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: Reisenfeld (Last) Zachary (First) R (Middle) Male ☑ Female ☐

Date of Birth: 04 / 24 / 1996 Telephone#(916) 990-8070

Home Address: 4073 Hensley circle

City: El dorado hilla State: Ca Zip Code: 95762

Name if Company: Synovos Job Title: Contractor

Social security No: 605905385 Rate of Pay: 13/hour

Location of Accident: Storeroom (Name of building) Shelves (Area(loading dock))

Date of accident: June 23, 2016 Time of accident: 8:40

Please describe fully how the accident occurred:

I was bending over stacking boxes and then fell a sudden pain in my lower back

(Continue on the back side, if necessary)

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

Tore my back

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

Name of your Supervisor: Matt ross

Name(s) of witness(es):

(attach witness(es) report(s)

When did you report the accident to your Supervisor? 8:50

Signature of Employee: Zach Reisenfeld (Zach Reisenfeld (Jun 23, 2016)) Date: Jun 23, 2016

employer solutions staffing group LLC
Leveraging Resources in a Changing Market

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Email Address: wc@employersolutionsgroup.com

Employee's name: Zach reisenfeld Phone Number 9169908070

Date of injury: June 23, 2016 Date Reported June 23, 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…)
Lower back pull

Have you experienced an injury like this before?
No

Please tell me what you were doing when the injury occurred?
Bending over stacking boxes on wooden pallets

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.
None, it was bending over

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

Zach Reisenfeld
Zach Reisenfeld (Jun 23, 2016)
Signature of Employee

Jun 23, 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). ZRR (ZRR) I have read, understand; and agree to the above responsibilities

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

Zach Reisenfeld
Zach Reisenfeld (Jun 23, 2016)

Employees Signature

Jun 23, 2016

Date

Zach Reisenfeld

Employee please print your name here

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Re: _____ Birthdate: 04/24/1996

Address: 4073 Hensley Circle S.S.N.: 605-90-5835

This will authorize employee's choosen 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.

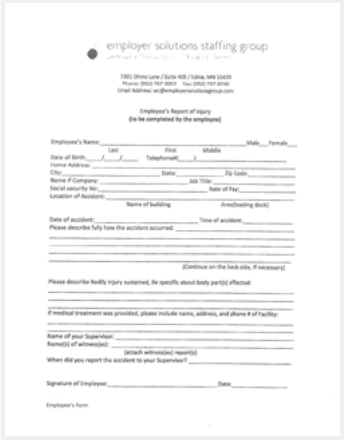
I understand that I may revoke this consent at any time by notifying, in writing, the healthcare facility listed above. Revoking this authorization does not apply to information that has already been released under this authorization. Upon fulfillment of the above-stated purposes, this consent will automatically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

Dated: Jun 23, 2016

Zach Reisenfeld
Zach Reisenfeld (Jun 23, 2016)
(Signature of Patient or Guardian)

_____
(Relationship to Patient if signed by Guardian)

_____
(Reason Patient is unable to sign)



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Employee's Report of Injury
(to be completed by the employee)

Injury Report forms: For Employee

Adobe Sign Document History 06/23/2016

Created:	06/23/2016
By:	Caitlin Scholl (Caitlin@corpmgmtgroup.com)
Status:	SIGNED
Transaction ID:	CBJCHBCAABAAy1s3AxAkCimeqoUmh9NvlGsgkr-MucXQ

“Injury Report forms: For Employee” History

Document created by Caitlin Scholl (Caitlin@corpmgmtgroup.com)
06/23/2016 - 10:42:11 MDT - IP address: 96.93.208.70

Document emailed to Zach Reisenfeld (zachreisenfeld@yahoo.com) for signature
06/23/2016 - 10:42:49 MDT

Document viewed by Zach Reisenfeld (zachreisenfeld@yahoo.com)
06/23/2016 - 10:45:18 MDT - IP address: 107.77.213.185

Document e-signed by Zach Reisenfeld (zachreisenfeld@yahoo.com)
Signature Date: 06/23/2016 - 11:04:58 MDT - Time Source: server - IP address: 166.216.158.187

Signed document emailed to Zach Reisenfeld (zachreisenfeld@yahoo.com) and Caitlin Scholl (Caitlin@corpmgmtgroup.com)
06/23/2016 - 11:04:58 MDT