

Accident Reporting & Treatment (ART) Form Part 1: Supervisor's Report Of Injury

Employee's Name _____ Marital Status _____ Date of Birth _____
 Home Address _____ Home Phone _____
 Emergency Contact # _____ Job Title _____
 Work Location _____ Reporting Supervisor _____
 Injury Date _____ Time _____ AM/PM Date Reported _____ Last Day Worked _____
 Describe what employee was doing when injured and how the injury occurred (be specific about body part injured):

When and to whom did the employee first report the incident: _____
 Witnesses: _____
 Supervisor Signature: _____ Date: _____

INFORMATION RELEASE

Any information related to this injury will be used for the purpose of evaluating and handling my claim for injury as a result of an incident occurring on or about the above noted date of injury and for no other purpose now or in the future.

I hereby authorize (Employer) or any of its representatives to be furnished any information and facts regarding this injury including reports and records, results of diagnosis, treatment prognosis, estimates of disability and recommendations for further treatment.

Employee's Signature: _____ Date: _____

Name of Medical Provider: _____ Arrival Time _____
 Nature of Injury: New Injury No injury/illness found Recurrence/aggravation of existing condition
 Work-related Non work-related Not known

Type of injury/illness: _____ Body part injured _____

RECOMMENDATIONS FOR WORK: <input type="checkbox"/> Regular Work <input type="checkbox"/> Restricted Duty	LIFTING <input type="checkbox"/> 1 – 5 lbs. <input type="checkbox"/> 6 – 15 lbs. <input type="checkbox"/> 16 – 25 lbs. <input type="checkbox"/> 26 – 40 lbs. <input type="checkbox"/> 41 – 50 lbs. <input type="checkbox"/> Over 50 lbs. <input type="checkbox"/> No Lifting	PUSHING/PULLING LIMITED TO: <input type="checkbox"/> 1 – 5 lbs. <input type="checkbox"/> 6 – 15 lbs. <input type="checkbox"/> 16 – 25 lbs. <input type="checkbox"/> 26 – 40 lbs. <input type="checkbox"/> 41 – 50 lbs. <input type="checkbox"/> Over 50 lbs. <input type="checkbox"/> No Pushing/Pulling	POSITION LIMITATION: <input type="checkbox"/> No repetitive motion Body Part: _____ <input type="checkbox"/> No reaching above shoulders <input type="checkbox"/> No reaching below waist <input type="checkbox"/> No repetitive stooping, twisting or bending <input type="checkbox"/> No pinching or forceful gripping <input type="checkbox"/> Standing limited to _____ hrs. <input type="checkbox"/> Sitting limited to _____ hrs.
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Treatment: _____
 Treatment Plan: _____
 Follow-up appointment on _____ with _____
 Comments: _____

Patient Return to supervisor; no restrictions Return to supervisor; send home
 Disposition: Return to supervisor; with restrictions for ___ days. Employee can return to work on _____ (date).
 Medical Provider Signature: _____
 Print Name: _____

RETURN-TO-WORK

The above mentioned restrictions (if applicable) have been reviewed and the employee:

Returned to full duty, no restrictions Has been placed in an appropriate restricted duty position
 Was sent home per medical instructions Other _____

Supervisor Signature: _____ Date: _____
 Employee Signature: _____ Date: _____

Note: To facilitate the best care for your employee, it is the Supervisor's responsibility to adhere to the above modifications.

Disclaimer

The information provided in this document is intended for use as a guideline and is not intended as, nor does it constitute, legal or professional advice. St. Paul Travelers does not warrant that adherence to, or compliance with, any recommendations, best practices, checklists, or guidelines will result in a particular outcome. In no event will St. Paul Travelers or any of its subsidiaries or affiliates be liable in tort or in contract to anyone who has access to or uses this information. St. Paul Travelers does not warrant that the information in this document constitutes a complete, and finite list of each and every item or procedure related to the topics or issues referenced herein. Furthermore, federal, state or local laws, regulations, standards or codes may change from time to time and the reader should always refer to the most current requirements.

Accident Reporting & Treatment (ART) Form

Part 2: Accident Investigation

(To be completed within 24 hours)

(To be completed by the Supervisor / General Manager) Describe in detail the task the employee was doing at the time of injury (include vehicle, equipment or tools used):

Interview witnesses or co-workers for additional insights. Attach sheet for additional info/comments.
 Was this the employee's regular work assignment? Yes No If no, was person trained for assignment? Yes No

