"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"
(Incident Report)
Pursuant to NRS 616C.015

Name of Employer Personnel Plus Inc. 413 W. Second Street, Carson City, NV 89703

Name of Employee		Social Security Number	Telephone Number
Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)	
What is the nature of the injury or occupational disease?		List any body parts involved:	
Briefly describe accident or circumstances of occupational disease: (Note: if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment)			
Names of witnesses:			
Did the employee leave work because of the injury or occupational disease? ____ **YES** ____ **NO**	If yes, when (date and time)?	Has the employee returned to work? ____ **YES** ____ **NO**	If yes, when (date and time)?
Was first aid provided? ____ **YES** ____ **NO**	If yes, by whom?	Name and address of treating physician, if applicable or known	
Did the accident happen in the normal course of work? (if applicable) ____ **YES** ____ **NO**			
Was anyone else involved? ____ **YES** ____ **NO**	Names of others involved		

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

Supervisor's Signature Date

Signature of Injured or Disabled Employee Date

TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://govcha.state.nv.us E-mail cha@govcha.state.nv.us

Employee should sign, date and retain a copy.
Original to Employer, Copy to Employee

BRIEF DESCRIPTION OF RIGHTS AND BENEFITS
(Pursuant to NRS 616C.050)

Notice of Injury or Occupational Disease (Incident Report Form C-1): If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the required forms.

Claim for Compensation (Form C-4): If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractor from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractor from the Panel of Physicians and Chiropractors. Any **medical costs** related to your industrial injury or OD will be paid by your insurer.

Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

Temporary Partial Disability (TPD): If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

Permanent Partial Disability (PPD): When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractor to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation and your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractor as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a PPD award.

Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

Transportation and Per Diem Reimbursement: You may be eligible for travel expenses and per diem associated with medical treatment.

Reopening: You may be able to reopen your claim if your condition worsens after claim closure.

Appeal Process: If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the **Department of Administration, Hearing Officer,** by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the **Department of Administration, Appeals Officer**. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a **petition for judicial review with the District Court**. You must do so within 30 days of the Appeal Officer's decision. You may be represented by an attorney at your own expense or you may contact the NAIW for possible representation.

Nevada Attorney for Injured Workers (NAIW): If you disagree with a hearing officer decision, you may request that NAIW represent you without charge at an Appeals Officer Hearing. For information regarding denial of benefits, you may contact the NAIW at: 1000 E. William Street**,** Suite 208, Carson City, NV 89701, (775) 684-7555, or 2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830

To File a Complaint with the Division: If you wish to file a complaint with the Administrator of the Division of Industrial Relations (DIR), please contact the Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775) 684-7270, or 1301 North Green Valley Parkway, Suite 200, Henderson, Nevada 89074, telephone (702) 486-9080.

For assistance with Workers' Compensation Issues: you may contact the Office of the Governor Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Toll Free 1-888-333-1597, Web site: http://govcha.state.nv.us, E-mail cha@govcha.state.nv.us

WORKERS' COMPENSATION INJURY PACKET – EMPLOYEE PORTION

PERSONAL DETAILS

Name _____ Social Security # _____ Date of Birth _____
Email Address _____ Phone Number _____
Home Address _____

ACCIDENT DETAILS

Date &Time of Accident _____ Date injury reported to Supervisor/Employer _____
Location of Accident _____

INJURY QUESTIONS

1. Were there any witnesses to the accident? **YES** **NO**
   - If yes, please provide their names _____
2. What parts of your body were affected? _____
3. Where are you experiencing pain or discomfort? _____
5. Have you had previous problems with the injured part of your body? **YES** **NO**
   - If yes, please explain _____
   - If yes, are you currently under related medical care? **YES** **NO**

SAFETY QUESTIONS

1. When you were hired, did you watch the Employer's safety video (if applicable)? **YES** **NO**
2. Did the Employer explain to you the requirements of the job? **YES** **NO**
3. Was safety equipment given to you? **YES** **NO**
4. Were you performing your regular/assigned work? **YES** **NO**

5. In your opinion, was there something that could have been done differently to prevent the incident?

_____

_____

6. In your opinion, what caused the injury?
   - Poor Housekeeping
   - Poor Training
   - Machine/Equipment Failure
   - Employer Fault
   - Employee Fault
   - Other or N/A _____

WARNING: Providing false or misleading information on any company document may result in disciplinary action including but not limited to termination of employment. By initialing below, you are acknowledging that the information listed on this form is accurate. False or misleading information may have an effect on your employment status.

