)

When did you report the accident to your Supervisor? Right away, he was the one that called the ambulance.

Signature of Employee: Octavio A Popoca Octavio A Popoca (Oct 10, 2016) Date: Oct 10, 2016

Employee's Form

employer solutions staffing group LLC
Leveraging Resources in a Changing Market

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Email Address: wc@employersolutionsgroup.com

Employee's name: Octavio A Popoca Phone Number 224-321-4617

Date of injury: 10/07/2016 Date Reported 10/07/2016

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…)
I have pain in my brain. It's caused because of the artery dissection.

Have you experienced an injury like this before?
NO

Please tell me what you were doing when the injury occurred?
I was in my work station, I turned around to see if the smart scope was in use, when i looked back to my station I was dizzy. At that moment i fell down.

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

What tools and equipment were you using at the time of injury?
At the moment of the accident I was NOT using any type of power tool.

Please describe the training you received prior to using this equipment.
yes, I was tought how to use the type of equipment that I was using.

Is there anything else you can tell us about how the injury occurred?
NO

Octavio A Popoca
Octavio A Popoca (Oct 10, 2016)
Signature of Employee

Oct 10, 2016
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 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). OAP _____ I have read, understand; and agree to the above responsibilities

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

Octavio A Popoca
Octavio A Popoca (Oct 10, 2016)
Employees Signature

Oct 10, 2016
Date

Octavio A Popoca
Employee please print your name here

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Re: _____ Birthdate: 11-20-1967

Address: 2312 8th parkway waukegan il, 60085 S.S.N.: 603-26-4947

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:

X	Entire Medical Record for All Dates	X	Operative Reports
X	History/Physical	X	Psychological Tests/Reports
X	AIDS/HIV Records	X	Correspondence
X	Consultation Reports	X	Discharge Summaries
X	X-Ray/Scan Reports and Films	X	Diagnostic Testing Reports and Films
X	Pathology Reports	X	Any and all chart notes, narrative reports, billings and medical records
X	Laboratory Reports	X	Mental Illness/Chemical Dependency, and/or alcohol abuse records
X	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.

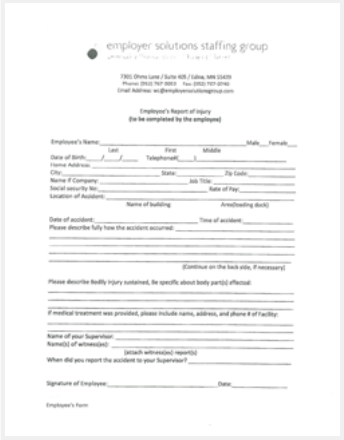
I understand that I may revoke this consent at any time by notifying, in writing, the healthcare facility listed above. Revoking this authorization does not apply to information that has already been released under this authorization. Upon fulfillment of the above-stated purposes, this consent will automatically expire. A photocopy or fax of this authorization is as valid as the original bearing my signature.

Dated: Oct 10, 2016

Octavio A Popoca
Octavio A Popoca (Oct 10, 2016)
(Signature of Patient or Guardian)

_____
(Relationship to Patient if signed by Guardian)

_____
(Reason Patient is unable to sign)



Injury Report forms: For Employee

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