WAGNER COLLEGE

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

Employee's Name: _____ Marital Status: _____

Home Address: _____

Emergency Contact #: _____ Home Phone: _____

Work Location: _____ Date Reported: _____

Injury Date: _____ Time: _____ ☐AM ☐PM 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 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:
- ☐ Regular Work
- ☐ Restricted duty

FOR LIFTING:
- ☐ 1-5 lbs.
- ☐ 6-15 lbs.
- ☐ 16-25 lbs.
- ☐ 26-40 lbs.
- ☐ 41-50 lbs.
- ☐ Over 50 lbs.
- ☐No Lifting

FOR PUSHING/PULLING LIMITED TO:
- ☐ 1-5 lbs.
- ☐ 6-15 lbs.
- ☐ 16-25 lbs.
- ☐ 26-40 lbs.
- ☐ 41-50 lbs.
- ☐ Over 50 lbs.
- ☐No Pushing/Pulling

POSITION LIMITATION
- ☐ No repetitive motion
  Body Part:
- ☐ No reaching above shoulders
- ☐ No reaching below waist
- ☐ No repetitive stooping, twisting or bending
- ☐ No pinching or forceful gripping
- ☐ Standing limited to 0 hrs
- ☐ Sitting limited to 0 hrs

Treatment: _____

Treatment Plan: _____

Follow up appointment on _____ with: _____

PATIENT DISPOSITION
- ☐ Return to supervisor; no restrictions
- ☐ Return to supervisor; with restrictions for _____ days
- ☐ Return to supervisor; send home
- ☐ Employee can return to work on _____ (date)

Medical Provider Signature: _____

Print Name: _____

SUPERVISOR

RETURN TO WORK

The above mentioned restrictions (if applicable) have been reviewed and the employee:
- ☐ Returned to full duty; no restrictions
- ☐ Was sent home per medical instructions
- ☐ Has been placed in an appropriate transitional duty position
- ☐ Other

Supervisor Signature _____ Date _____

Employee Signature _____ Date: _____