



7301 Parkway Drive Hanover, MD 21076 800-336-7091 Fax to: _____

Employee Incident Report

Each employee is required to complete this form after experiencing an unintentional work related injury. This form is used as official documentation that an on-the job injury has occurred. Please be as specific as possible when completing. Please use the back of the paper if needed. PLEASE PRINT CLEARLY

Employee Information:

Employee Name: Rodney Lester Larson	Address: (No P.O. Box) Street: 4713 Dominick Drive City, State, Zip: Minnetonka, MN 55343	Home Telephone Number: (952) 960-1935	Cell Telephone Number: +63-906-277-4003
Social Security Number: 478-52-1117	Job Title: System Engineer	Date of Birth: 09/27/1944	Marital Status: Married
THE LAW PROVIDES FOR SEVERE PENALTIES IF YOU WITHHOLD A MATERIAL FACT OR MAKE A FALSE STATEMENT ON THIS OR ANY OTHER FORM TO OBTAIN WORKERS' COMPENSATION BENEFITS			

Incident Information:

Date Injury Occurred: January 21, 2015	State Injury Occurred: Palpitations, numbness	Time of Day Injury Occurred: 3 PM	Client Name: MTS – in Japan
Address: Where Injury Occurred: Shimizu Seismic Laboratory		Body Part(s) Injured: Heart artery	Date Returned to Work: January 23, 2015

Incident Occurrence:

How did the Injury occur? (Describe fully the events, which resulted in this injury or disease. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors, which led or contributed to this claimed injury or disease) Very stressful trip to Japan starting on January 17. Ferry cancelled due to Typhoon on 17 th , rescheduled for 18 th – ferry company gave seats away – had to travel in open economy class – very uncomfortable in Philippines. On 19 th , flew to Japan. Trip uneventful. Tuesday noon had an episode of skipped heartbeats and numbness in arm and leg at noon walking to lunch. Lasted about 30 minutes. No other problem that day. On Wednesday, Jan 21, had another episode at noon walking to lunch but this episode lasted for over 2 hours. Felt great general discomfort and had some palpitations now and again until 3PM. Went to hospital at 3PM. In emergency room, cardiologist analyzed as an unstable heart condition that required an immediate angioplasty and possible stent insertion. He put probability at 30% of a major MI soon. Discovered a problem in an artery in angiogram and inserted stent. Seems to have alleviated most of the symptoms. All tests were OK after surgery – stayed overnight and Doctor gave OK to return to work on Thursday. Released from hospital and rested at hotel rest of Thursday.	
Were any safeguards provided? Used? If so, Please Explain: none	
What were you doing before the incident? Editing system manual for the shaking table system.	
Have you ever had the same or similar injury before? If so, please provide type of injury, date of injury and type of medical treatment received. YES. I had a mild MI in 1999 and had a stent installed in my heart. In 2006 and 20013 I had additional stents installed as precautions due to scheduled angiograms to test my existing condition. All previous stents are still considered OK (patent in medical terms).	
Do you have any medical conditions that may impact your recovery? (Diabetes, high blood pressure, etc.) I have high blood pressure and control cholesterol	
Did you report this incident to anyone at the Client? If so, to whom and when did you report it? Dave Kusner, Shimizu Project Engineer and he reported to my MTS supervisor	Did you notify anyone at Allegis Group, Inc. about the incident? If so, to whom and when did you notify? NO, I do not have insurance because it was not available for overseas.
Did anyone witness this incident? If so, please list full name(s) and telephone number(s): Name: David Kusner Telephone Number: (952) 261-3834	

Medical Information:

Do/Did you require medical treatment? Y or N (If yes , Please provide. Name the doctor, clinic, address and phone number of facility you will see/were seen. YES, see attached document from the hospital that has all the information requested.	Was a Drug Screen performed? Y or N If not, why? No, it was not deemed necessary Date and time of Next Doctor's Appointment? February 25, 2015
Did the Doctor Report you could return to work? Y or N YES If yes, was it (circle one) FULL DUTIES OR RESTRICTED DUTIES If RESTRICTED, List your restriction:	
I hereby certify that the above statements are true to the best of my knowledge or belief. I am aware that the law provides for severe penalties if I knowingly and/or with fraudulent intent withhold a material fact or make a false statement on this or any other form in order to obtain workers' compensation benefits. Additionally, I understand that Allegis Group requests that I keep them apprised of my medical/work status at all times. I further understand that Aerotek will try to offer transitional duty assignments to employees based on prescribed medical limitations resulting from job related injuries whenever possible. I agree to contact my Aerotek office to comply with this request.	
Employee Signature:	Date:



