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: Ronald King Male ☑ Female ☐
Last First Middle

Date of Birth: 11/15/67 Home Telephone: 262-623-2379

Home Address: 1700 E. Date Street #1011

City: San Bernardino State: CA Zip Code: 92404

Name of Company: Lake Region Medical Job Title: Machine Operator

Social Security #: 393-76-9466 Rate of Pay: 14.50/hr

Location of Accident: Lake Region Medical Press 17
Name of building Area (loading dock)

Date of accident: 02/08/2018 Time of accident: 5:30 PM

Please describe fully how the accident occurred:

(Continue on the back side, if necessary)

What body part(s) are affected? (be specific):

Name of your Supervisor: Ana Alonso

Name(s) of witness(es): none
[attach witness(es) report(s)]

When did you report the accident to your Supervisor? at 6:15 pm

Employee Signature: Ronald King
Ronald King (Feb 12, 2018) Date: Feb 12, 2018

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Email Address: wc@employersolutionsgroup.com

Injured Employee Questionnaire

Employee's Name: Ronald King Phone Number 262-623-2379

Date of Injury: 02/08/2018 Date Reported at 6:15 pm

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, etc...)

Have you experienced an injury like this before?

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

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

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

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

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

Ronald King
Ronald King (Feb 12, 2018)

Employee Signature

Feb 12, 2018

Date

Employee Form

0710WC

AUTHORIZATION FOR THE RELEASE OF INFORMATION

RE Employee: Ronald King Birth Date: 11/15/67

Address: 1700 E. Date Street #1011 San Bernardino,CA 92404 SSN: 393-76-9466

This will authorize: Chosen medical Provider
(Medical Provider/Facility)

To release to an authorized representative of CMG 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.

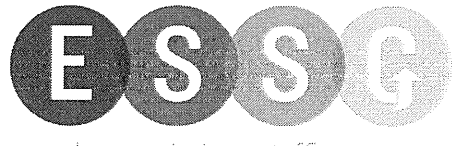
I understand that my receiving treatment, payment, enrollment or eligibility of benefits is not conditional on my signing this form.

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: Feb 12, 2018 Patient Signature: Ronald King
Ronald King (Feb 12, 2018)
(Patient or Guardian Signature)

self
(Relationship to patient IF guardian signs)

self
(Reason patient is unable to sign)



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

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

Ronald King
Ronald King (Feb 12, 2018)
____
Employee Signature

Feb 12, 2018
____
Date

Ronald King
____
Employee Printed Name

ESSG

Employee's Report of Injury

(to be completed by the employee)

Employee's Name:_____ Male ☐ Female ☐

Date of Birth:_____ Home Telephone:_____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Name of Company:_____ Job Title:_____

Social Security #:_____ Rate of Pay:_____

Location of Accident:_____

Date of accident:_____ Time of accident:_____

Please describe fully how the accident occurred:

(Continue on the back side, if necessary)

What body part(s) are affected? (be specific):

Name of your Supervisor:_____

Name(s) of witness(es):_____

When did you report the accident to your Supervisor?_____

Employee Signature:_____ Date:_____

Employee Form

CMG Employee Injury Report Forms

Adobe Sign Document History 02/13/2018

Created:	02/12/2018
By:	Jamie Ready (jamie@corpmgmtgroup.com)
Status:	Signed
Transaction ID:	CBJCHBCAABAAo4G5ntmFQThInnb1cy-3D9tW1S6j3efS

"CMG Employee Injury Report Forms" History

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