Accident Reporting and Treatment (ART) Form

Important Instructions

Assess the Situation

Emergencies

Note: This Form is to be used for individuals involved in a work-related injury. The employee should contact his/her supervisor.

Call Campus Police x5555

The Occupational Health Center
Beth Israel Deaconess Hospital
148 Chestnut Street
Needham, MA 02492
(781) 453-3041 M-F 8:00AM-4:00PM
Emergency (781)453-5400
M-F 4:00PM-8:00AM and Weekends

In the event of serious bodily injury to an employee (e.g., amputation, loss of an eye, crushing injury, heart attack, loss of consciousness, toxic gas exposure, obvious fractures, profuse bleeding), you should:

1. Call Campus Police at x5555.
2. Administer first aid.
3. Secure the accident scene. Your primary concern is the employee; once medical treatment is acquired proceed with Step 1.
4. Campus Police will call The Occupational Health Center and arrange for appropriate emergency medical transport to bring the injured employee with all copies of the ART Form. If Campus Police is unavailable, the supervisor (or designee) will transport the injured worker.

Non-Emergencies

BEFORE TREATMENT

Employee

Supervisor

1. The employee will notify his/her supervisor in the event of an injury.
2. The ACCIDENT DATA section should be completed.
3. The employee must read the PAYMENT AUTHORIZATION section and sign his/her name.
4. The supervisor will call Campus Police at x2121.
5. Campus Police or supervisor will assess the situation and when necessary administer first aid and complete the FIRST AID section.
6. At the supervisor's discretion, he/she will accompany the injured employee to The Occupational Health Center.

AFTER TREATMENT

Meadowbrook TPA Associates
10 New England Business Center
Suite 303
Andover, MA 01810
Policy # 000225
888-444-4872

7. The Occupational Health Center will fax Form to Human Resources at (781) 283-3663 and return Form via mail to Wellesley College, Human Resources, 106 Central Street, Wellesley, MA 02481.
8. The transporter will present the ART Form to the provider for completion of their section and return the ART Form to the employer within 24 hours.
9. The supervisor and employee will complete the RETURN-TO-WORK section, the supervisor will retain a copy, forward a copy to Human Resources and a copy to Wellesley College's Director of Environmental Health and Safety within 24 hours of the occurrence of the injury.

Rev. 12/2010

Please have your supervisor fill out the Accident Analysis Form and submit to the Director of Environmental Health and Safety.

Wellesley College ACCIDENT REPORTING AND TREATMENT (A.R.T.) FORM

ACCIDENT DATA

Date _____ Name of Employee _____

Home Address_____City_____Zip_____

Home Phone #_____ Work Phone #_____ Birth date_____

Job Title_____ Department_____

Date of Injury_____ Location of Injury/Incident _____
(i.e. Tower, Green Hall)

Description of what happened _____

_____

Type of Injury _____ Body part Injured _____
(i.e. cut, sprain/strain)

Supervisor (please write clearly) _____ Witness _____

PAYMENT AUTHORIZATION

I hereby authorize Wellesley College (or any of its representatives) , to furnish any information and facts regarding this injury, including reports and records, results of diagnosis, treatment and prognosis, estimates of disability, and recommendations for further treatment. This information is to 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.

Employee Signature_____ Date_____

FIRST AID Nature of Injury First Aider _____

☐ New injury ☐ No injury/illness found ☐ Recurrence/aggravation of existing condition

Type of Injury_____ Body part injured_____
(i.e. cut, sprain/strain)

Treatment _____ Follow up (if any) _____

Recommendations/Return to Work_____ Date_____

OUTSIDE PROVIDER Where was the employee taken for initial treatment?_____ Arrival Time _____

Nature of injury: ☐ New injury ☐ No injury/illness found ☐ Recurrence/aggravation of existing condition

Type of injury:_____ Body part injured: _____

Comments/Recommendations/Modifications: _____

_____

_____

Medical Provider Signature: _____ Date:_____

RETURN TO WORK To be completed by the employee and his/her supervisor.

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

☐ Has been placed in an appropriate alternate duty position ☐ Returned to full duty, no modifications

☐ Cannot be accommodated at this time ☐ Was sent home per medical instruction ☐ Employee refused modified duty

Supervisor (please write clearly)_____ Date: _____

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

Please make two copies of the completed form. Send one copy to the DIR. OF ENVIRON. HEALTH & SAFETY, keep on copy for your SUPERVISOR, and submit a copy HUMAN RESOURCES.

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

Member:

Address or Location No.:

WHEN: Date and Time of Accident: Reported to:

Report to Supervisor or First Aid Delayed? Yes o No o If "Yes," Why:

WHO: Injured Person: Occupation:

Dept.: Length of Employment: Age:

Full time o Part time o Temporary o Student o Date of Hire:

INJURY/LOSS: Nature/Extent of Injuries or Property Damage:

WHERE: Exact Location Where Accident Occurred:

WHAT: Type of Accident:

Was employee doing something other than required duties at time of accident?

Yes o No o If "Yes," what and why:

Description of Accident (detail what employee was doing, and what physical objects, tools, machines, structures of equipment were involved):

WHY: Determine Accident causes and comment fully here.

1) Immediate Causes: 1) Unsafe act(s) / unsafe condition(s) :

2) Basic Causes: 2) Management, people, equipment, material, environment :

PREVENTION: What should be done and by whom to prevent recurrence of this type of accident?

What action are you taking to see that this is done?

Follow-up requirements:

Date of follow-up:

Investigated By _____ Date: _____

Supervisor's Signature: _____ Date of this report: _____

Department Manager's Signature: _____ Date: _____

Executive's Signature: _____ Date: _____