

Accident Investigation Packet

Employee: _____ Social Security Number: _____

Call the Injury hotline to report the injury immediately @ 888.237.1223

Did the Employee fail to report the injury to us timely? Yes No

If yes, why was the injury reported late? _____
(If reported late, within 24 hours counsel client on timely reporting injuries to Eplica)

Please scan the following to workcomp@eplicaservices.com or fax to 619.260.3900 within 48 hours of injury:

Accident Investigation to include

- Accident Investigation Forms
- Supervisor Statement
- Witness Statement(s)
- Employee Statement
- Body Chart
- Medical Release Form
- Sample Job Description

Complete Employment Application of injured employee W4 and I-9 Form

Photos attached: body part (when appropriate), site location, injured worker head shot

Is the client able to accommodate the work restrictions (if any)? Yes No

If no, will the branch be able to accommodate modified duty? Yes No

Please explain job assigned: _____

Has the employee accepted modified duty? Yes No

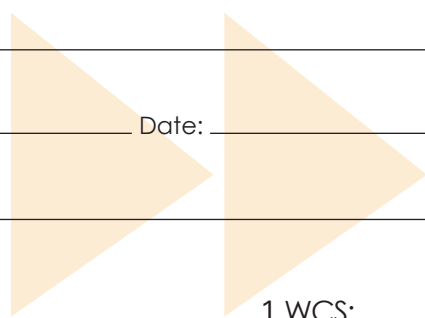
If yes, what date will/did they return to work? _____

Completed by: _____ Date: _____

Print Name: _____

Manager's Signature: _____ Date: _____

Print Name: _____



Accident Investigation Form

Employee Information

Social Security Number: _____ Birth Date: _____

Employee Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

Original Date of Hire: _____ Date Assigned to Client: _____

Workers' Compensation Code: _____ Pay Rate: \$ _____

Job Title: _____ Job Description: _____

Accident, Illness, or Injury Information

Date of accident: _____ Time of Accident: _____

Date accident reported: _____ Time Reported: _____

Client Name: _____ Address: _____

Location /department of accident (Be specific): _____

Accident reported to Supervisor: Yes No

Supervisor Name: _____ Phone number: _____ attach statement

Witness Name: _____ Phone number: _____ attach statement

Witness Name: _____ Phone number: _____ attach statement

Witness Name: _____ Phone number: _____ attach statement

Employee was working: Alone With others (crew size: _____)

Employee was: Directly supervised Indirectly supervised Not supervised

■ Describe in detail the employee's actions leading up to and including the accident. Include: task being performed, work location, equipment used, weight of items lifted, usage of Personal Protective Equipment, etc.

Accident occurred while: Performing work duties During break period
 Entering/leaving work Other

Accident Investigation Form

Nature of Injury / Illness

■ Describe the nature of the injury/illness and parts of body affected (left, right, upper, lower)

Treatment Information: No Treatment Medical Treatment Fatality

Name of clinic or hospital: _____ Transported by: _____

Analysis

■ What issues may have caused or contributed to this accident / injury / illness?

- | | |
|---------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> Operating equipment without authority | <input type="checkbox"/> Improper loading |
| <input type="checkbox"/> Improper lifting technique | <input type="checkbox"/> Repetitive motion |
| <input type="checkbox"/> Failure to use Personal Protective Equipment or improper use | <input type="checkbox"/> High volume/speed |
| <input type="checkbox"/> Poor Housekeeping | <input type="checkbox"/> Operating at unsafe speed |
| <input type="checkbox"/> Lack of training, knowledge or skill | <input type="checkbox"/> Safety guards/devices removed or disabled |
| <input type="checkbox"/> Poor physical match between employee & task | <input type="checkbox"/> Actions of another employee |
| <input type="checkbox"/> New procedure, practice in place | <input type="checkbox"/> Allergic reaction |
| <input type="checkbox"/> Work surface differences (falls, trips) | <input type="checkbox"/> Employee diverted from known procedure |
| <input type="checkbox"/> Horse Play | |
| <input type="checkbox"/> Other, Explain: _____ | |

■ Current condition of machinery, equipment, building or premises involved: _____

Suggested Corrective Action Plan

THE PRIMARY REASON FOR CONDUCTING AN ACCIDENT INVESTIGATION IS TO PREVENT A REPEAT OF THE ACCIDENT OCCURRING.

