EMPLOYEE MSD REPORT TO THE EMPLOYER

REPORT NO. _____

SECTION 1 **Instructions to the employee:** Complete the top section of this form to describe the MSD signs or symptoms that you are now experiencing. Sign, date and immediately submit the form to your employer.

NAME _____ ID. NO. _____

PLANT _____ JOB NAME _____ SHIFT _____

HOURS WORKED/WEEK _____ TIME ON THIS JOB: YEARS _____ MONTHS _____

MSD SIGNS

Check box(es) that describe current MSD signs you are experiencing.

☐ Decreased range of motion ☐ Deformity ☐ Decreased grip strength ☐ Loss of muscle function ☐ Other

Comments: _____

Check area:

☐ Neck ☐ Shoulder ☐ Elbow/Forearm ☐ Hand/Wrist ☐ Finger
☐ Upper Back ☐ Lower Back ☐ Thigh/Knee ☐ Lower Leg ☐ Ankle/Foot

Comments: _____

MSD SYMPTOMS

Check box(es) that describe current MSD symptoms that you are experiencing.

☐ Painful joints ☐ Pain, tingling or numbness in hands or feet ☐ Shooting or stabbing pains in arms or legs
☐ Burning sensation ☐ Swelling or inflammation ☐ Pain in wrists, shoulders, forearms or knees
☐ Stiffness ☐ Fingers or toes turning white ☐ Back or neck pain

Comments: _____

EMPLOYEE'S SIGNATURE _____ DATE REPORT SUBMITTED _____

SECTION 2 **Instructions to the employer:** Determine whether the reported MSD or MSD signs or symptoms is/are work related. If you choose, request the assistance of a Health Care Professional (HCP) in making this determination.

Is the MSD incident work related? ☐ Yes ☐ No

Was the assistance of a Health Care Professional (HCP) requested? ☐ Yes ☐ No

Requires: ☐ Days away from work ☐ Restricted work ☐ Medical treatment beyond first aid

The employee's job routinely involves exposure to one or more relevant risk factors.

☐ Repetition ☐ Force ☐ Awkward postures ☐ Contact stress ☐ Vibration

Comments: _____

SECTION 3 **MSD MANAGEMENT ACTION**

The employee is being provided the following MSD management.

☐ Access to a Health Care Professional (HCP) ☐ Evaluation and follow-up
☐ Any necessary work restrictions, including time off to recover

Comments: _____

EMPLOYER REPRESENTATIVE'S SIGNATURE _____ DATE RETURNED TO EMPLOYEE

3 copies: (1) Employer (2) Employer copy: Return to employee after sections 2 and 3 are completed (3) Employee