

PHYSICIAN'S REPORT OF WORKER'S COMPENSATION INJURY Time Out: 9:18 AM

A COPY OF THIS REPORT MUST BE SENT TO THE INJURED WORKER AND THE INSURER.

1. REPORT TYPE  Initial  Progress  Closing

EXAM DATE 04/08/2020

2. CASE INFORMATION

Date of Injury Apr 8, 2020

Insurer Claim #

Injured Worker Matthew Senne

Insurance Name

Gallagher Bassett

Social Security #

Insurance Fax

Date of Birth May 16, 1983

Employer Name

Colorado Lighting

Employer Fax

Employer Solutions Staffing Group

3. INITIAL VISIT (only)

a. Injured worker's description of accident/injury  
"Plastic hit eye"

b. Are your objective findings consistent with history and/or work-related mechanism of injury/illness?  Yes  No  TBD

4. CURRENT WORK STATUS  Working  Not Working

5. WORK-RELATED MEDICAL DIAGNOSIS(ES) S05.01X/lnj conjunctiva and corneal abr

6. PLAN OF CARE

a. TREATMENT PLAN

Diagnostic tools/tests Initial evaluation

Procedures

Therapy

Medications

1) Ketorolac Ophthalmic Solution 0.5% 4 times a day 1) Saline eyedrop solution as needed

Supplies

Other

Decrease screen time

b. WORK STATUS

Able to return to full duty on

Able to return to modified duty from 4/8/2020 to 4/9/2020

Unable to work from to

Able to return to part time work on for hours per day

c. LIMITATIONS/RESTRICTIONS  No Restrictions  Temporary Restrictions  Permanent Restrictions

Lifting (maximum weight in pounds) lbs.  Walking hours per day

Repetitive lifting lbs.  Standing hours per day

Carrying lbs.  Sitting hours per day

Pushing / Pulling lbs.  Crawling hours per day

Pinching / Gripping  Kneeling hours per day

Reaching over head  Squatting hours per day

Reaching away from body  Climbing hours per day

Repetitive Motion Restrictions

Other Must wear eye protection at all times at jobsite

7. FOLLOW UP CARE AND REFERRALS - \*7c. requires a notice by certified mail to insurer & patient within 3 business days. (See Instructions)

a.  Return Appointment Date 4/9/2020 @ 7:30 AM

b.  Referral for  Treatment (specify)  Evaluation (specify)

Impairment Rating  Other (specify)

Referred Provider's Name Phone #

c.  Discharged for Non-Compliance\*  Discharged from Care for Nonmedical Reasons\*

8. MAXIMUM MEDICAL IMPROVEMENT (MMI)

Injured Worker has reached MMI Date of MMI

Injured Worker is not at MMI, but is anticipated to be at MMI in/on

MMI date unknown at this time because Active

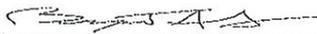
9. MAINTENANCE CARE AFTER MMI  Yes  No

If yes, specify care:

10. PERMANENT MEDICAL IMPAIRMENT (REQUIRED)

No permanent impairment  Permanent Impairment (attached required worksheets and narrative)

Anticipate permanent impairment  Needs referral to Level II physician for impairment rating (see 7b above)

11. PHYSICIAN'S SIGNATURE  Date of Report 4/8/2020

Print Name Alvarez, Bryan T MD License # 49085 Phone # (303) 292-0034



employer solutions staffing group, inc

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: Senne Matthew Male [checked] Female [ ]
Last First Middle

Date of Birth: 5/16/83 Home Telephone: 832-610-0716

Home Address: 22265 E Bellview Ln

City: Aurora State: CO Zip Code: 80015

Name of Company: ESSG/Corporate Management Group Job Title: Apprentice Electrician

Social Security #: 311-90-0616 Rate of Pay: \$18.50 hr

Location of Accident: Colorado Lighting 2171 E 74th Ave Denver CO 80229
Name of building Area (loading dock)

Date of accident: 4/8/2020 Time of accident: 7:00 AM

Please describe fully how the accident occurred:
Unloading old 2x4 light fixture into the recycled truck, one fell out and when it made impact a piece of the plastic shot into my right eye
(Continue on the back side, if necessary)

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

Name of your Supervisor: William Robinson

Name(s) of witness(es): NA
[attach witness(es) report(s)]

When did you report the accident to your Supervisor? 4/8/2020

Employee Signature: [Signature] Date: 3-8-20

**AUTHORIZATION FOR THE RELEASE OF INFORMATION**

RE Employee: Matthew Senne Birth Date: 5/16/1983

Address: 22265 E Belleview Ln, Aurora CO 80015 SSN: 311-90-0616

This will authorize: Health One Occupational Medical Center  
(Medical Provider/Facility)