■ What corrective actions may help to prevent future occurrences? (to be discussed with manager and client)

- | | |
|--------------------------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Task observation / job shadowing | <input type="checkbox"/> Further accident analysis |
| <input type="checkbox"/> Reevaluate match between employee and task | <input type="checkbox"/> Changes to work environment |
| <input type="checkbox"/> Issued PPE and Personal Protective Equipment training | |
| <input type="checkbox"/> Other, Explain: _____ | |

Investigation complete Yes No

If no, explain necessary follow up: _____

Investigated by: _____ Date: _____

Signature: _____ Print Name: _____



Employee Statement

Employee Information

Name: _____ Phone number: _____
Address: _____ City/State/Zip: _____
Social Security Number: _____ Birth date: _____

Accident, Illness, or Injury Description

1. When did this accident, illness, injury happen? Date: _____ Time: _____

2. How did the accident happen? (Be specific): _____

3. Describe what you were doing at the time of the accident: _____

Was this part of your normal job duties? _____

4. Who saw the accident happen? (list any witnesses, anyone you told, anyone working near you): _____

5. Were you wearing Personal Protective Equipment (PPE) at the time of the accident? Describe: _____

Have you received training on PPE? Yes No

6. Is there anything you feel could have prevented accident? (If yes, please describe): _____

7. What part of your body was injured? LEFT RIGHT UPPER LOWER Body part? _____

8. Have you had prior injuries? (i.e. car accident, work injury, personal injury) Please explain: _____

9. Do you play sports? Yes No

10. Do you have other employment? Yes No

Check here and sign if you are choosing not to seek medical treatment. Signature: _____

My signature indicates that the information I have given in this statement is truthful and accurate. I also understand that as part of the accident investigation my photograph will be taken for identification purposes.

Signature: _____ Date: _____

Print Name: _____ Date: _____

Check here if you will "accept" Modified Duty

Check here if you are "declining" Modified Duty

I understand I may have work restrictions due to my reported injury. I understand if I decline modified duty I will not be entitled to Total Temporary Disability (TTD) benefits and will not be able to return to work until I have a full duty release from the primary treating physician.

Signature: _____ Date: _____

Print Name: _____ Date: _____

Mark the affected areas on the drawing. Specify the type of pain or sensation using the appropriate symbols listed below. Please show with an arrow on the body from where the pain is the worst now.

Front

Back

Symbols (La Guía)

Pain (Dolor)

Aching (Adolorido)

#####

Numbness (Adormecido)

^^^^^^

Pins & Needles (Hormigueo)

