QTI Employee Occupational Injury or Illness Report

This form is to be completed by the employee immediately or as soon as possible following the injury/illness.

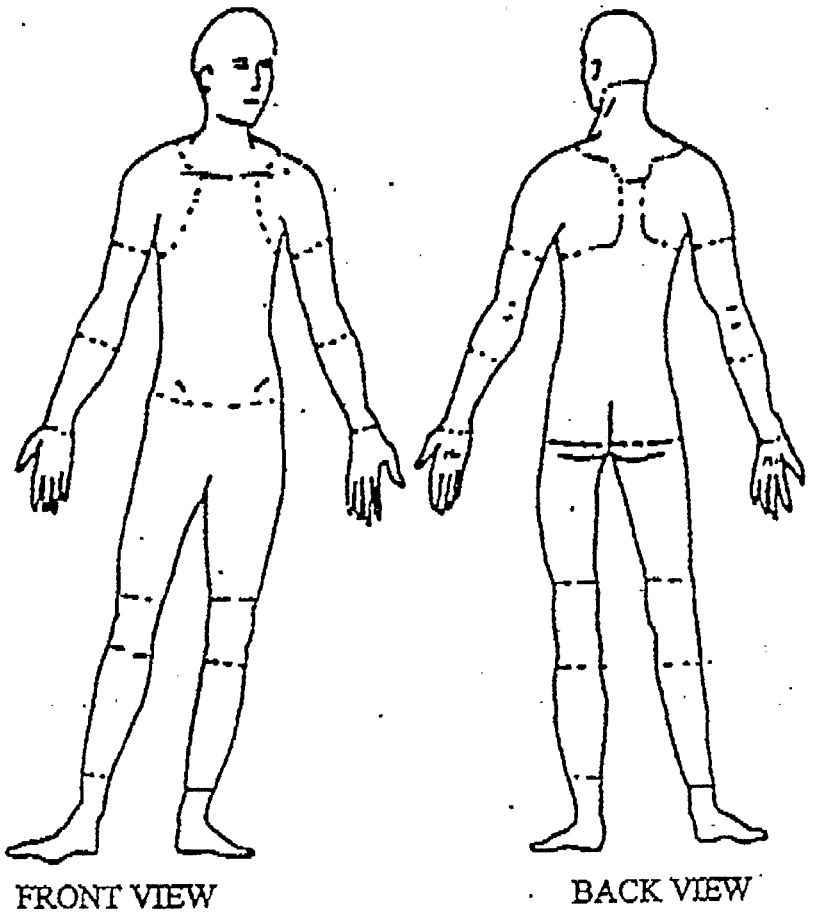
Name (Last, First):	Social Security Number:
Address:	Date Report Completed:
City, State Zip:	Time Report Filled Out: am pm
Current Phone Number:	Date of Accident:
Birthdate: Sex • Male • Female	Time of Accident: am pm
Name of Client Site Where Injury Occurred: Hourly Wage: $	Job Title:
Supervisor/Witnesses Names:	
Employee Statement (Describe in your own words how your accident occurred):	
What was the specific task being performed when the injury occurred?:	
Is this task part of your usual job duties?:	Were you trained on this task: • Yes • No If so, when:
Describe the injury or illness:	
Have you ever had a similar injury or illness?: • Yes • No If so, when?:	
Are you going to receive medical treatment?: • Yes • No Have you already received medical treatment?: • Yes • No	If your answer is yes to either questions, please provide the following information
Clinic Name & Address: Phone #:	
Physician's Name:	
Please explain the nature of medical treatment received:	
IN YOUR OPINION, HOW COULD THIS INJURY HAVE BEEN PREVENTED?:	

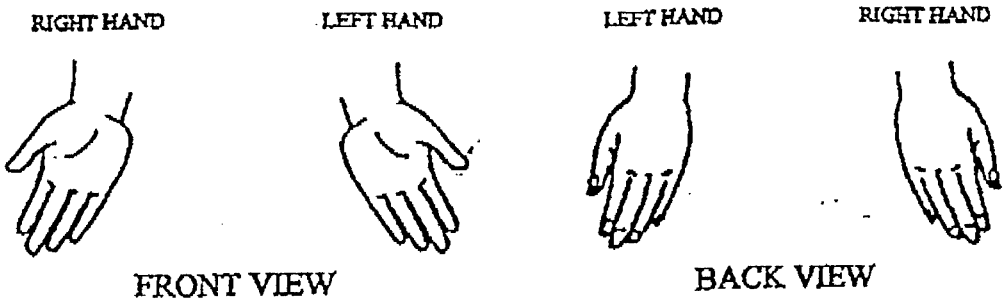
I certify that the statements on this form are true and accurate and I understand that the declaration of a false Worker's Compensation Claim is a violation of Wisconsin's Criminal Code which may result in a fine and imprisonment and in termination from employment. (WI Statute No. 943.395)

Employee's Signature Date

Revised 5/3/16

On the diagram(s) below, please shade in those areas of your body that the injury/illness occurred.





Employee Name: _____

Employee Signature: _____

Date: _____

Revised 5/3/16

QTI HR Supervisor Incident Report

This form is to be completed by the job site Supervisor and forwarded to the QTI Safety & Compliance Department
Contact QTI's Safety & Compliance Department via phone to notify of injury as soon as possible – 608-258-5525

Background Information

Name of Employee		**QTI Notified:** **Date:** **Time:** **AM/PM**
Employee's Job Title	Male Female	Job
Employee's Specific Job Duties		Employment Start Date:
Client Company Name		Employee's Current Phone # ( ) -

Treatment Information

Clinic Name & Address: Was the employee sent for a drug screen: Yes No	Physician's Name (if known): Treatment Date(s):	Not Seeking Medical Attention ☐

Incident Information

Date of Incident	Time of Incident AM / PM	Client Incident Report Available? ☐
Supervisor Notified: Yes No Name:	Employee Returned to Work After Accident: If Yes, on what date? No Yes ⇨	
Witness Names and Contact Info:		

Incident Analysis

What happened to cause this injury or illness? Describe the employee's activities when the injury or illness occurred with details of how the event or exposure occurred. Include name (s) of other individuals involved. Specify tools, machinery, objects, chemicals, etc. that were involved in or caused the injury.

