

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

____ - ____ - ____

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?

YES
NO

TIME EMPLOYEE BEGAN WORK

____ : ____ AM
PM

TIME OF OCCURRENCE

____ : ____ AM
PM



344 1197-1

LAST DAY WORKED

____ - ____ - ____
MONTH DAY YEAR

DATE DISABILITY BEGAN

____ - ____ - ____
MONTH DAY YEAR

DATE EMPLOYER NOTIFIED

____ - ____ - ____
MONTH DAY YEAR

DATE RETURNED TO WORK

____ - ____ - ____
MONTH DAY YEAR

DATE OF HIRE

____ - ____ - ____
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 KNOWN)

[Grid for injury code]

[Grid for body part code]

[Grid for cause of injury code]

TYPE OF INJURY OR ILLNESS

[Grid for injury or illness description]

PARTS OF BODY AFFECTED

[Grid for parts of body affected]

CAUSE OF INJURY

[Grid for cause of injury]

DID INJURY OR ILLNESS OCCUR ON EMPLOYER'S PREMISES?

YES
NO

IF OUT OF STATE, SPECIFY STATE OF INJURY

[Grid for state of injury]

WERE 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

[Text area for equipment used]

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

[Text area for injury description]

IF FATAL, GIVE DATE OF DEATH

[Grid for date of death: MONTH, DAY, YEAR]

INITIAL TREATMENT:

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

PHYSICIAN/HEALTH CARE PROVIDER

Form for physician details: FIRST NAME, STREET, CITY, STATE, ZIP

Form for hospital details: HOSPITAL NAME, STREET, CITY, STATE, ZIP

POLICY PERIOD FROM:

[Grid for policy period from: MONTH, DAY, YEAR]

POLICY PERIOD TO:

[Grid for policy period to: MONTH, DAY, YEAR]

POLICY/SELF INSURED NUMBER:

[Grid for policy/self insured number]

WITNESS FIRST NAME

[Grid for witness first name]

WITNESS PHONE NUMBER

[Grid for witness phone number]

WITNESS LAST NAME

[Grid for witness last name]

Form for person completing form and insurance carrier details: PERSON COMPLETING THIS FORM (NAME, TITLE, PHONE), INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR (NAME, STREET, CITY, STATE, ZIP, BUREAU CODE, FEIN)

DATE PREPARED

[Grid for 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.