To release to an authorized representative of Colorado Lighting 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:**

- Entire Medical Record for all Dates
- History/Physical
- AIDS/HIV Records
- Consultation Reports
- X-Ray/Scan reports and Films
- Pathology Reports
- Laboratory Reports
- Other (Specify): \_\_\_\_\_
- Operative Reports
- Psychological Tests/Reports
- Correspondence
- Discharge Summaries
- Diagnostic Testing Reports and Films
- Any and all Chart Notes, Narrative Reports, Billings and Medical Records
- Mental Illness/Chemical Dependency, and/or Alcohol Abuse records

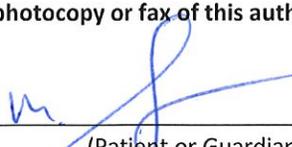
This information is needed for the following purpose: **WORKERS' COMPENSATION**

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: 3-8-20 Patient Signature   
(Patient or Guardian Signature)

\_\_\_\_\_  
(Relationship to patient IF guardian signs)

\_\_\_\_\_  
(Reason patient is unable to sign)



employer solutions staffing group<sup>llc</sup>

PO Box 46270 Minneapolis, MN 55344-9956

Phone: (952) 767-0053 Fax: (952) 767-0740

Email Address: wc@employersolutionsgroup.com

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

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

  
Employee Signature

3-8-20  
Date

Matthew Seime  
Employee Printed Name



employer solutions staffing group<sub>inc</sub>

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: Matthew Senne Phone Number 832-610-0716

Date of Injury: 04/08/2020 Date Reported 04/08/2020

**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? No

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

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? None

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

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

  
Employee Signature

3-8-20  
Date



employer solutions staffing group<sub>inc.</sub>

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](mailto:wc@employersolutionsgroup.com)

Last Name: Senne		First and Other Names: Matthew	
Date of Birth: 5/16/83	Jobsite: Colorado Lighting	Start Date at Jobsite: 1/20/2020	
Social Security #: 311-90-0616		Position: Apprentice Electrician	
Employee's Phone (Home): NA		Employee's Phone (Mobile): 832-610-0716	
Date of incident: 4/8/2020	Time of incident: 7:00		AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>
Name of witness(es):		Witness(es) phone #(s):	
Name of Supervisor: Will Robinson		Date and time notified: 7:05 AM , 4/8/2020	

**Cause of Injury/Source (please select one)**

Cut, Puncture or Scrape

**Type of Injury/Illness (please select one)**

Select Applicable

corneal abrasion

- 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:**

*While unloading fixtures into recycling truck a piece of plastic flew up on hit matt in the right eye.*

Name and Address of Hospital/Clinic where taken for treatment: HealthOneOccupationalMedicalCenter,9195 Grant St	
Hospital/Clinic Phone: 832-610-0716	
Recruiter/Supervisor Signature: <i>Will Robinson</i>	Recruiter/Supervisor Phone: <i>720-366-4840</i>
Recruiter/Supervisor Print Name: <i>Will Robinson</i>	



employer solutions staffing group, inc

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: Matthew Senne Date of Birth: 5/16/1983
Social Security Number: 311-90-0616 Phone#: 832-610-0716
Date Of Injury: 4/8/2020 Time of Injury: 7:00 a.m. p.m.
Job Description: Apprentice Electrician

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: 4/8/20
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
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.

## Job Description Recruiter/Supervisor Statement

Employee Name: Matthew Senne

Job Title: Apprentice Electrician

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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	HRS
Stand	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input checked="" type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	HRS
Walk	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input checked="" type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	HRS
Drive	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	HRS

**TOTAL DURING ENTIRE 8-HOUR DAY**

Sit	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	HRS
Stand	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input checked="" type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	HRS
Walk	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input checked="" type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	HRS

**Lifting**

OCCASIONALLY    FREQUENTLY    CONTINUOUSLY    NONE

Up to 10 lbs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
11-20 lbs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
21-25 lbs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
26-50 lbs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
51-100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

**Carrying:**

OCCASIONALLY    FREQUENTLY    CONTINUOUSLY    NONE

Up to 10 lbs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
11-20 lbs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
21-25 lbs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
26-50 lbs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
51-100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

**Use of Hands**

	SIMPLE GRASPING	FINE WORK	PUSHING PULLING	LOW SPEED ASSEMBLY	HIGH SPEED ASSEMBLY
Left	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Right	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Comments:**

**Worker needs to:**

OCCASIONALLY    FREQUENTLY    CONTINUOUSLY    NONE

Bend	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twist	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please explain in detail what the employee does on a daily basis:

*Will Robinson*

Recruiter/Supervisor Signature

*4/18/2020*

Date