

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:

MALE MARRIED

FEMALE SINGLE

NUMBER OF DEPENDENTS

DATE OF BIRTH

MONTH

DAY

YEAR

OCCUPATION OR JOB TITLE

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

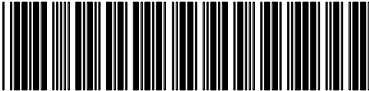
AM

AM

NO

PM

PM



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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?

YES

NO

IF OUT OF STATE, SPECIFY
STATE OF INJURYWERE SAFEGUARDS OR SAFETY
EQUIPMENT PROVIDED?

YES

NO

WERE SAFEGUARDS OR SAFETY
EQUIPMENT USED?

YES

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

POLICY/SELF INSURED NUMBER:

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

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.