CITY OF PITTSBURGH
BUREAU OF POLICE - WORK INJURY REPORT FORM

Report On the Job Injuries to UPMC Work Partners @ 1-800-633-1197

Date of call to UPMC: Time of Call to UPMC: Name of UPMC contact:

Name: (Last) (First) (MI) Social Security No:

Job Title: Department:

Supervisor's Name: Date of Incident: Time of Incident: ☐ AM ☐ PM

Did You Seek Medial Treatment? ☐ Yes ☐ No Name of Hospital/Doctor:

Did the City EMS Transport You? ☐ Yes ☐ No What Body Part do you feel is injured?

Did Anyone Witness the Incident? ☐ Yes ☐ No ☐ Unknown CCR#

Name & Phone Number of Any Witness:

Please describe what happened in detail. Be sure to answer the following questions: Where and how did the incident occur? What type of equipment were you using, if any? What were the environmental conditions at the time of the incident? Describe your symptoms as of the time of this report.

The description of the incident as detailed above is not intended to limit reporting of additional medical symptoms that may be discovered at a later date.

Completing this form serves to notify the City of Pittsburgh that the above named employee is filing an injury/infectious disease report under the provision of the Pennsylvania Heart and Lung Act of 1935, PL 477 No. 193 (as amended), the Pennsylvania Occupational Disease Act of 1939, PL 566 No. 284 and the Workers' compensation Act of 1915, PL 736 No. 338 (as amended).

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Employee Signature Date

Original Form is to be sent to the Assistant Chief of Administration,

a copy must go to **1**) Dept. of Personnel and Civil Service-Employee Compensation and **2)** Employee