



employer solutions staffing group L.L.C.

Leveraging Resources in a Changing Market

7301 Ohms Lane Suite 405 Edina, MN 55439
 Phone: (952) 767-0053 Fax: (952) 767-0740
 Email Address: wc@employersolutionsgroup.com

Employee's name: Shirley Baca Phone Number 7204294620
 Date of injury: 8/2015 Date Reported 12/23/2015

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? my elbow is in pain.

Please tell me the nature of your injury. Where does it hurt? What type of injury? (strain, sprain, cut, bruise, ect...)

My elbow is hurt, from moving my wrist & arm in the same motion for months. I wake up

Have you experienced an injury like this before?

No

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

Working on the welder in Perclose

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

One of them, I can also inspect

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

The welder

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

I was trained to weld on this machine. It was a few week training

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

I think its just from doing the same motion for hours in a day, week, month

Shirley Baca
Shirley Baca (Dec 23, 2015)
 Signature of Employee

12/23/2015
 Date



employer solutions staffing group

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

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

Shirley Baca
Shirley Baca (Dec 23, 2015)

Employee Signature

Shirley Baca

Employee please print your name here

Dec 23, 2015

Date

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Re: _____
Address: _____

Birthdate: _____
S.S.N.: _____

This will authorize _____
(Medical Provider/Facility)

to release to an authorized representative of _____ 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:

- | | |
|---|--|
| <input checked="" type="checkbox"/> Entire Medical Record for All Dates | <input checked="" type="checkbox"/> Operative Reports |
| <input checked="" type="checkbox"/> History/Physical | <input checked="" type="checkbox"/> Psychological Tests/Reports |
| <input checked="" type="checkbox"/> AIDS/HIV Records | <input checked="" type="checkbox"/> Correspondence |
| <input checked="" type="checkbox"/> Consultation Reports | <input checked="" type="checkbox"/> Discharge Summaries |
| <input checked="" type="checkbox"/> X-Ray/Scan Reports and Films | <input checked="" type="checkbox"/> Diagnostic Testing Reports and Films |
| <input checked="" type="checkbox"/> Pathology Reports | <input checked="" type="checkbox"/> Any and all chart notes, narrative reports, billings and medical records |
| <input checked="" type="checkbox"/> Laboratory Reports | <input checked="" type="checkbox"/> Mental Illness/Chemical Dependency, and/or alcohol abuse records |
| <input checked="" type="checkbox"/> 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: Dec 23, 2015

Shirley Baca
Shirley Baca (Dec 23, 2015)

(Signature of Patient or Guardian)

(Relationship to Patient if signed by Guardian)

(Reason Patient is unable to sign)

Incident Questionnaire

Adobe Document Cloud Document
History

December 23, 2015

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