_____ _____
Initials **Date**

SIGNATURES

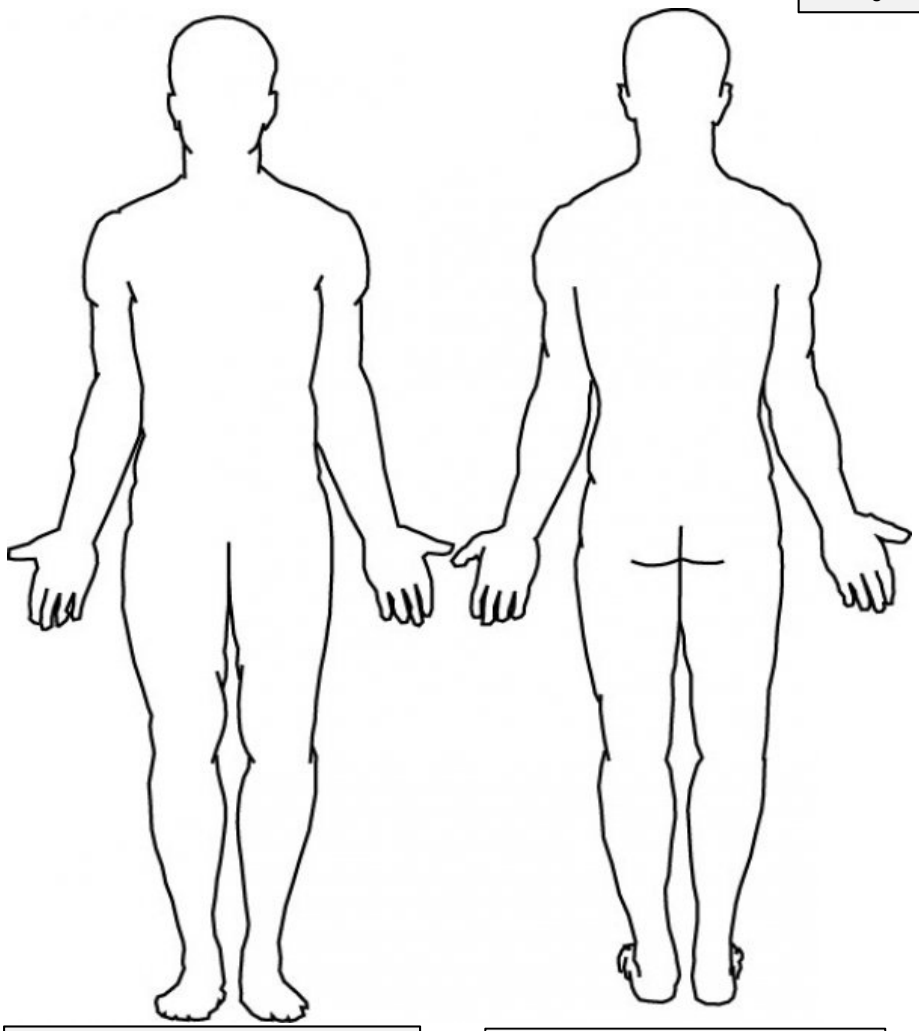
_____ _____ _____
Employee Name (Print) Employee Signature Date

_____ _____ _____
Client Representative (Print) Client Representative Signature Date

INJURY DIAGRAM 1

Name _____
DOI _____
Location _____
Body Part(s) _____

Burning	++++++
Numbness	======
Stabbing	/1/////
Cramping	xxxxxx
Pins & Needles	oooooo
Aching	>>>>>>



Circle the number that best describes your current pain in your _____ **(body part)**

0 1 2 3 4 5 6 7 8 9 10

Circle the number that best describes your current **back and neck pain**

0 1 2 3 4 5 6 7 8 9 10

I, _____ (print name), declare under penalty of perjury that I have personally completed the attached body and head diagram. I further declare that the injuries indicated are the only areas of injury related to the alleged work injury documented here and/or to my employment.

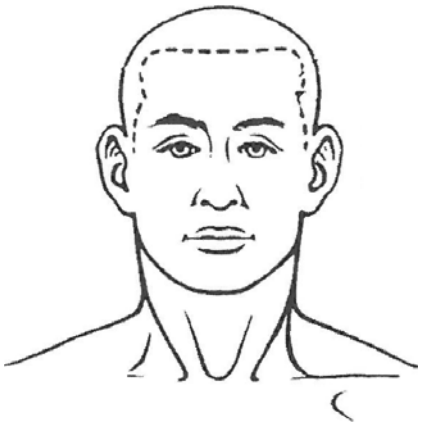
Employee Name _____ Employee Signature _____
(Please print)