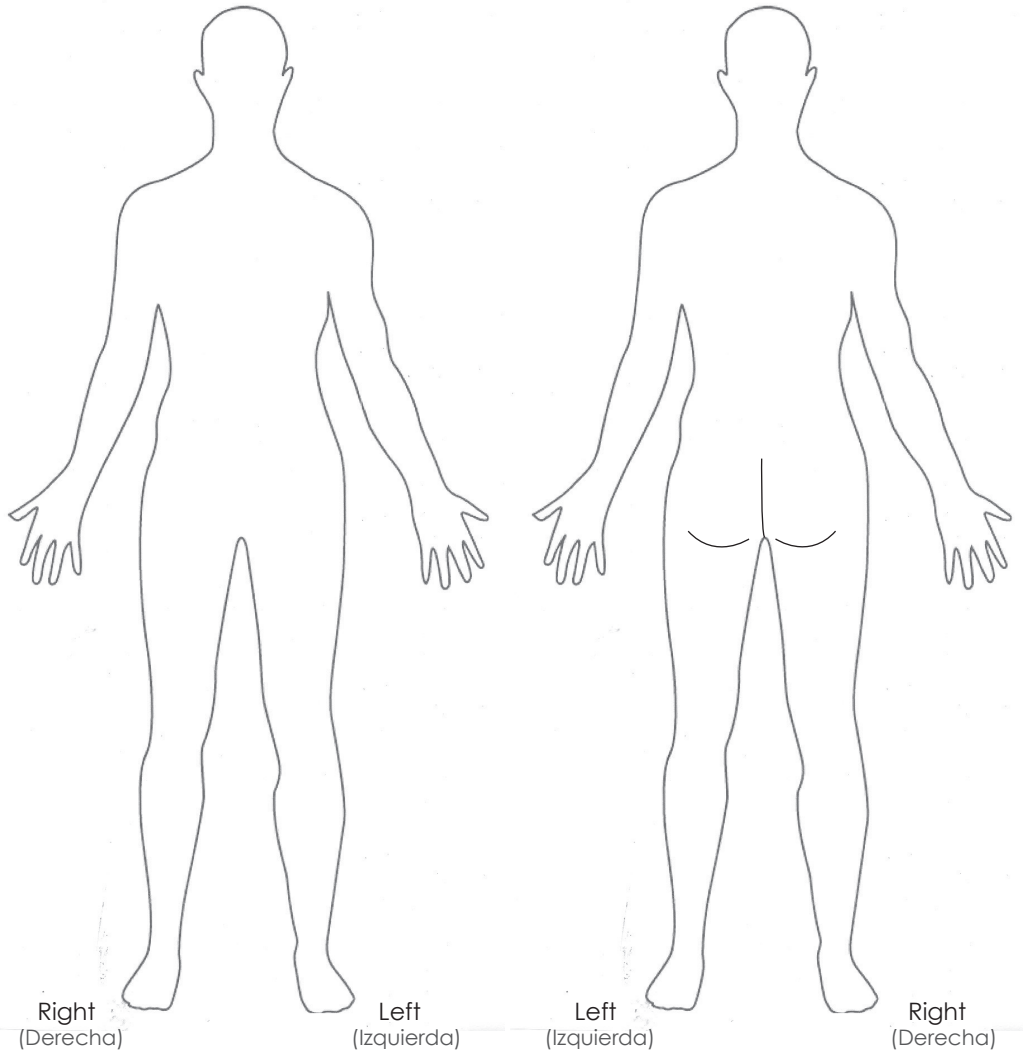
.....

Burning (Caliente)

oooooo

Stabbing (Piquetes)

////////



Print Name: _____ Date: _____

Signature: _____

Witness: _____ Date: _____



Incident Sketch

INCIDENT SKETCH

Sketch the area where the alleged injury occurred. Please note any other employees or machinery/equipment in the area.

Attach picture if available.



Injured Worker's Signature: _____

Date: _____

Witness: _____

Date: _____

Authorization To Release Medical Information

Please check box below for the appropriate injury location

- California**
This authorization to release medical information is being requested of you to comply with the terms of the confidentiality of the Medical Information Act of 1981, section 56, et seq, of the California Civil Code and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- Non-California**
This authorization to release medical information is being requested of you to comply with the terms of the confidentiality of the Medical Information Act of 1981, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I hereby authorize my medical provider to release all medical information (including appropriate medical history, physical condition, services rendered and treatment) with regard to my workplace injury(s) to Eplica Corporate Services, Inc. for the purposes of processing my workers' compensation claim.

.....
This authorization will be in effect immediately and shall remain in effect through the life of my claim.
.....

