

DES Work Comp Injury Report

Please be advised that your statements will be verified through an investigation.

Full Name: _____ SEX: _____

SS#: _____ -- _____ -- _____ DATE OF BIRTH: ____/____/____

Client Company assigned at: _____

Client Company Address: _____

City: _____ State: _____ Zip Code: _____

Phone (_____) _____ Current rate of pay \$ _____

Date of Injury: _____ Time of Injury: _____ AM or PM

Work Shift days & Times: _____ Work Comp Code: _____

Client Company Supervisor Name (first & last): _____

Was anyone at the client company notified at the time of injury? Yes/No

If yes, who? _____

What's their position or dept if known? _____

If not, why? _____

Did you notify your DES of the injury? Yes / No

Name of DES representative reported to: _____

Date Injury Reported: _____ Time Injury Reported: _____ AM / PM

If you did not immediately report injury to DES, explain why?

What date were you assigned at the client company? _____

What's your position & job description? Please attach a written J.D.

Employee Signature: _____

Have you done this type of work before? Yes / No

Where: _____ When: _____

Explain in DETAIL how the injury happened (what specific activity):

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Employee Signature: _____

What body part was injured? Please be specific about body part(s)

affected: _____

Was any immediate medical treatment given to your injury? Yes / No

If yes; what specific treatment did you receive? _____

Name of clinic and/or Doctor who gave you medical treatment:

Were you wearing protective/safety gear? Yes / No

If No; why not? _____

Were you following accepted company safety rules? Yes / No

If No; why not? _____

What department were you working in when the injury occurred?

Was this your assigned department when you accepted the job

assignment? Yes / No

If no, what department were you assigned to and who re-assigned you to
another department? _____

Employee Signature: _____

Where were other employees positioned at the time of your injury?

Name of witnesses to the injury: _____

Are the witnesses also our employees? Yes / No

If no, who do the witnesses work for? _____

Have you suffered a similar injury in the past? Yes / No

If yes, name of Doctor(s) who provided treatment:

Please list outside hobbies, sports, or other activities that you are involved in: _____

Do you presently have a second job or another job? Yes / No

If yes, please give the name of the company & type of job and hours worked:

.....
Please note, if you have a second job and they cannot accommodate any
Doctor's restrictions you may be given, you are to notify DES
immediately. FAILURE TO DO SO MAY AFFECT YOUR WORKER'S
COMPENSATION CLAIM.
.....

Employee Signature: _____

Your Current Address:

Street: _____

City: _____ State: _____ Zip Code: _____

Telephone # () _____ - _____ Alternate # () _____ - _____

I certify that the above statements are true and accurate and I understand that the assertion of false worker's compensation claims is a violation of the state's criminal code, which may result in a fine and imprisonment and will result in me being terminated from employment. I further understand that this shall include, but is not limited to claiming an injury which occurred off of the job as work related, false statements to my Doctor, the employer's worker's compensation insurance carrier, my employer or the Department of Industry, Labor, and Human Relations as to the nature, cause and/or extent of my injuries which are knowingly made to falsely secure or increase compensation.

EMPLOYEE SIGNATURE

DATE

DES REPRESENTATIVE SIGNATURE

TRANSLATOR CERTIFICATION (IF NEEDED):

I certify that I have assisted in the completion of the foregoing report by thoroughly explaining the contents of said report. I further certify that upon completion of the report, I translated the written answers to the employee and he/she acknowledges the correctness of the same by signing each page.

TRANSLATOR'S SIGNATURE

DATE

Employee Warning Notice

Employee Name _____ Date of Warning _____

Job Assignment _____

Safety Violation☐ Carelessness☐ Violation of Safety Rules

Date of Incident _____ Time _____

Description of Accident:

I have read this Employee Warning Notice and understand it.

Employee Signature_____
Date_____
Employer Representative_____
Date

Medical Treatment Waiver Form

I understand that I have been offered the opportunity to receive medical treatment from an authorized company representative. I also understand and take responsibility for waiving treatment at this time.

