

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 SL = Seasonal  
PT = Part-time VO = Volunteer  
ZZ = Other

EMPLOYER

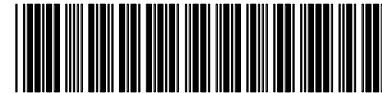
STREET ADDRESS

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  
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 ON EMPLOYER'S PREMISES?	IF OUT OF STATE, SPECIFY STATE OF INJURY	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?	WERE SAFEGUARDS OR SAFETY EQUIPMENT USED?
YES		YES	YES
NO		NO	NO

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

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

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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

POLICY/SELF INSURED NUMBER:

WITNESS FIRST NAME

WITNESS PHONE NUMBER

WITNESS LAST NAME

PERSON COMPLETING THIS FORM:

NAME:  
TITLE:  
PHONE:

INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)

NAME:  
STREET  
CITY          STATE          ZIP  
BUREAU CODE:          FEIN:

DATE PREPARED

MONTH          DAY          YEAR



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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.