



employer solutions staffing group<sup>sm</sup>  
Leveraging Resources in a Changing Market

7301 Ohms Lane / Suite 405 / Edina, MN 55439  
Phone: (952) 767-0053 Fax: (952) 767-0740  
Email Address: wc@employersolutionsgroup.com

Employee's name: \_\_\_\_\_ Phone Number \_\_\_\_\_

Date of injury: \_\_\_\_\_ Date Reported \_\_\_\_\_

**Please complete this Questionnaire as accurately as possible to help process your injury information. Incompletion of this form may affect or cause delay of claim.**

How are you feeling now?

Please tell me the nature of your injury. Where does it hurt? What type of injury? ( strain, sprain, cut, bruise, ect...)

Have you experienced an injury like this before?

Please tell me what you were doing when the injury occurred?

Is this part of your normal job functions? , If not what training did you receive prior to this Job Function?

What tools and equipment were you using at the time of injury?

Please describe the training you received prior to using this equipment.

Is there anything else you can tell us about how the injury occurred?

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

Injured Employee Questionnaire