What is the specific nature of the injury or illness? Please include exact description of body part (s) involved. (Example: left hand laceration, right foot contusion, pain in ring finger, etc.)

Completed By:	Date Completed:
Title:	Sent to Safety & Compliance: ☐ YES
Rev. 04/2011	**Email: safety@qstaff.com or Fax: 608-663-4805**

Voluntary and Informed Consent for Disclosure of Health Care Information

The provision of your social security number is mandatory under Wisconsin Statutes and will be used to identify the claimant. Failure to provide it may result in penalties or delayed payment of benefits. Personal information you provide may be used for secondary purposes [(Privacy Law, s. 15.04(1)(m)].

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.state.wi.us/wc/
e-mail: DWDDWC@dwd.state.wi.us

By law, all health care providers must provide to any employee, employer, worker's compensation insurer or their representative any information reasonably related to any alleged work injury. However, determining the relationship of prior medical records to a work injury can be difficult and time-consuming. Therefore, to assist in the timely investigation of your claim, this document authorizes the health care provider to release medical information without attempting to determine the extent of its relationship to your alleged work injury.

You are not required to sign this document. You may refuse to sign this document without jeopardizing your right to collect worker's compensation benefits. However, by assisting in the investigation of your claim, you are likely to receive benefits quicker than if you refuse to authorize the release of medical information.

Health Care Provider Name		Street Address	
P. O. Box	City	State	Zip Code
Patient (Employee) Name	Employer Name QTI Human Resources, Inc.		
Patient Social Security Number - -	Patient Birth Date	WC Claim No.	

The patient named above hereby authorizes the health care provider named above to disclose all records checked below in its possession relating to the patient's health, treatment and evaluation to:

Name and Address of Party Authorized to Receive Protected Information
QTI Human Resources Inc. PO Box 552 Madison, WI 53701 Attn: Safety 608-257-1057 (phone) 608-663-4805 (fax)

or its designated representatives, and to furnish to them a legible, certified duplicate of all records, writings, reports, test results and x-rays in its possession containing such information. This authorization includes *all* records, reports, correspondence, or other materials in the possession of the health care provider authorized, even if those materials were not generated by the health care provider, and the redisclosure of such materials is hereby authorized. This release is for use in the investigation, preparation, evaluation, and/or hearing of the worker's compensation claim described above.

CHECK ONE:

☒ **A.** **Physical Only**. Release all records, correspondence, and any other information from whatever source regarding the patient's physical health, treatment and evaluation including, but not limited to, any made or provided by any physician, nurse, chiropractor, osteopath, dentist, physical therapist, hospital, or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited to Wis. Stat. §§ 146.81 and 146.82, and 45 C.F.R. § 164.508.

☐ **B.** **Physical and Other**. Release all records, correspondence, and any other information from whatever source regarding the patient's physical and mental health, drug and alcohol abuse, HIV and AIDS tests, treatment, and evaluation including, but not limited to, any made or provided by any physician, psychiatrist, psychologist, nurse, chiropractor, osteopath, dentist, physical therapist, hospital or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited Wis. Stat. §§ 51.30, 146.025, 146.81 and 146.82, 42 C.F.R., Chap. 1, subpart C, § 2.31 and 45 C.F.R. § 164.508.

Patient Signature (or Person Authorized to Sign for Patient) — for Option B:

Patient Signature (or Person Authorized to Sign for Patient):	Date:

WKC-9488-E (R. 12/2003)

In signing this consent form, I acknowledge that I understand that:

- I am authorizing release of the records and information listed above.
- I am waiving any privilege that may otherwise prevent disclosure of the records and information listed above.
- I understand that the health care provider named above, whom I am authorizing to disclose my protected health information, may not condition my treatment, payment, enrollment or eligibility for benefits (if applicable) on whether I sign this authorization, except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.
- I may revoke this authorization at any time by a written request to the party authorized above to receive information, except that the party authorized above to receive such information may rely upon any personal health information received before the revocation of this authorization.
- I may obtain a copy of the disclosed records and information, upon written request to the party authorized above to receive information, at no charge to me.
- My personal health information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by federal law. My personal health information may be released to any of the following: the employer, the worker's compensation insurer, the Department of Workforce Development, other parties to this matter or their attorneys; the Labor and Industry Review Commission; any court on any action or proceeding relating to this matter; experts retained or consulted by any party; and any of their agents, employees, or representatives. I specifically authorize and consent to any such disclosure and redisclosure.
- I am entitled to a copy of this consent form after I sign it.

If you have any questions about this document, you should contact the Worker's Compensation Division at (608) 266-1340. You should not sign this document if the name of the health care provider is blank.

This consent is subject to revocation at any time. If not revoked, this consent is effective for two (2) years from date signed. This authorization expressly waives any requirement that it must be used within a certain number of days after the date of signing, or that it must be dated within any time period before the date it is used. This authorization shall also extend to records of future treatment, after the date of signing of this authorization, as long as such treatment occurs while this authorization is still in effect. A photocopy copy shall be as valid as the original.

Patient Signature (or Person Authorized to Sign for Patient):	Date:
If not signed by patient, authority/designation to sign is based on the fact that the patient is: ☐ A minor ☐ Incompetent ☐ Disabled ☐ Deceased ☐ Other:	