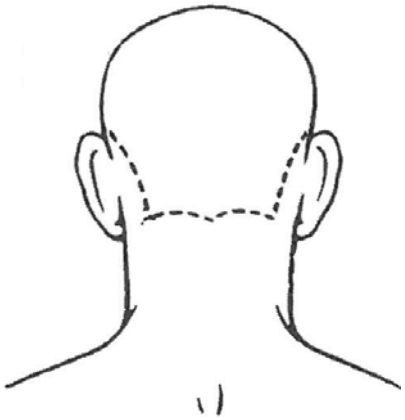
Date _____

INJURY DIAGRAM 2

Burning	++++++
Numbness	======
Stabbing	/1/1/////
Cramping	xxxxxx
Pins & Needles	oooooo
Aching	>>>>>>

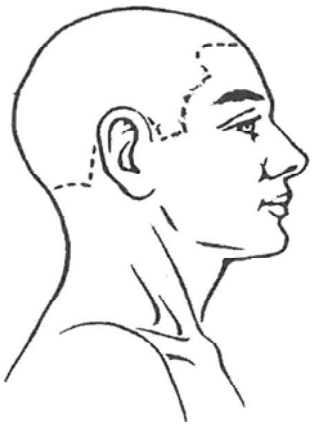
Name _____
DOI _____
Location _____
Body Part(s) _____

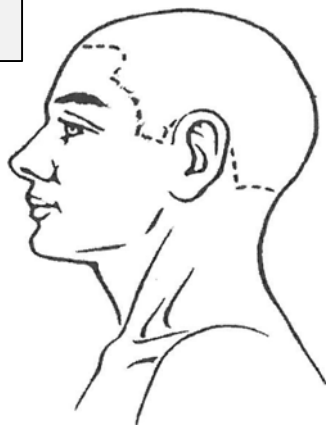




Circle the number that best describes your current pain in your _____ **(body part)**

0 1 2 3 4 5 6 7 8 9 10





I, _____ (print name), declare under penalty of perjury that I have personally completed the attached body and head diagram. I further declare that the injuries indicated are the only areas of injury related to the alleged work injury documented here and/oto my employment.

Employee Name _____ (Please print)

Employee Signature _____

Date _____

INJURED EMPLOYEE'S STATEMENT

Describe in your own words how the injury/accident occurred.

Were you instructed to do the specific task you were doing when the accident occurred? Yes No

If yes, by whom?

Were you trained to do the task before the actual work began? Yes No

If yes, by whom?

Please describe any safety hazards you observed.

I certify the above statements are true and correct.

Employee Name (Please Print)_____

Employee Signature _____ Date _____

Client Representative _____ Date _____
(Please print)

Client Representative Signature _____

POST INCIDENT EMPLOYEE ACKNOWLEDGMENT

**** SEND WITH INJURED WORKER TO CLINIC ****

I, _____, understand that I will be drug/alcohol screened by the treating clinic. Failure to be screened within 8 hours (from initial notice of injury) will be considered a terminable offense.

I also understand that I must return all work status and/or doctor's reports to my Employer Representative immediately after being released from the medical facility and if/when released to work with or without restrictions, work will be available to me. Failure to report for light duty may affect workers' compensation benefits.

Employee Name _____ Employee Signature _____
(Please print)

Current Job Title: _____ Date of Hire _____

Date of Accident _____ Today's Date _____

Body part(s) to be treated on behalf of INVO PEO: _____

Client Representative _____ Phone _____

This form does not guarantee benefits or payment. A copy of this form must be given to the Medical Provider (MPN in CA).

NOTE TO MEDICAL PROVIDER

- When permitted and ordered a rapid (if available) 9 or 10 panel drug screen is **required** with MRO confirmation of non-negative results.
- INVO PEO adheres to a strict Return to Work Program and will make every effort to accommodate the restrictions given (if any) to return this employee to light/modified duty.
- Submit all drug/alcohol screen results and work status updates directly to INVO PEO Claims either by email at wc.invopeo@invopeo.com or via fax at (866) 986-0118. Call (865) 481-0910 with questions.
- All treatment billing for Workers' Compensation Claims will be coordinated with our TPA.

DESCRIPTION OF EMPLOYEE'S JOB DUTIES

** TO BE COMPLETED BY CLIENT WITH EMPLOYEE **

INSTRUCTIONS: This form shall be completed jointly by the Client and employee and is intended to describe the employee's job duties. The completed form will be reviewed by the treating doctor to determine whether the employee is able to return to his/her job. This is an important document and should accurately show the requirements of the employee's job.

