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

Contents Include:

I. Employee and Supervisor Report of Accident/Injury - (Employee and Site Supervisor)
II. Injury Questionnaire – (Employee)
III. Authority for Treatment Form - (Provide to Medical Treatment Center)
IV. Medical Condition Report - (Employee and Physician)
V. Doctors Initial Treatment Report - (Physician)
VI. Accommodation Checklist - (Supervisor)
VII. Job Description - (Supervisor)
VIII. Employee Restriction Responsibility Form - (Employee)
IX. Decline of Medical Treatment Form - (Employee)

CRAS maintains a national 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: Accidents may require a follow-up drug screen if accident/injury falls under reasonable suspicion.

Once employee is safely transported contact a CRAS supervisor;

Diane Gurdak
CEO
520-270-9923
diane@crastaffing.com

Kristy Orlandi
Chief Operations Officer
561-660-4846
kristy@crastaffing.com

Kam Gurdak
Controller
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.

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.

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

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?

AUTHORITY FOR TREATMENT

To: _____ Date: _____/_____/_____
Doctor

This certifies that Construction Recruiters America Staffing, Inc. is giving authorization for the initial medical treatment to _____ on _____/_____/_____. The injury that has been reported to us and that is authorized to have treatment performed to it is the _____

_____

(Body parts injured): _____

_____

Authorized Employer Contact/Supervisor: _____

Date: _____/_____/_____

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: _____

PHYSICIAL 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	WEEK	WEEK	WEEK	WEEK	WEEK	WEEK
(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

Accommodation Check List

Employee Name: _____ Date Of Injury: _____/_____/_____

Position: _____ Shift: ( ) First ( ) Second ( ) Third

At the time of the injury was the employee performing a part of their job description/daily activities? ( ) YES ( ) NO

Employee's regular scheduled work week (please check): ( ) Mon ( ) Tue ( ) Wed ( ) Thurs ( ) Fri ( ) Sat ( ) Sun

Can site location accommodate the injury: ( ) YES ( ) NO Accommodating Position: _____

If you are able to accommodate, what type of work is being offered? (please check): ( ) Light Duty ( ) Regular Duty

If you are not able to accommodate, what was the employee's last work day?: _____/_____/_____

Have you discussed any questions regarding the employee's injury with the job site location?: ( ) YES ( ) NO

If yes, what was discussed?

_____

_____

_____

_____
Signature/Title

_____/_____/_____
Date

_____
Please Print Name

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

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

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