CAUSAL FACTORS		YES	NO	COMMENTS	CORRECTIVE ACTION
Environment					
1.1	Did the work area design contribute to the injury?	<input type="checkbox"/>	<input type="checkbox"/>		
1.2	Was the area cluttered?	<input type="checkbox"/>	<input type="checkbox"/>		
1.3	Did the employee have to be in this area to complete the job?	<input type="checkbox"/>	<input type="checkbox"/>		
1.4	Were other conditions (noise, air contaminants, extreme temperatures, etc.) a contributing factor?	<input type="checkbox"/>	<input type="checkbox"/>		
1.5	Other	<input type="checkbox"/>	<input type="checkbox"/>		
Equipment/Tools					
2.1	Was the correct equipment being used?	<input type="checkbox"/>	<input type="checkbox"/>		
2.2	Was the correct equipment readily available?	<input type="checkbox"/>	<input type="checkbox"/>		
2.3	Did any defects or change in equipment/material contribute to hazardous conditions?	<input type="checkbox"/>	<input type="checkbox"/>		
2.4	Is regular maintenance done on machinery/equipment?	<input type="checkbox"/>	<input type="checkbox"/>		
2.5	Are there any maintenance logs?	<input type="checkbox"/>	<input type="checkbox"/>		
2.6	Was the employee using PPE (Shoes, apron, goggles)?	<input type="checkbox"/>	<input type="checkbox"/>		
Method					
3.1	Was the employee performing according to SOP?	<input type="checkbox"/>	<input type="checkbox"/>		
3.2	Was there a better method to perform task?	<input type="checkbox"/>	<input type="checkbox"/>		
Employee					
4.1	Was safety equipment specified for this job? (List all)	<input type="checkbox"/>	<input type="checkbox"/>		
4.2	Was this equipment being used?	<input type="checkbox"/>	<input type="checkbox"/>		
4.3	Have safety procedures been established for this task?	<input type="checkbox"/>	<input type="checkbox"/>		
4.4	Were safety procedures being followed? If no, why?	<input type="checkbox"/>	<input type="checkbox"/>		
4.5	Was the employee trained on necessary equipment?	<input type="checkbox"/>	<input type="checkbox"/>		
4.6	Was the employee authorized to operate the equipment?	<input type="checkbox"/>	<input type="checkbox"/>		
Management					
5.1	Were the behaviors that caused the injury/illness observed before?	<input type="checkbox"/>	<input type="checkbox"/>		
5.2	If so, What was done?				
5.3	Does management require safe work practices related to this task? If yes, explain. How?	<input type="checkbox"/>	<input type="checkbox"/>		
5.4	Does management follow/support safety procedures?	<input type="checkbox"/>	<input type="checkbox"/>		
5.5	Have safety related changes been made/suggested in this area?	<input type="checkbox"/>	<input type="checkbox"/>		

To Correct Unsafe Acts <input type="checkbox"/> Review/change procedures <input type="checkbox"/> Instruct injured person <input type="checkbox"/> Instruct others <input type="checkbox"/> Process Improvement Explain: _____ _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Discipline injured person <input type="checkbox"/> Oral <input type="checkbox"/> Written	To Correct Unsafe Conditions <input type="checkbox"/> Eliminate condition <input type="checkbox"/> Install safety guard <input type="checkbox"/> Warn others of hazards <input type="checkbox"/> Implement inspections <input type="checkbox"/> Request repairs Vendor: _____ <input type="checkbox"/> Initiate Ergonomic Review <input type="checkbox"/> Other _____	CORRECTIVE ACTIONS <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Action</th> <th style="width: 20%;">Assigned To</th> <th style="width: 20%;">Date</th> </tr> </thead> <tbody> <tr><td>1.</td><td></td><td></td></tr> <tr><td>2.</td><td></td><td></td></tr> <tr><td>3.</td><td></td><td></td></tr> <tr><td>4.</td><td></td><td></td></tr> <tr><td>5.</td><td></td><td></td></tr> </tbody> </table> Corrective Actions completed <input type="checkbox"/> Yes <input type="checkbox"/> No	Action	Assigned To	Date	1.			2.			3.			4.			5.		
Action	Assigned To	Date																		
1.																				
2.																				
3.																				
4.																				
5.																				

Employee: _____ Date: _____
 Supervisor: _____ Date: _____
 General Manager: _____ Date: _____

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**Accident Reporting & Treatment (ART) Form
Part 3: Employee Statement**

My name is: _____

Date of injury: _____ Time of injury: _____

This is what happened (include what, when, where, how and why):

Do you recall anything unusual or unexpected that happened?

Are there work conditions that contributed to this injury?

How would you explain why you were injured?

Did the supervisor ask you to perform an unsafe act? _____

How would you prevent this injury from occurring again? _____

When did you first notice the injury or illness? _____

When did you tell your supervisor? _____

When did you first notice the pain? _____

Did pain develop suddenly or gradually? _____

Have you ever had this pain before? _____ If yes, when & how often? _____

Employee Signature _____ Date _____

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