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

EMPLOYEE FIRST NAME

EMPLOYEE LAST NAME

OTDEET ADDDEOO

STREET ADDRE	.55						
CITY					STAT	E	ZIP CODE
COUNTY					PHONE N	UMBER	
EMPLOYEE: MALE	MARRIED	NUMBER OF DEPI	ENDENTS	DATE OF BIRTH			
				MONTH	DAY	YEAR	
OCCUPATION O	R JOB IIILE						
	NCCI CL	ASS CODE (IF KNOWN)	EMPLOYM	IENT STATUS	FT = Full -time PT = Part-time	SL = Seasonal VO = Volunteer ZZ = Other	
EMPLOYER							
STREET ADDRE	SS						
CITY					ST	ATE	ZIP CODE
SIC CODE		EMPLOYER FEIN			PHONE N	UMBER	
COUNTY					NAICS CODE		
	DAY OF INJURY?	TIME EMPLOYEE BEGAN		TIME OF OC	CURRENCE		
YES NO			AM PM			AM PM	
LAST DAY WOR	KED		DATE DISA	BILITY BEGAN			344 1 ⁻
MONTH	DAY	YEAR	MONTH	I DAY	YEAR		

DATE OF INJURY

MONTH DAY YEAR

FEMALE	SINGLE			MONTH	DAY	YEAR		
OCCUPATION O	R JOB TITLE			WONTH		TEAK		
	NCCI CLASS	CODE (IF KNOWN)	EMPLOYMEN	I STATUS	FT = Full -time PT = Part-time	SL = Seasonal VO = Volunteer ZZ = Other		
EMPLOYER								
STREET ADDRE	SS							
CITY					ST	ATE	ZIP CODE	
SIC CODE EMPLOYER FEIN				PHONE N	IUMBER			
COUNTY					NAICS CODE			
FULL PAY FOR I	DAY OF INJURY?	TIME EMPLOYEE BEG	AN WORK	TIME OF OC	CURRENCE			
YES			AM			AM		
NO			PM			PM		
LAST DAY WOR	KED		DATE DISABILI	Y BEGAN		1 1881	344	1197-1
MONTH	DAY	YEAR	MONTH	DAY	YEAR			
DATE EMPLOYE	RNOTIFIED		DATE RETURNED	TO WORK			DATE OF HIRE	
MONTH	DAY	YEAR	MONTH	DAY	YEAR		MONTH	DAY
CONTACT FIRST	Γ NAME				CONTACT PH	ONE NUMBER		
CONTACT LAST	NAME							

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

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.

YEAR

						LIBC-344
TYPE OF INJURY CODE	PART OF BODY AFFECTED CODE	CAUSE OF INJURY CODE	E (ENTER CODES, IF KNC	OW)		
TYPE OF INJURY OR ILLNESS						
PARTS OF BODY AFFECTED						
CAUSE OF INJURY						
DID INJURY OR ILLNESS OCCUR ON EMPLOYER'S PREMISES? YES	STATE OF INJURY	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? YES	WERE SAFEGUARDS EQUIPMENT USED? YES	OR SAFETY		
ALL EQUIPMENT, MATERIALS, OR CHE	EMICALS EMPLOYEE WAS USING WI	HEN ACCIDENT OR ILLNESS EXPOSU	INE OCCURRED			
HOW INJURY OR ILLNESS/ABNORMAL				JECTS OP OT	IBSTANCES DIDECT	
			ANOLODE ANY OL	NOR SL		UNOIBLE
			IN	INITIAL TREATM	/ENT:	
IF FATAL, GIVE DATE OF DEATH					ICAL TREATMENT	
	YEAR				BY EMPLOYEE	
MONTH DAY PHYSICIAN/HEALTH CARE PROVIDER	YEAR			CLINIC / F	HOSPITAL	
				PANEL P	PHYSICIAN	
FIRST NAME:	LAST NAME:			EMPLOY	EE PHYSICIAN	
STREET	STATE	ZIP			ENCY CARE	
CITY	SIAIE	<u></u>			ALIZED MORE THAN	N 24 HOURS
			P	POLICY PERIOD	D FROM:	
				MONTH	DAY	YEAR
STREET						
CITY	STATE	ZIP	F	POLICY PERIOD	ו טי	
POLICY/SELF INSURED NUMBER:				MONTH	DAY	YEAR
WITNESS FIRST NAME		WITNESS F	PHONE NUMBER			
WITNESS LAST NAME						
PERSON COMPLETING THIS FORM:		INSURANCE CARRIER O		ISTRATOR (IF S	SELF-INSURED)	
NAME:		NAME:				
TITLE:		STREET				
PHONE:		CITY			STATE	ZIP
		BUREAU CODE:	FEIN	N:		

DATE PREPARED

DAY MONTH

YEAR

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.

344 1197-2

