CMG
CORPORATE MANAGEMENT GROUP

April 28, 2016

To Whom it may concern:

Jonathan will be coming for a walk-in appointment with a doctor for a worker compensation claim. His employer is **Employer Solutions Staffing Group**, through Corporate Management Group, at our client site, Kong.

We would like the doctor to determine if the injury with the employee is compensable.

For Medical Billing and accompanying reports;

Gallagher Bassett Services, Inc

P.O. Box 23812

Tucson, AZ 85734

1-866/324-5585

Insurance Adjuster: Veronica Vargas, direct line 303-218-7877

We do not have a claim # yet.

Thank you!

Caitlin Scholl

Administrative Assistant

Phone: 303.920.1425

Fax: 303.736.7767

Email: caitlin@corpmgmtgroup.com

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Fax Cover Sheet

Total pages (including cover sheet): 4

To: HealthOne Occupational Medical Center at Englewood

From: Corporate Management Group/Employer Solutions Staffing Group

Regarding: Jonathan Cavalier workers compensation claim

employer solutions staffing group
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

WORK STATUS REPORT/MEDICAL SERVICE FORM

EMPLOYEE INFORMATION

Name: Jonathan Cavalier
Social Security Number: 520-79-6975
Date Of Injury: ongoing
Job Description: Machine Operator
Date of Birth: 3/10/16
Phone#: (320) 936-8616
Time of Injury: n/a ☐ a.m. ☐ p.m.

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: 4/28/16
Authorized Employer Signature: [signature]

EMPLOYER HAS LIGHT DUTY WORK AVAILABLE

TO BE COMPLETED BY PROVIDER

Diagnosis: Rt Quervains (L) wrist CTS (L) hand
Date of Examination: 4/28/16 Time: 12:00 ☐ a.m. ☒ p.m.

Treatment Plan:
- X Must Return for re-evaluation on: ___/___/___ 1 wk
- X To received PT/OT Services Duration: 2 x week 4 x weeks
- Surgery Scheduled. ___/___/___
- Time: ☐ a.m. ☐ p.m. ☐ Inpatient ☐ Outpatient
- No further care required Discharge Date: ___/___/___

Expected Healing Time:
- Days ___ Weeks ___ Months ___
- Other to be determined

Current Status:
- May work full duty now (no restrictions) ___/___/___ (Date)
- X May work light duty now with identified restrictions through 5/5/16
- 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: For every 30 minutes of repetitive work 15 minutes of no repetitive work. Do not use only (R) hand for work with splint

Next Follow Up Appointment:

PHYSICIAN INFORMATION

Physician Name: Danny Halat FNP-C
Physician Signature: [signature] Phone: (303) 788-9292
Date: 4/28/16

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.

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Re: Jonathan Cavalier
Address: 3055 W Floyd Ave Denver CO 80110
Birthdate: 03/21/1994
S.S.N.: 530796975

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 relevent 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

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: Apr 26, 2016

(Signature of Patient or Guardian)

(Relationship to Patient if signed by Guardian)

(Reason Patient is unable to sign)