WORKSHEET

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

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 SL = Seasonal
PT = Part Time VO = Volunteer
ZZ = Other

EMPLOYER

STREET ADDRESS

CITY STATE ZIP CODE

SIC CODE EMPLOYER FEIN PHONE NUMBER

COUNTY

FULL PAY FOR DAY OF INJURY?
YES ☐ NO ☐

TIME EMPLOYEE BEGAN WORK
:
AM ☐ PM ☐

TIME OF OCCURRENCE
:
AM ