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Services for Staffing Companies™

To be Completed by the Recruiter

Incident Report Only 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: ______

■ **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

Analysis

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

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

- ☐ Task observation / job shadowing
- ☐ Reevaluate match between employee and task
- ☐ Issued PPE and Personal Protective Equipment training
- ☐ Further accident analysis
- ☐ Changes to work environment
- ☐ Other, Explain: ______

Investigation complete ☐ Yes ☐ No

If no, explain necessary follow up: ______

______

Investigated by: ______ Date: ______

Signature: ______ Print Name: ______

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To be Completed by the Employee

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

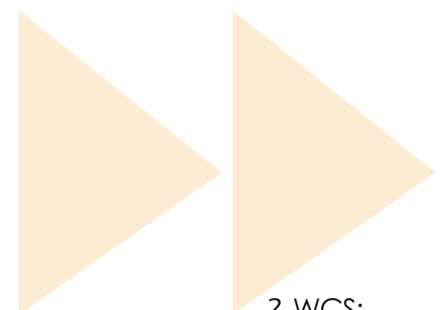
10. Do you have other employment? ☐ Yes ☐ No

☐ Check here to confirm that you are not choosing to seek medical treatment.

My signature indicates that the information I have given in this statement is truthful and accurate.

Signature: ______________________ Date: __________

Print Name: ______________________ Date: __________



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To be Completed by the Employee

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.

Symbols

Pain
*****

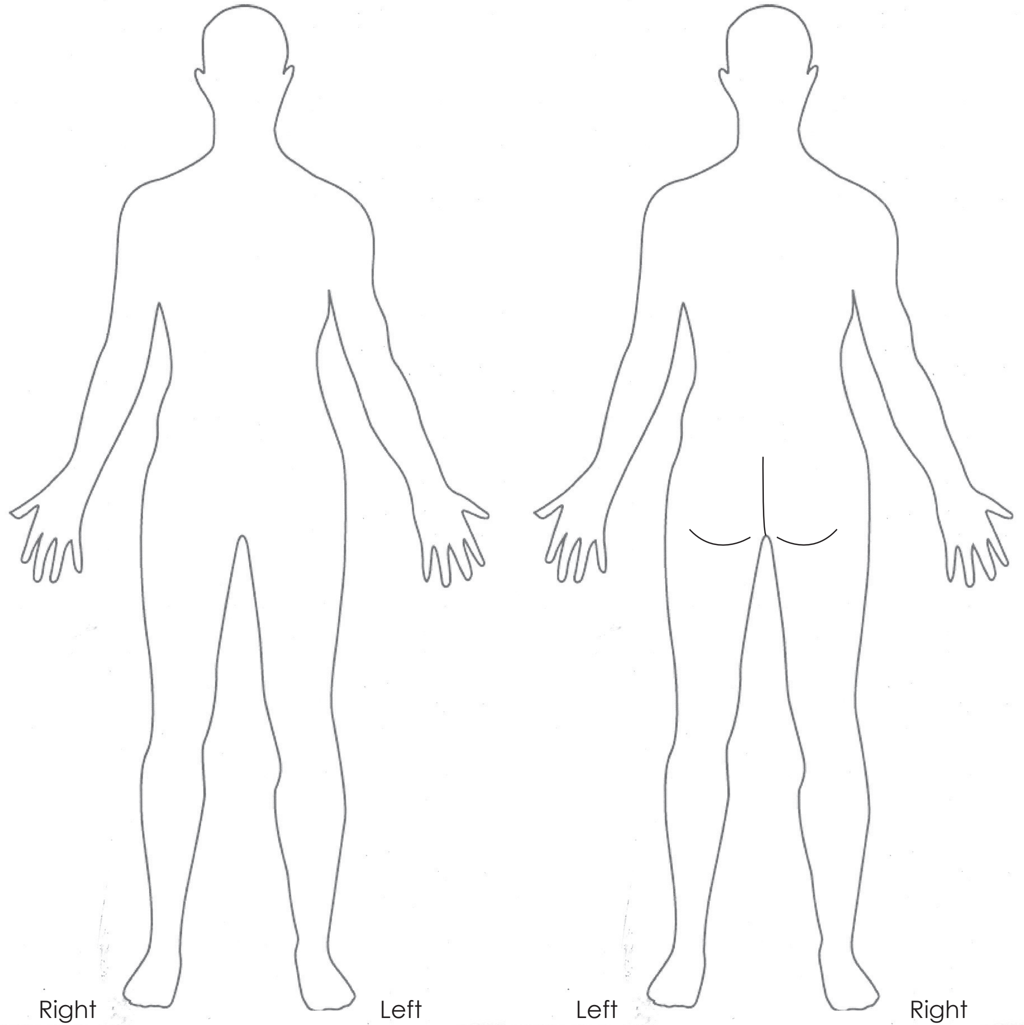
Aching
#####

Numbness
^^^^^^^^

Pins & Needles
••••••••••••

Burning
oooooo

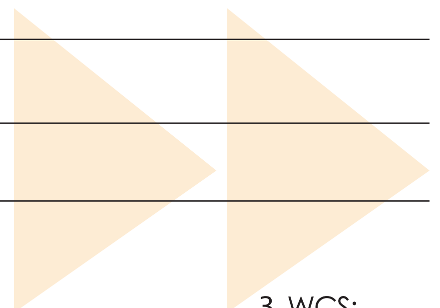
Stabbing
/////////



Print Name: ______________________ Date: ______________

Signature: ______________________

Witness: ______________________ Date: ______________



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To be Completed by the Employee

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.

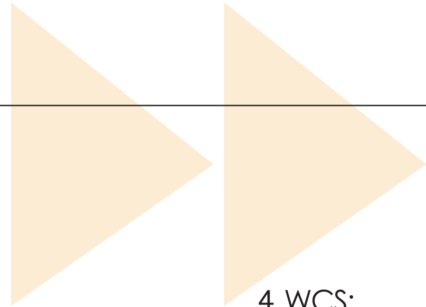
Printed Name: ______________________ Last 4 Digits of Social Security No.: ______________

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

Signature: ______________________ Date: ______________



Consent and Release

For Drug Testing and Medical Information

ACKNOWLEDGMENT OF DRUG TESTING RESULTS

Name of company Staffing Representative/Testing
Administrator verifying results with the candidate: ______________________________

I, ______________________, acknowledge the results of my saliva drug screening that was administered to me on ______________________, 20_______. I agree that the drug screen produced the following results (staffing representative to check all positive results P; print N/A if the result was negative):

- ☐ TH (Tetrahydrocannabinaol)
- ☐ CO (Cocaine)
- ☐ PC (Phencyclidine)
- ☐ ME (d-Methamphetamine)
- ☐ AM (d-Amphetamine)
- ☐ OP (Opiates)

Printed Name: ______________________ Last 4 Digits of Social Security No.: ______________

Witness: ______________________________

Signed: ______________________ Dated: ______________