EMPLOYEE'S OCCUPATIONAL DISEASE OR INJURY REPORT PA 0360 / 10-14

PORT AUTHORITY NY NJ
AIR LAND RAIL SEA

Injured Employee	**WITHIN 24 HOURS AFTER INJURY OR ONSET OF DISEASE:** 1. Complete Part I and submit to your supervisor. 2. Contact the Office of Medical Services.
Supervisor	1. Direct Employee to contact the Office of Medical Services. 2. Complete Part II of report, obtaining medical information from the Office of Medical Services. 3. Submit completed report to facility or division manager for review and signature.
Facility or Division Mgr.	**WITHIN 5 WORKING DAYS AFTER INJURY OR DISEASE:** 1. Review report, ensure that the injured employee has contacted the Office of Medical Services, sign report in lower right corner. 2. Have photo copies made and route original to Workers' Compensation (225 PAS, 12th Fl., PA Zip 12012), one copy to Inspection & Safety Div. (PATC, RM 301, PA Zip 43), one copy to the Office of Medical Services (233 PAS, 8th Fl., PA Zip 1308).

PART I - PREPARED BY EMPLOYEE IN OWN HANDWRITING

Name of Employee		Home address (No. & Street, City, State, Zip Code)			Area Code	Home Tel. No.
Job Title		Employee No.	Date of Birth	Sex	Marital Status ☐ Widowed ☐ Married ☐ Divorced ☐ Single ☐ Separated	
Date of Injury	Time M	Shift/Duty Hrs.	Date Injury Reported or Disease Diagnosed	Did It Occur on P.A. Premises?	☐ Yes ☐ No	Weather Conditions
Facility or Division	Org. Unit No. / Tel. Ext.		To Whom Reported - Name/Title			
Location Where Injury Took Place or Disease Was Contacted		State Where Injury or Disease Occurred ☐ NY ☐ NJ		Name of Witness		
Was Medical Treatment Received? ☐ No ☐ Yes → ☐ First Aid ☐ P.A. Clinic ☐ Hospital ☐ Private M.D.		Date of Treatment		Name and Address of Doctor or Hospital		

Describe the injury or disease in detail (Example: Cut on right forearm requiring stitches)

Describe how the injury or disease occurred. Indicate what your were doing at the time of the incident. Name the object, substance or condition which directly caused the injury or disease:

What could have prevented your injury or disease? Describe any corrective measures that should be taken to prevent a recurrence.

Signature of person other than employee completing this report	Signature of employee	Date

PART I I - PREPARED BY EMPLOYEE'S IMMEDIATE SUPERVISOR

Describe how the injury or disease occurred. Indicate cause.

Comment on the preventive suggestion given by the employee above. What action have you taken to prevent a recurrence?

Consult the Office of Medical Services or Clinic to obtain the following information. If employee was treated at a Non-Port Authority facility, ask the Office of Medical Services to obtain the data from the treating medical facility.

Name of doctor or nurse supplying information	Name of clinic	Is this injury expected to be disabling? ☐ Yes ☐ No

Description of the injury or disease

If the nature of the injury or disease will require employee to be absent from work, estimate length of absence: _____ Days

Immediate Supervisor's Signature	Print Immediate Supervisor's Name	Facility or Division Manager's Signature	Date

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