PHILADELPHIA REDEVELOPMENT AUTHORITY

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WORK RELATED INJURY/INCIDENT REPORT
State Workers' Insurance Fund Policy #06127710

For HR Use Only:
Date reported to SWIF: _____
Claim #: _____
Full Day of Pay for Injury Day? Yes or No

1. Today's Date: _____

2. Employee's Name: _____ 3. Social Security #: _____

4. Home Address: _____ 5. Phone Number: _____

6. Job Title: _____ 7. Date of Birth: _____

8. Date of Hire: _____ 9. Marital Status: _____

10. Employment Status: FT or PT *(circle one)* 11. Gender: Male or Female *(circle one)*

12. Date of Injury: _____ 13. Time of Injury: _____ 14. Time Employee Began Work: _____

15. Where did the accident occur (address)? _____

16. What was the employee doing at the time of the accident? _____

17. Was the employee handling any equipment at the time of the accident? If so, what type? _____

18. Did the employee miss one or more entire shifts from work due to this injury? Yes ☐ No ☐

19. If yes, date disability began: _____ 20. Date Returned to Work: _____

21. Type of Illness/Injury: _____

22. What part(s) of the employee's body were affected by the accident? _____

23. Detailed description of how the injury occurred: _____

Created 4/7/2011
Revised 12/12/2014
Revised 8/3/2016
Revised 11/3/2016

24. Did the employee seek medical treatment for the injury? Yes☐ No ☐

25. Treating Physician Contact Info: _____

_____

26. Type of Treatment & Medications Provided: _____

_____

27. Witness(es) Name(s) and Phone Number(s): _____

_____

28. Reported To Whom (Name and Position): _____

_____

29. Name and job title of person preparing this report, if not the injured employee:

_____

I certify that the above statements are true and accurate. I understand that all claims are subject to investigation. I authorize the treating physician to release information relating to this injury to the Philadelphia Redevelopment Authority. I understand that the filing of this claim does not guarantee payment for medical treatment or lost wages. If liability is not accepted, I will be responsible for all charges for medical treatment. All claims for lost time from work must be supported by a physician's report.

30. _____ 31. _____ 32. _____

Printed Name of Employee | Signature of Employee | Date

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Revised 12/12/2014
Revised 8/3/2016
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