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Print Name: _____

Witness: _____ Date: _____

Witness Signature: _____

Print Name: _____



Supervisor Statement

SUPERVISOR INFORMATION

Name: _____ Phone number: _____

Company: _____

TEMPORARY EMPLOYEE INFORMATION

Name: _____ Job title: _____

ACCIDENT, ILLNESS OR INJURY DESCRIPTION

1. When did this accident, illness or injury happen? _____

2. How were you notified of this incident? _____

3. How did the accident happen? Describe what you saw or the information you received from others: _____

4. What was the employee doing at the time of accident or injury? _____

5. Who witnessed the accident? _____

6. Was the injured employee wearing Personal Protective Equipment (PPE) at time of accident? Describe: _____

7. Was employee trained on PPE? Yes No

8. Is there anything you feel could have prevented the accident or injury? Yes No

9. If the employee was injured while operating machinery or vehicle (forklift/pallet jack),
was he or she trained on proper use of the machine or vehicle? Yes No

10. Are you questioning the mechanism of this injury? Yes No
If yes, please explain: _____

11. Are you aware of the employee playing sports, having other employment, or any personnel or performance issues?
Please explain: _____

12. Is there anything else we need to know about this person? _____

Print name: _____ Date: _____

Signature: _____ Date: _____

Witness Statement

Check here if there are no witnesses.

.....
Supervisor signature: _____ Date: _____
.....

TEMPORARY EMPLOYEE INFORMATION

Name: _____

WITNESS INFORMATION

Name: _____ Phone number: _____

Address: _____

ACCIDENT, ILLNESS OR INJURY DESCRIPTION

1. When did this accident, illness or injury happen? _____

2. How did the accident happen? Describe what you saw or what you were told: _____

3. What was the employee doing at the time of accident or injury? _____

4. Did anyone else see the accident happen? If so, please provide names: _____

5. Was the injured employee wearing Personal Protective Equipment (PPE) at time of accident? Describe: _____

6. Is there anything you feel could have prevented the accident or injury? _____

7. Is there anything else we need to know about this person? _____

Print name: _____ Date: _____

Signature: _____ Date: _____

Consent and Release

For Drug Testing and Medical Information

Reason for testing: Post incident

I hereby consent to a standard drug screening to be administered as directed by one or more of the following entities: TEG Staffing, Inc.; Eastridge Personnel of Las Vegas, Inc.; TEGP, Inc. dba Employer Services; Secure Talent, Inc.; Eplica Corporate Services, Inc.; and/or their related entities, subsidiaries, or divisions (collectively, the "Company").

I authorize the company to release the results of this test to appropriate company personnel and/or designated client(s) of the company that require drug testing, for purposes of determining my suitability for an assignment and employment with the company. I further understand that if the test result is positive, I will not be considered eligible for employment with the company (or any related entity) unless and until I can establish that I am not a current user of illegal drugs, in accordance with the Americans with Disabilities Act. I understand that if I dispute the results of the company administered test, I may obtain my own drug-screening exam (at my own cost) with a licensed testing laboratory within 24 hours of the previously administered test. The company will not accept any test results taken more than 24 hours or less than 30 days after the company administered test. This consent and authorization shall remain valid for a period of one (1) year from the date of my signature below.

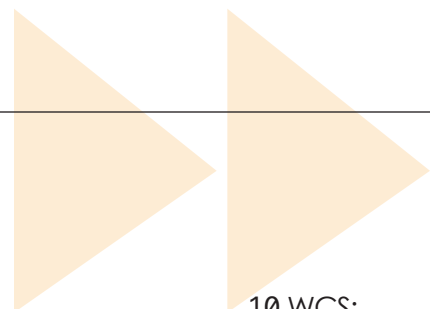
Printed Name: _____ Last 4 Digits of Social Security No.: _____

Signature: _____ Date: _____

RELEASE OF LIABILITY

I hereby release any and all claims against TEG Staffing, Inc.; Eastridge Personnel of Las Vegas, Inc.; TEGP, Inc. dba Employer Services; Eplica Corporate Services, Inc.; Secure Talent, Inc. and/or their related entities, subsidiaries, or divisions (collectively, the "Company"), their client(s), their officers, directors, agents, and employees, which may arise out of the drug testing process, including disclosure of results or adverse employment action taken in reliance on the results of the drug test. I understand that the company is not responsible for the accuracy of drug test results.

