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 Tir____________
Nature of Injury: ☐ New Injury ☐ No injury/illness found ☐ Recurrence/aggravation of existino condition
☐ Work-related ☐ Non work-related ☐ Not known
Type of injury/illness: ____________ Body part injure____________

RECOMMENDATIONS FOR WORK:	LIFTING	PUSHING/PULLING LIMITED TO:	POSITION LIMITATION:
☐ Regular Work	☐ 1 – 5 lbs.	☐ 1 – 5 lbs.	☐ No repetitive motion
☐ Restricted Duty	☐ 6 – 15 lbs.	☐ 6 – 15 lbs.	Body Part: ____________
	☐ 16 – 25 lbs.	☐ 16 – 25 lbs.	☐ No reaching above shoulders
	☐ 26 – 40 lbs.	☐ 26 – 40 lbs.	☐ No reaching below waist
	☐ 41 – 50 lbs.	☐ 41 – 50 lbs.	☐ No repetitive stooping, twisting or bending
	☐ Over 50 lbs.	☐ Over 50 lbs.	☐ No pinching or forceful gripping
	☐ No Lifting	☐ No Pushing/Pulling	☐ Standing limited to _____ hrs.
			☐ Sitting limited to _____ hrs.

Treatment: ____________
Treatment Plan: ____________
Follow-up appointment on ____________ with ____________
Comments: ____________

Patient Disposition: ☐ Return to supervisor; no restrictions ☐ Return to supervisor; send home
☐ 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.

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Exhibit 5B

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

To Correct Unsafe Acts	To Correct Unsafe Conditions	CORRECTIVE ACTIONS
☐ Review /change procedures	☐ Eliminate condition	Action / Assigned To / Date
☐ Instruct injured person	☐ Install safety guard	1.
☐ Instruct others	☐ Warn others of hazards	2.
☐ Process Improvement	☐ Implement inspections	3.
Explain: ____________	☐ Request repairs	4.
____________	Vendor: ____________	5.
☐ Other____________	☐ Initiate Ergonomic Review	Corrective Actions completed ☐ Yes ☐ No
☐ Discipline injured person	☐ Other ____________	
☐ Oral ☐ Written		

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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