ACORD® WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER / ADMINISTRATOR CLAIM NUMBER *	REPORT PURPOSE CODE *
	JURISDICTION * / JURISDICTION LOG NUMBER *	
	INSURED REPORT NUMBER / OSHA CASE NUMBER	
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	LOCATION #: / PHONE #
INDUSTRY CODE / EMPLOYER FEIN		

CARRIER / CLAIMS ADMINISTRATOR

CARRIER (NAME AND ADDRESS)	POLICY PERIOD TO / CHECK IF APPROPRIATE ☐ SELF INSURANCE	CLAIMS ADMINISTRATOR (NAME AND ADDRESS)
PHONE (A/C, No, Ext):		PHONE (A/C, No, Ext):
CARRIER FEIN *	POLICY / SELF-INSURED NUMBER	ADMINISTRATOR FEIN *
AGENT NAME:	AGENT CODE NUMBER:	

EMPLOYEE / WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX: ☐ MALE ☐ FEMALE ☐ UNKNOWN	MARITAL STATUS: ☐ UNMARRIED/SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	OCCUPATION / JOB TITLE	
E-MAIL ADDRESS:			EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE *	

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:	AVERAGE WEEKLY WAGES	# DAYS WORKED / WEEK	FULL PAY FOR DAY OF INJURY? (Y / N) ☐ / DID SALARY CONTINUE? (Y / N) ☐

OCCURRENCE / TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	DATE OF INJURY / ILLNESS	TIME OF OCCURRENCE ☐ CANNOT BE DETERMINED ☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME / PHONE (A/C, No, Ext):	TYPE OF INJURY / ILLNESS	PART OF BODY AFFECTED
DID INJURY / ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? (Y / N) ☐	TYPE OF INJURY / ILLNESS CODE *	PART OF BODY AFFECTED CODE *

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS / ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE *

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? (Y / N) ☐ / WERE THEY USED? (Y / N) ☐

PHYSICIAN / HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFFSITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT: ☐ NO MEDICAL TREATMENT ☐ MINOR: BY EMPLOYER ☐ MINOR CLINIC / HOSP ☐ EMERGENCY CARE ☐ OVERNIGHT HOSPITALIZATION ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED
WITNESS NAME: / PHONE (A/C, No, Ext):	WITNESS NAME: / PHONE (A/C, No, Ext):	

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME	TITLE	PHONE NUMBER

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"Merging Talent with Opportunity"

Drug Screen Authorization

Any employee who has a positive result for alcohol or any of the illegal substances listed, will be immediately terminated. In addition, any employee who refuses to submit to the testing procedure will be immediately terminated.

Printed Applicant Name:_____Social Security #:_____

Circle Company Screening For: WISE LABOR SOURCE ONESOURCE RMG

Person Performing Test:_____

Time In: _____ Time Out:_____ Lot #:_____ Expiration Date:_____

Temperature of Sample:_____

Results for: 2-Panel 5-Panel 10-Panel 12-Panel K2 Strip		
Cocaine (COC)	Positive	Negative
Marijuana (THC)	Positive	Negative
Amphetamine (AMP)	Positive	Negative
Opiate (OPI)	Positive	Negative
Methamphetamine (MET)	Positive	Negative
Benzodiazepine (BZO)	Positive	Negative
Phencyclidine (PCP)	Positive	Negative
Barbiturate (BAR)	Positive	Negative
Methadone (MTD)	Positive	Negative
Methylenedioxymethamphetamine (MDMA)	Positive	Negative
Methamphetamines (mAMP)	Positive	Negative
Tricyclic Antidepressants (TCA)	Positive	Negative
K2	Positive	Negative

List any drugs taken in the last 30 days:_____

I hereby authorize and give Wise Staffing Group and entities (Wise Staffing Services, Inc., Labor Source LLC., Onesource Staffing, LLC., Resource Management Group, LLC.) full permission to release the results of this test to the company I am screening for. Such waived and released to claims include but not limited to, invasion of privacy, intentional infliction of mental distress, handicap discrimination, and possible clerical of laboratory error.

Applicant Signature: _____Date:_____

Signature of Person Performing the Test:_____Date:_____

Check Company Working For: WISE ☐ LABOR SOURCE ☐ ONESOURCE ☐

Read the Following Statement Before Signing this Form.

By signing below, I certify that the information provided is true and correct to the best of my knowledge. I also certify that I understand that if I refuse medical treatment, services, and/or supplies provided by my Wise Staffing Group and its member companies (Wise Staffing Services, Inc., Labor Source, LLC., Onesource Staffing, LLC., and Resource Management Group, LLC.) or if I refuse employment suitable to any partial disability caused by the above injury, that this could lead to my termination and may jeopardize my insurance benefits.