INSTRUCTIONS FOR COMPLETION

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Employee Signature: _____

Date: _____

Revised 11-2013

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Employee Information:

Employee Name: EMPLOYEE FULL LEGAL NAME	Address: (No P.O. Box) Street: EMPLOYEE ADDRESS City, State, Zip:	Home Telephone Number: XXX-XXX-XXXX	Cell Telephone Number: XXX-XXX-XXXX
Social Security Number: XXX-XX-XXXX	Job Title: CLIENT PROVIDED TITLE	Date of Birth: MM/DD/YYYY	Marital Status: M or S

THE LAW PROVIDES FOR SEVERE PENALTIES IF YOU WITHHOLD A MATERIAL FACT OR MAKE A FALSE STATEMENT ON THIS OR ANY OTHER FORM TO OBTAIN WORKERS' COMPENSATION BENEFITS

Incident Information:

Date Injury Occurred: SPECIFIC DATE IF KNOWN	State Injury Occurred:	Time of Day Injury Occurred: 0:00 AM/PM SPECIFY EXACT TIME	Client Name: CONTRACTOR'S PLACE OF WORK-NOT AEROTEK
Address: Where Injury Occurred: STREET ADDRESS OF CLIENT SITE WHERE ACCIDENT OCCURRED		Body Part(s) Injured: SPECIFIC BODY PART(S) DEFINE LEFT OR RIGHT	Date Returned to Work: IF RETURNED OR N/A

Incident Occurrence:

How did the Injury occur? (Describe fully the events, which resulted in this injury or disease. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors, which led or contributed to this claimed injury or disease)

SPECIFIC DESCRIPTION OF ACCIDENT. WHO WAS INVOLVED, WHAT HAPPENED, HOW DID IT HAPPEN AND WHY

Were any safeguards provided? Used? If so, Please Explain: **ANY PERSONAL PROTECTIVE EQUIPMENT (PPE) ETC.**

What were you doing before the incident?

PRIOR WORK OR ACTIVITY BEFORE INCIDENT

Have you ever had the same or similar injury before? If so, please provide type of injury, date of injury and type of medical treatment received.

PLEASE PROVIDE DETAILS ON SIMILAR OR SAME INJURY IF APPLICABLE

Do you have any medical conditions that may impact your recovery? (Diabetes, high blood pressure, etc.)

Did you report this incident to anyone at the Client? If so, to whom and when did you report it?

NAME AND TIME OF CLIENT PERSONNEL INFORMED

Did you notify anyone at Allegis Group, Inc. about the incident? If so, to whom and when did you notify?

NAME AND TIME OF AEROTEK PERSONNEL INFORMED

Did anyone witness this incident? If so, please list full name(s) and telephone number(s): **ANY WITNESS FROM THE CLIENT OR AEROTEK**

Name: _____ Telephone Number: _____

Medical Information:

Do/Did you require medical treatment? Y or N (If yes , Please provide. Name the doctor, clinic, address and phone number of facility you will see/were seen.
Y or N, NAME AND CONTACT INFORMATION OF MEDICAL FACILITY, TBD IF NOT YET DETERMINED. LIST CLIENT MED SITE IF APPLICABLE

Was a Drug Screen performed? Y or N If not, why?
Y or N

Date and time of Next Doctor's Appointment?
IF APPLICABLE

Did the Doctor Report you could return to work? Y or N: **Y OR NO**
If yes, was it (circle one) **FULL DUTIES OR RESTRICTED DUTIES**
IF RESTRICTED, List your restriction:

I hereby certify that the above statements are true to the best of my knowledge or belief. I am aware that the law provides for severe penalties if I knowingly and/or with fraudulent intent withhold a material fact or make a false statement on this or any other form in order to obtain workers' compensation benefits. Additionally, I understand that Allegis Group requests that I keep them apprised of my medical/work status at all times. I further understand that Aerotek will try to offer transitional duty assignments to employees based on prescribed medical limitations resulting from job related injuries whenever possible. I agree to contact my Aerotek office to comply with this request.

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