

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

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 | To Correct Unsafe Conditions | CORRECTIVE ACTIONS | | |
|---|---|---|-------------|------|
| <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 | <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 _____ | Action | Assigned To | Date |
| | | 1. | | |
| | | 2. | | |
| | | 3. | | |
| | | 4. | | |
| | | 5. | | |
| | | Corrective Actions completed <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Employee: _____ Date: _____

Supervisor: _____ Date: _____

General Manager: _____ Date: _____

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 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

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.