Signature of Injured Employee: _____

Medical Records Release

I, _____ , authorize that my employer, anyone acting on their behalf including but not limited to, their insurance carrier, attorney or other representative, shall be permitted to examine and obtain copies of all hospital, medical, vocational, drug screen records, interview all doctors, rehabilitation professionals vendors regarding all matters relating to any issue relevant to my Workers' Compensation Claim.

A copy of this authorization is to be considered as an original for this purpose.

Signature of Injured Employee:_____ Today's Date:_____

Check Company Working For: WISE ☐ LABOR SOURCE ☐ ONESOURCE ☐

Authorization of Treatment

Employer:_____
Employee Name:_____
Employee DOB:_____
Employee SSN:_____

Guarantor: 432 Magazine Street
Tupelo, MS 38802
662-680-5062

Protocol:

- Please submit all medical paperwork to fax# (662)841-9961
- Medical invoices should be mailed to **company checked above and guarantor address.**

Part of body affected for treatment: _____

Authorized by:_____

Phone:_____

Date:_____

PHARMACY INFORMATION

Employee listed below is authorized to received medication that has been prescribed by their treating physician, for their alleged work-related injury.

Select Company Working For: LABOR SOURCE ☐ ONESOURCE ☐

Printed Employee Name: _____

SSN: _____ DOB: _____ Date of Injury: _____

Pharmacy: __WALGREENS_____

Health Lift Help Line: ___(844) 328-2048_____

BIN: 020743 Member ID: _____ (SOCIAL SECURITY NUMBER)

GROUP NUMBER: PHARMACY GENERATED: _____ (WORK ADDRESS & PHONE NUMBER)

Authorized By:_____

Phone Number: _____

Date: _____

Employee is to give this complete authorization form to the pharmacy at the time they present them with their prescription that was given to them by the treating physician.

Modified Duty Form

Check Company Working For: WISE ☐ LABOR SOURCE ☐ ONESOURCE ☐

Date: _____

Dear: (Employee Name): _____

Wise Staffing Group and its member companies (Wise Staffing Services, Inc., Labor Source, LLC., Onesource Staffing LLC., and Resource Management Group, LLC.) desires to provide our injured employees with the most expedient and quality medical care for their work-related injuries. We have developed a modified duty plan that will allow our injured workers to return to work on a modified duty status by making accommodation for work restrictions.

You have been advised by the doctor that you have been released to modified status as of _____. The letter serves as notice to you that modified duty is available as of _____ and you should report to work at (time) _____ am/pm on this date for your assignment.

_____ _____

Worksite Address

Failure to report will be considered an unexcused absence, and you will not be paid for the days missed. We feel a strong commitment to providing gainful employment to our injured workers during their recovery from work related injuries, and we would appreciate your cooperation. If you have any questions or concerns, call your Supervisor.

I accept modified Duty ☐ I decline modified duty ☐

Employee Signature: _____ Date: _____

☐ Employee is not present in office, offer made by **telephone** and employee declined modified duty. Form sent to employee via mail on (date)_____.
☐ Employee is not present in office, offer made by **telephone** and employee accepted modified duty.

Office Managers Signature: _____

Check Company Working For: WISE ☐ LABOR SOURCE ☐ ONESOURCE ☐

DECLINE OF MEDICAL TREATMENT OR OBSERVATION

Employee's Name: _____ Date Reported: _____

Date of Injury: _____ Time of Injury: _____

Supervisor: _____ Client /Location: _____

Witness(es): _____

Nature of Injury/Condition: _____

Description of Injury [Body Part(s) Injured]: _____

_____

Brief Narrative Description of the Incident: _____

_____

I, hereby acknowledge my declination of medical treatment and/or observation offered to me by _____ for the injury or illness reported on _____. I recognize that signing this declination does not necessarilyimpact my later eligibility for Workers' Compensation benefits as subject to statute and insurer review.

At this time, I acknowledge that my supervisor/employer, in good faith, has offered andmade available to me an opportunity to seek necessary medical treatment and/or observation.

At a later time, I may request from my employer, via my supervisor, a medical authorization to obtain medical treatment and/or observation for the above-describedinjury.

_____
Employee's Signature

_____
Date

_____
Employee Representative/Witness

INCIDENT REPORT

WORK RELATED/NEAR MISS

Check Company Working For: WISE ☐ LABOR SOURCE ☐ ONESOURCE ☐

REPORTED BY: _____ **DATE OF REPORT**: _____

INCIDENT INFORMATION

INCIDENT TYPE: _____ DATE OF INCIDENT: _____

LOCATION: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

INCIDENT DESCRIPTION: _____

_____

_____

_____

_____

NAME OF WITNESSES:

_____

_____

ACTION TAKEN:

_____

_____

_____

_____