Employee Name Last: First: M.I.:		
Employer Name: Job Address:		
Job Title:	Hours Worked Per Day:	Hours Worked Per Week:
DESCRIPTION OF JOB RESPONSIBILITIES: (Describe All Job Duties)		

I. Check the frequency of activity required of the employee to perform the job.

Activity (Hours per day)	**Never (0 hours)**	**Occasionally (up to 3hours)**	**Frequently (3-6 hours)**	**Constantly (6-8+ hours)**
Sitting				
Walking				
Standing				
Bending (Neck)				
Bending (Waist)				
Squatting				
Climbing				
Kneeling				
Crawling				
Twisting (Neck)				
Twisting (Waist)				
Hand Use: Dominant Hand **RIGHT** or **LEFT**				
Is repetitive use of hand required?				
Simple Grasping (Right hand)				
Simple Grasping (Left hand)				
Power Grasping (Right hand)				
Power Grasping (Left hand)				
Fine Manipulation (Right hand)				
Fine Manipulation (Left hand)				
Pushing & Pulling (Right hand)				
Pushing & Pulling (Left hand)				
Reaching (above shoulder level)				
Reaching (below shoulder level)				

II. Please indicate the daily lifting and carrying requirements of the job. Indicate the height the object is lifted from floor, table or overhead location and the distance the object is carried.				
LIFTING	**Height**	**Occasionally (up to 3hours)**	**Frequently (3-6 hours)**	**Constantly (6-8+ hours)**
0-10 lbs.				
11-25 lbs.				
26-50 lbs.				
51-75 lbs.				
76-100 lb.				
100+ lbs.				
CARRYING	**Distance**	**Occasionally (up to 3hours)**	**Frequently (3-6 hours)**	**Constantly (6-8+ hours)**
0-10 lbs.				
11-25 lbs.				
26-50 lbs.				
51-75 lbs.				
76-100 lb.				
100+ lbs.				

Is Buddy Lifting used on items carried/lifted weighing 50 pounds or more? Yes No

Describe the heaviest item required to carry and the distance to be carried:

_____

III. Please indicate if your job requires any of the following:			
TASK	**YES**	**NO**	**If YES, briefly describe**
Driving cars, trucks, forklifts and other equipment			
Working around equipment and machinery			
Walking on uneven ground			
Exposure to excessive noise			
Exposures to extremes in temperature, humidity or			
Exposure to dust, gas, fumes or chemicals			
Working at heights			
Operations of foot controls or repetitive foot movement			
Use of special visual or auditory protective equipment			
Working with bio-hazards such as: blood borne pathogens, sewage, hospital waste, etc.			

Employee Comments

_____

Client Representative Comments

_____

Client Representative Signature:	Date:
Employee Signature:	Date:

AUTHORIZATION FOR RELEASE OF EMPLOYMENT AND MEDICAL RECORDS

RE: _____ (Employee Name)

Social Security Number _____

Date of Birth _____

Provider Name _____

Address _____

_____

Phone Number _____

To Whom It May Concern:

Permission is hereby given to furnish and release to _____ and affiliated companies and CCMSI or any representative thereof, and INVO PEO and its companies, the following information:

1. All medical records pertaining to the examinations, treatments or consultations including but not limited to: billing records; x-rays, MRIs and diagnostic testing including reports; history records; diagnosis and prognosis records; nurses' and doctors' notes and all reports; and any psychiatric or mental health records; and all reports relating to diagnosis, care and treatment for drug and alcohol abuse.

2. All employment records pertaining to employment with your company, including but not limited to, personnel records, payroll records, medical records and time records.

3. I have the right to revoke this authorization at any time by writing to the healthcare provider listed above. Understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

I understand that the information obtained will be used by The Carrier, Employer, and Third Party Administrator, or any representative thereof, for the evaluation and processing of any claim(s) for workers' compensation benefits as a result of any claimed work-related injuries. I do not give permission for any other use or re-disclosure of this information.

This Authorization is valid until my claim has be accepted or denied, but in no event beyond one year from the date of my claimed injury. A photocopy of this Authorization is effective as the original.

I understand that I am entitled to a copy of this Authorization.

Employee Name _____ Employee Signature _____
(Please print)

Date _____

REFUSAL OF MEDICAL TREATMENT

I, _____, report being involved in a work related incident, on or
Employee Name (Print)

about _____, while employed by INVO PEO and refused medical treatment at this time.

□ I have received first aid only

□ I was shown and/or given the Panel of Physicians / MPN (in states where allowed).

By signing this form I acknowledge that should I need medical care in the future for this incident, I will notify an Employer Representative immediately to ensure that I receive timely and appropriate care. Failure to notify any change of condition may result in disciplinary action.

_____ _____

Employee Signature Client Signature

_____ _____

Date Date

24 Hour Follow Up

I, _____ called the injured employee on _____ to check on their current medical and work status.
Client Representative Date

I documented this information in the employee's electronic HR file.