



The following attachments should be kept within proximity to any/all site supervisors as applicable to project.

Contents Include:

1. Injury Questionnaire
2. Medical Condition Report
3. Doctors Initial Treatment Report
4. Employee Restriction Responsibility form
5. First Fill – Workers' Compensation First Fill Program
6. Employee and Supervisor Report of Accident/Injury
7. Job Description/Employer Statement
8. Decline of Immediate Medical Treatment

CRAS has an account with Concentra, in the event an employee is injured transport the employee to the nearest Concentra location.

In case of an emergency take the employee to the nearest hospital and provide the hospital Emergency Dept. Instructions Form, provided within the packet.

NOTE: All accidents require a follow-up 10-Panel Non-DOT Drug test.

Once employee is safely transported contact a CRAS supervisor via call or text. If no response within 20 minutes contact one of the other supervisors listed below.

Kristy Richmond
561-516-0906; kristy@crastaffing.com
Kam Barbour
561-914-6585; kam@crastaffing.com

Keep in mind contents provided within Accident/Injury Packet must be filled out entirely and returned to CRAS within 48 hours following the accident/injury.

Should the employee refuse medical treatment they MUST sign the Decline of Medical Treatment Form; provided within the contents of the packet. This form is also to be filled out if the employee is choosing to seek medical treatment at a later time.

Lastly, have the employees sign off on the CRAS timesheet providing last 4 SS# and sign off Y or N if they were injured on the jobsite at the completion of each shift.

Failure to report a work-related injury immediately could result in denial of workers' compensation benefits.

Sincerely,

Kristy Richmond

Injury Questionnaire

Employee Name:
Date of Report:
Date of Injury: ____/____/____ Date Reported: ____/____/____ Hire Date: ____/____/____

1. How are you feeling now?
- Please describe the nature of your injury. Where does it hurt? What type of injury (Strain, Sprain, Cut, Bruise, Etc.)
2. Have you ever experienced an injury like this before?
3. Who else witnessed your injury?
4. Are you aware of others that have experienced this type of injury while working at this function?
5. When/where did your injury occur? (Time, Place)
6. What time did you first report the injury, and to who?
7. What were you doing (job function) at the time of the injury?
8. Is this job part of your normal job functions?

9. If you are part of a rotating cell function:
a. Are the proper rotations being followed on a timely basis?
b. How long were you in the current function when the injury occur?
c. What function(s) did you perform earlier in your rotation?
d. Anything different about how the rotations are running today?
10. What tools, PPE equipment is required for this function?
11. Were the proper tools and PPE available and were you using them when the injury occurred?
12. How did the injury occur (step-by-step)?
13. Were there other contributing factors?
14. How would you avoid this type of injury in the future?
15. Do you have any other jobs outside our company?

MEDICAL CONDITION REPORT

TO EMPLOYEE (Please Print Clearly):

Employee's Name: _____ Home Phone: (_____) _____ - _____
Home Address (include zip)
Work Facility:
Employee's Job Title:
Length of Absence: _____ From: ____/____/____ To: ____/____/____
Attending Physician's Name, Address & Telephone Number (Please print)

TO ATTENDING PHYSICIAN (PLEASE PRINT CLEARLY):

The following information is requested on the above Construction Recruiters America Staffing, Inc. employee:

1. Diagnosis:
2. Date of onset:
3. Estimated Return to Work Date:
4. Medication Taken and Significant Side Effects, If Any:
5. Anticipated Work Restrictions: (Complete Page 2)
6. Approximate Date of Employee's Follow-Up Appointment:

MEDICAL CONDITION REPORT PAGE 2 (ATTENDING PHYSICIAN MUST COMPLETE)

EMPLOYEE'S NAME: _____

PHYSICAL LIMITATIONS

If there are NO restrictions, please leave blank & sign and Date at bottom. Otherwise, circle number of hours employee CAN DO activity listed below:

