CITY OF PITTSBURGH
WORK INJURY REPORT FORM

Report All On-The-Job Injuries to Work Partners @ 1-800-633-1197

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

Name: (Last) (First) (MI) Last 4 digits of your Social Security #:

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? What type of Personal Protective Equipment (PPE) was being worn 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.

_____ _____

Employee Signature Date

**** A copy of this document must go to the Department of Human Resources & Civil Service – Office of Risk Management**