Signature: _____ Date: _____



Modified Duty Assignment Workforce While Working in the Branch

Position Summary/Principal Responsibilities:

Each employee that has a work related injury and has been released by their medical provider with work restrictions will be offered modified duty either in the branch or at a client location whenever possible. It is the responsibility of the employer and the employee to follow these physician mandated restrictions. The modified duty assignment is to be treated as any normal work assignment.

The employer can provide modified duty to the employee in a number of ways. If an employee is working modified duty at the branch, the primary responsibility of the employee is to support the office with light office duties within the work restrictions as provided by the treating physician. Depending on the employee's restrictions, the following job duties may be assigned while working in a branch:

- Alphabetizing of applications, pay boards, etc.
- Making copies of applications
- Making copies of benefit packages
- Staple work comp information to Policies & Procedures
- Orientation packets for On-Site staff
- Test monitor in lobby
- Check handouts
- Clean keyboards
- Clean chairs in lobby
- Entering company address and fax information on blank I-9's or timecards
- Highlighting important items on blank applications
- Making copies of safety tour packets
- Staple 8850's
- QC calls
- Z status project
- Look up client company web sites
- Clean blinds
- Clean kitchen
- Other duties as assigned as within restrictions
- Filing

Except for scheduled breaks, please note that at no time during your work shift is it acceptable to read magazines, use the internet/computer, read personal books, or use the company phone for personal use, unless approved by your staffing coordinator for such activities. Failure to follow these rules may be grounds for disciplinary action up to and including termination.

Absence Policy:

As noted in the Policy & Procedures given to you at time of hire, while on assignment you are expected to arrive for the assignment (including your modified duty assignments), on time and to be prepared to work. If you will be absent or late, you must call your staffing coordinator and/or any available operator or voicemail at least one hour prior to the start of your shift. While on assignment, you are expected to be in your designated work area performing the job presented to you by your staffing coordinator unless you are on an approved break as directed by your staffing coordinator.

All health related absences must be supported by a note from your physician. If you do not have a note from your physician to support the absence, the time missed will be considered an unexcused absence. To the greatest extent possible, physician appointments should be scheduled before or after work when possible. If you are not able to work, a note from your physician must indicate the days you will be unable to work. For appointments related to your work injury, you must provide a copy of your return to work slip noting any revised modified duty restrictions from your physician. All non-medical time off requires approval by your staffing coordinator or branch manager. Unexcused absences while working Modified Duty is grounds for disciplinary action, up to and including termination.

Sample Job Description

Break Policy:

State Law requires that all employees are granted a 10-minute rest break every 4 hours of work and a meal break of no less than 30 minutes after each 5 hours of work. If your restrictions require deviations from these meal and break rules, please inform your staffing coordinator. While on your rest break, you are not permitted to leave the building premises. You are free to leave the premises for your meal breaks. Rest breaks are considered time worked and will be paid. You will not be paid for your half hour meal period. Leaving the premises during rest breaks will be grounds for disciplinary action, up to and including termination.

Cell Phone Usage Policy:

Use of a cell phone is prohibited while at work unless you are on an approved meal or rest break. Any calls related to your claim can be directed to the branch manager. Cell phones may be used in the event of an emergency; please inform your staffing manager in the event of an emergency.

Additional Items:

All employees on modified duty assignments are not to lift items over 5 pounds or as otherwise indicated according to your particular work restrictions. If you need assistance with gathering supplies, please ask any available staffing coordinator and they will gladly assist you. Please refer to the Eastridge Policies & Procedures for additional standards.

I _____, have read and understand the following Modified Duty Work Job Description.

Employee Signature: _____ Date: _____

Staffing Coordinator/Branch Manager: _____ Date: _____

Eplica/Work Comp Dept: _____ Date: _____