Sedentary - lifting to 10 pounds	10	8	6	4	2	0
Light – Lifting 10 to 20 pounds	10	8	6	4	2	0
Moderate – Lifting 20 to 50 pounds	10	8	6	4	2	0
Heavy – Lifting 50 to 100 pounds	10	8	6	4	2	0
Pulling, Pushing, Carrying	10	8	6	4	2	0
Reaching or Working Above Shoulder	10	8	6	4	2	0
Walking	10	8	6	4	2	0
Standing	10	8	6	4	2	0
Sitting	10	8	6	4	2	0
Stooping	10	8	6	4	2	0
Kneeling	10	8	6	4	2	0
Repeated Bending	10	8	6	4	2	0
Climbing	10	8	6	4	2	0
Twisting at Waist	10	8	6	4	2	0
Operating a Motor Vehicle, Crane, Tractor etc	10	8	6	4	2	0
Expected length of limitation (s) above	<u>WEEK</u>	<u>WEEK</u>	<u>WEEK</u>	<u>WEEK</u>	<u>WEEK</u>	<u>WEEK</u>
(Circle time from Today)	1	2	3	4	5	6

If longer than 6 weeks, anticipated durations is: _____

If permanent, please state: _____

PHYSICIAN'S SIGNATURE

DATE

Doctors Initial Treatment Report

(Doctor should complete and return to the employee on first visit)

Date of Injury: _____/_____/_____ Date of First Treatment: _____/_____/_____ Prior Treatment: _____/_____/_____
Description of Injury:
Diagnosis:
Diagnostics:
Treatment Plan:
Restrictions:
Disabled: () YES () NO
Medications:
Possible Return to Work Date:
Date of Next Visit:
Prognosis:
Work Related: () YES () NO () UNKNOWN

Doctor's Signature

Date

Print Doctor's Name

Report of Accident/Injury

EMPLOYEE RESTRICTION RESPONSIBILITY FORM

In the event in which you must seek further medical attention, you are obligated to inform the treating physician your employer, Construction Recruiters America Staffing, Inc. is willing to accommodate modified duties as specified by the treating physician.

It is your sole responsibility as the employee requiring modified duty to comply within the guidelines implemented by CRAS and treating physician; see below for further instruction.

- Complete an Attending Physician's Return to Work Recommendation Record following each visit, and return to CRAS immediately after each appointment: via email diane@crastaffing.com or fax 1-888-457-3336.
- Know your restrictions and abide within them at all times.
- Do not attempt tasks that exceed the restrictions set forth by your treating physician. In the event you feel unsure of whether or not the tasks given to you fall within the strict guidelines set forth by your treating physician advise your supervisor immediately.
- The medical restrictions are in effect 24 hours a day. Be sure to implement these restrictions not only while on the job site but also within your personal time as well. Should you have hobbies or other outside interests, consult with the treating physician on additional restrictions which may be applicable to your injury.
- Employees whom conduct activities which are inconsistent with the medical restrictions and/or treatment patterns as mandated through treating physician, either on the job site or within your personal time, are subject to disciplinary actions.

Initial and sign below confirming you are aware of the policies implemented by Construction Recruiters America Staffing, Inc. in the event modified duty is mandated. Should you have any questions or concerns feel free to contact your CRAS recruiter for further explanation.

_____ I have read, understand, and agree to the above responsibilities.
Initial

_____ I acknowledge receiving a separate copy of this form for my personal records.
Initial

Employee Signature

Date

Employee Name

First Fill – Workers' Compensation First Fill Program

Mitchell **ScriptAdvisor** has been selected by **Next Level Administrators** to assist you in obtaining prescription drugs related to your workers' compensation claim. This form enables you to fill prescriptions written by your authorized workers' compensation physician for medications related to your injury. Simply **fill in the form below** and present it at the pharmacy at the time your prescription is filled. This form should ensure that you will have NO out-of-pocket expenses when you fill your first prescription.

For your convenience, **Mitchell ScriptAdvisor** has an extensive network of retail pharmacies including major chain drug stores. For pharmacy locations, you may call our toll-free number or visit our website at **www.ipsusa.com** to use the pharmacy locator.



Employee

- Present this sheet to the pharmacist along with your prescription
- Provide your SS# and Date of Injury at the pharmacy to use as your Member ID#
- Please note: You may receive a permanent retail card in the mail for your workers' compensation injury.



Pharmacy

- This sheet is a Temporary Prescription ID Card for a **14 Days'** Supply Fill and Max \$\$ Amount of **\$150.00**.
- All data needed to process this script through the Script Care Adjudication System is included in the drug card represented below.

Mitchell **ScriptAdvisor**

Temporary Prescription Benefit Card



Member Name:

Member ID:

ID #: SS# + Date of Injury (MMDDYY) – Example: 123456789101411

Rx BIN: 004410

PCN: SCI

Group: IPS001077TC

Questions? Contact us at 866.846.9279

This card is to be used for prescriptions related to your workers' compensation injury-related injuries covered under your insurance policy. Use of this card does not waive any limitations or exclusions for the policy. This card does not confirm coverage. To confirm eligibility or obtain specific information, please contact the Help Desk with the information from the front of this card.



