UPMC WorkPartners
Providing Health & Productivity Solutions

REPORT OF INJURY

Employer's Name and address _____ Date _____

City _____ State _____ Zip _____ County _____ Employer's Phone _____

Injured Worker's Last Name _____ First Name _____ Middle _____ Recur/New injury Date _____

Home street Address _____ Home Phone Number _____

City _____ State _____ Zip _____ County _____ Marital Status _____ Time Work Began _____ am/pm

Social Security Number _____ Date of Birth ___/___/___ Date of Hire ___/___/___

Occupation _____

Full/Part-Time _____ If Part-Time, Days Worked Mon – Tues – Wed – Thur – Fri – Sat – Sun _____ Name of Other employer _____

Hourly Rate _____ Pass Days _____ Supervisor _____ Supervisor Number _____

Date of Incident ___/___/___ Time _____am/pm Date Reported ___/___/___ Time _____am/pm

Did incident occur on employer's premises: Yes No Where: _____

Performing regular job at the time of incident: Yes No

Losing Time: Yes No Last Day worked: ___/___/___

Description of Incident (who, what, when, where, how and why) _____

List of body parts injured: _____

Prior Injures and with what employer: _____

Treatment Sought and with whom: _____

Name and phone number of witnesses: _____

Remarks: _____

Report Taken by: _____ Date: _____ Time: _____