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 Tim _____

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 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.

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: _____

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 _____