

Additional Injury Report Information Sheet

This sheet is to be faxed to 412-624-1817 with the *Employer's Report of Occupational Injury or Disease* and a signed *Pennsylvania Workers' Compensation Act Employee Acknowledgment*.

· Injured Worker's Information:

Name: _____ Campus phone #: _____

Date of Injury: _____ Date of Hire: _____

Department: _____ (5 digit) Department ID #: _____

WORK SHIFT: Circle days regularly worked: Sun Mon Tue Wed Thur Fri Sat

Hours regularly worked: _____ am/pm to _____ am/pm

Hourly Wage: _____ Union Employee: Yes No

· Injury Information:

Location where incident or injury took place:

Address: _____

Building: _____ Floor/Room Number: _____

For needle-stick injuries only: List sharps type/brand: _____

· Direct Supervisor's Information:

Name: _____

Title: _____

Campus address: _____ E-mail: _____

Campus phone #: _____ Fax #: _____

· Supervisors or managers please answer the following question:

What has been or will be done to prevent recurrence of the injury or illness?

If you have any questions, please call Michele:

Workers' Compensation
1827 Cathedral of Learning
Pittsburgh, PA 15260
412-624-1198
Fax: 412-624-1817
www.bc.pitt.edu/wc

For office use only: Code: _____

Revised: 2/4/2008