Mitchell International
866.221.6588

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EMPLOYEE AND SUPERVISOR REPORT OF ACCIDENT/INJURY

Parts I and II to be completed by employee and returned to supervisor

I. EMPLOYEE DATA

Social Security Number _____ - _____ - _____ Date of Injury ____/____/____ Employee Name (Last, First, MI) _____			
Street Address _____		City _____	State _____ Zip Cod _____
Date of Birth ____/____/____ Sex (☐) Male (☐) Female No. of Dependents _____		Telephone Number(_____) _____ - _____	
Tax Filing Status (☐) A. Single (☐) B. Single, Head of Household (☐) C. Married, Filing Joint (☐) D. Married/Filing Separate			
Date of Hire ____/____/____		Occupation _____	Job Site Location _____

II. EMPLOYEE'S STATEMENT OF ACCIDENT/INJURY

Describe, in your words, what you were doing at the time of the incident and what happened.	
What part(s) of your body were injured? (Be specific, indicate right/left)	
Were there any witnesses? (☐) YES (☐) NO If yes, please indicate names	
_____ Employee Signature	_____ Date

III. SUPERVISOR'S REPORT OF ACCIDENT/INJURY

Description of accident/injury after investigation:	
_____ Employee Signature	_____ Date

Job Description/Employer Statement

Employee Name _____

NOTE: In terms of an 8-hour workday.

Occasionally – 1%-33%

Frequently – 34%-66%

Continuously – 67%-100%

In an 8-hour workday, Employee does the following: (OCCASIONALLY; FREQUENTLY; CONTINUOUSLY; NONE)

Sit				
Stand				
Walk				
Drive				

TOTAL DURING ENTIRE 8-HOUR DAY

Sit	1	2	3	4	5	6	7	8
Stand	1	2	3	4	5	6	7	8
Walk	1	2	3	4	5	6	7	8

Lifting: (OCCASIONALLY; FREQUENTLY; CONTINUOUSLY; NONE)

0-10 lbs.			
11-20 lbs.			
21-25 lbs.			
26-50 lbs.			
51-100 lbs.			
> 100 lbs.			

Carrying: (OCCASIONALLY; FREQUENTLY; CONTINUOUSLY; NONE)

0-10 lbs.			
11-20 lbs.			
21-25 lbs.			
26-50 lbs.			
51-100 lbs.			
> 100 lbs.			

Use of Hands: (OCCASIONALLY; FREQUENTLY; CONTINUOUSLY; NONE)

	SIMPLE GRASPING	FINE WORK	PUSHING/PULLING	LOW SPEED ASSEMBLY	HIGH SPEED ASSEMBLY
LEFT					
RIGHT					

Employee job duty entails: (OCCASIONALLY; FREQUENTLY; CONTINUOUSLY; NONE)

BEND			
SQUAT			
CRAWL			
CLIMB			
REACH			
KNEEL			
TWIST			

Provide a brief description encompassing the employee's general work day activities

Employer Signature _____

Date _____

This form is only to be signed in the event in which you do not require medical treatment in relation to the report of an on the job incident.

You are required to choose Option 1 or Option 2

Decline of Medical Treatment

OPTION 1

I, _____, acknowledge that I have reported an on the job incident. CRAS, or applicable supervisors, has offered me medical attention to be administered by CRAS' designated worker's compensation physician. However, at this time I feel I do not require medical attention and by choosing to sign this form I am stating that I can safely complete the essential functions of my job without compromising the safety of my co-workers, residents, or myself. I understand should my condition change in relation to this work-related incident it is my responsibility to notify CRAS' administrator prior to seeking any medical attention.

OPTION 2

I, _____, acknowledge reporting an on the job incident. CRAS, or applicable supervisors, has offered me medical attention to be administered by CRAS' designated worker's compensation physician. However, this is not a life-threatening emergency and does not require me to seek treatment after hours. Further, I am in agreement to leave the job site and report to the urgent care center in which my employer has provided to me for further evaluation and treatment in the morning. By signing this form I am stating I can safely leave the job site on my own accord and understand in the event in which my condition changes in relation to this work-related incident it is my responsibility to notify CRAS' administrator prior to seeking any medical attention.

Employee Signature

Date

Supervisor Signature

Date