Signature

Date

Employer Representative

Date

Employee Release For Medical Information

Employee's Name: _____

Date of Birth: _____

Address: _____

NAME(S) AND/OR CLASSES OF MEDICAL PROVIDER(S) AUTHORIZED TO
RELEASE MEDICAL INFORMATION: _____

TYPE OF INFORMATION OR SPECIFIC MEDICAL RECORDS AND DATE(S) OF
TREATMENT TO BE RELEASED: _____

This authorization (or a copy thereof) will allow the person(s) listed above to furnish
_____ and its legal representatives specific
medical information for treatment and diagnosis related to injuries, sickness or disease
sustained by the patient and arising out of or related to this accident or medical condition.

This information will be used only to establish the merits of claims for benefits or
damages presented to the insurance company.

This information will not be released to other persons without your permission, except to
protect you, ourselves or in compliance with any applicable law, government regulation
or court order.

For your protection, the information is not directly available to you. With your consent, it
may be provided to your physician or legal representative.

This authorization can be revoked at any time. It is not valid for more than one year.

I HAVE READ THE ABOVE AND UNDERSTAND THE PURPOSE AND USE OF
THE MEDICAL INFORMATION RELEASE AUTHORIZATION.

SIGNATURE OF EMPLOYEE _____

Date: _____

DES
Employment Group
Modified Duty Offer

Dear: _____

Dr. _____ told us that while he/she thinks you are not currently ready to return to your regular job, he/she strongly encourages modified-light duty work with certain restrictions.

We have a position with functions that do not exceed any of your work restrictions cited by Dr. _____

Your restrictions are: _____

Our desire is that you return to work with job restrictions immediately. Our organization will do everything possible to support you in your return to work. Your return to work through modified duty will speed your recovery so that you will be able to return to your regular job very soon.

Your rate of pay is _____ Your assignment _____

Duties that you will be performing: _____

Please indicate below whether you accept or reject the offer of modified duty described herein.

Accept: _____ Date: _____

Reject: _____ Date: _____



Daily work schedule

8am~ Report to Work

10am~ 15 Minute Break

12pm~ 30 Minute Lunch Break

2pm~ 15 Minute Break

4:30pm~ End of Work Day

Smoking and cell phone policy

Smoking and cell phones are only to be used during your lunch and 15 minute breaks. Any unauthorized breaks & bad behavior will result first in a verbal warning, second written warning & final termination. **NOTE** all serious offenses will be terminated on the first offense.

Light duty work

Any light duty work that is given to you by your supervisor needs to be done on a timely basis that is within your doctor restrictions due to your specific injury. If there are any problems/concerns please bring it to the attention of your supervisor. It is also your responsibility to sign in/out when you arrive & depart our office including breaks, lunch & doctor visits. Your rate of pay while on light duty is \$7.25/hr.

Employee Name (Print) _____

Employee Signature _____ Date _____

DES Supervisor Name (Print) _____

DES Supervisor Signature _____ Date _____

Corporate Office:

1300 Cummins Road Des Moines, IA 50315 USA Phone: (515) 288-2300 Fax: (515) 288-6700
www.desstaffing.com

Client Accident Investigation Form (Filled out by client supervisor/rep)

NOT TO BE FILLED OUT BY DES EMPLOYEE

PARTICULARS OF ACCIDENT

Date of accident M T W T F S S	Time	Location	Date reported
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THE INJURED PERSON

Name		Address	
Age	Phone number		
Date of accident		Length of employment — at plant	on job
TYPE OF INJURY:	☐ Bruising	☐ Dislocation	☐ Other (specify)
☐ Strain/sprain	☐ Scratch/abrasion	☐ Internal	Injured part of body
☐ Fracture	☐ Amputation	☐ Foreign body	Remarks
☐ Laceration/cut	☐ Burn scald	☐ Chemical reaction	

DAMAGED PROPERTY

Property/ material damaged	Nature of damage
	Object/substance inflicting damage

THE ACCIDENT

Description

Describe what happened

Analysis

What were the causes of the accident?

Any witnesses?

If so, names & contact info:

HOW BAD COULD IT HAVE BEEN?

☐ Very serious ☐ Serious ☐ Minor

WHAT IS THE CHANCE OF IT HAPPENING AGAIN?

☐ Minor ☐ Occasional ☐ Rare

Prevention

What action has or will be taken to prevent a recurrence?

	By whom	When

TREATMENT AND INVESTIGATION OF ACCIDENT

Type of treatment given	Doctor/Hospital	
Accident investigated by	Date	