

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF LABOR AND INDUSTRY  
BUREAU OF WORKERS' COMPENSATION  
1171 S. CAMERON STREET, ROOM 103  
HARRISBURG, PA 17104-2501  
(TOLL FREE) 800-482-2383  
TTY (TOLL FREE) 800-362-4228

# EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

EMPLOYEE SOCIAL SECURITY NUMBER

DATE OF INJURY

MONTH

DAY

YEAR

EMPLOYEE FIRST NAME

EMPLOYEE LAST NAME

STREET ADDRESS

CITY

STATE

ZIP CODE

COUNTY

PHONE NUMBER

EMPLOYEE:

NUMBER OF DEPENDENTS

DATE OF BIRTH

MALE MARRIED

FEMALE SINGLE

OCCUPATION OR JOB TITLE

MONTH

DAY

YEAR

NCCI CLASS CODE (IF KNOWN)

EMPLOYMENT STATUS

FT = Full-time  
PT = Part-time

SL = Seasonal  
VO = Volunteer  
ZZ = Other

EMPLOYER

STREET ADDRESS

CITY

STATE

ZIP CODE

SIC CODE

EMPLOYER FEIN

PHONE NUMBER

COUNTY

NAICS CODE

FULL PAY FOR DAY OF INJURY?

TIME EMPLOYEE BEGAN WORK

TIME OF OCCURRENCE

YES

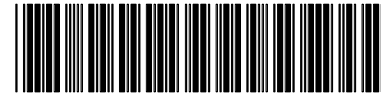
AM

AM

NO

PM

PM



LAST DAY WORKED

DATE DISABILITY BEGAN

344 1197-1

MONTH DAY YEAR

MONTH DAY YEAR

DATE EMPLOYER NOTIFIED

DATE RETURNED TO WORK

DATE OF HIRE

MONTH DAY YEAR

MONTH DAY YEAR

MONTH DAY YEAR

CONTACT FIRST NAME

CONTACT PHONE NUMBER

CONTACT LAST NAME

NOTICE: Report should be clearly completed, (preferably typed) and original mailed to the Bureau at the address in the upper left corner and a copy to employee and insurer.

TYPE OF INJURY CODE                      PART OF BODY AFFECTED CODE                      CAUSE OF INJURY CODE (ENTER CODES, IF KNOW)

TYPE OF INJURY OR ILLNESS

PARTS OF BODY AFFECTED

CAUSE OF INJURY

|  |   |  |  |
|--|---|--|--|
| DID INJURY OR ILLNESS OCCUR<br>ON EMPLOYER'S PREMISES? | IF OUT OF STATE, SPECIFY<br>STATE OF INJURY | WERE SAFEGUARDS OR SAFETY<br>EQUIPMENT PROVIDED? | WERE SAFEGUARDS OR SAFETY<br>EQUIPMENT USED? |
| YES  |   | YES  | YES  |
| NO   |   | NO   | NO   |

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES DIRECTLY RESPONSIBLE

IF FATAL, GIVE DATE OF DEATH

MONTH                      DAY                      YEAR

PHYSICIAN/HEALTH CARE PROVIDER

|             |                                |
|-------------|--------------------------------|
| FIRST NAME: | LAST NAME:                     |
| STREET      |                                |
| CITY        | STATE                      ZIP |

|                |                                |
|----------------|--------------------------------|
| HOSPITAL NAME: |                                |
| STREET         |                                |
| CITY           | STATE                      ZIP |

INITIAL TREATMENT:

- NO MEDICAL TREATMENT
- MINOR BY EMPLOYEE
- CLINIC / HOSPITAL
- PANEL PHYSICIAN
- EMPLOYEE PHYSICIAN
- EMERGENCY CARE
- HOSPITALIZED MORE THAN 24 HOURS

POLICY PERIOD FROM:

MONTH                      DAY                      YEAR

POLICY PERIOD TO:

MONTH                      DAY                      YEAR

POLICY/SELF INSURED NUMBER:

WITNESS FIRST NAME

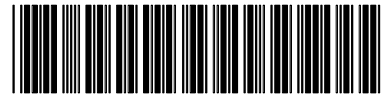
WITNESS PHONE NUMBER

WITNESS LAST NAME

|  |   |
|--|---|
| <p>PERSON COMPLETING THIS FORM:</p> <p>NAME:</p> <p>TITLE:</p> <p>PHONE:</p> | <p>INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)</p> <p>NAME:</p> <p>STREET</p> <p>CITY                      STATE                      ZIP</p> <p>BUREAU CODE:                      FEIN:</p> |
|--|---|

DATE PREPARED

MONTH                      DAY                      YEAR



344 1197-2

Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165.