UPMC WorkPartners
Providing Health & Productivity Solutions

RMU ROBERT MORRIS

EMPLOYEE REPORT OF INJURY/INCIDENT

Please send completed form to Laura Todd, Human Resources by interoffice mail or email toddl@rmu.edu or deliver in person within 24 hours of incident occurring.

Robert Morris University	6001 University Boulevard		
Employer's Name	**Street Address**		**Date**
Moon Township	PA	15108	Allegheny	412-397-4343
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**	**Cell Phone Number**

Last 4 SSN	**Date of Birth**	**Marital Status**	**Time Work Began** AM/PM
Occupation		**Full/Part-Time**	**Date of Hire**

If Part-Time, Days Worked: Mon – Tues – Wed – Thur – Fri – Sat – Sun **Name of Other Employer**

Supervisor Name	**Supervisor Phone Number**	**Hourly Rate**
Date of Incident	**Time of Incident** AM/PM	**Date Reported**	**Time Reported** AM/PM

Did incident occur on employer's premises: Y or N **Where (Be Specific):**

Performing regular job at the time of incident: Y or N **Losing Time: Y or N** **Last Day worked:**

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

List of body parts injured: _____

Incident Analysis-Describe what action, condition, and/or circumstances caused the incident:

_____

_____

_____

Summarize other conditions related to the incident, even contributing factors that may have reduced the severity. (ex. What type of personal protective equipment (PPE) was being worn-gloves, safety glasses, goggles, mask, etc.?): _____

_____

_____

Were there any contributing physical or environmental factors: _____

_____

Prior Injures and with what employer: _____

Treatment Sought and with whom: _____

Name and phone number of witnesses: _____

Was there any property damage: _____

_____

Preventative/Corrective Actions taken: _____

_____

_____

Additional Remarks: _____

Report Taken By: _____ **Date:** _____ **Time:** _____ **AM/PM**

Supervisor Signature: _____ **Employee Signature:** _____

HR/Safety Department Use Only

☐ **Please check if Human Resources has received this form. Date:** _____

☐ **Please check if Safety Services has received this form. Date:** _____

Investigation/Follow-Up Notes: _____

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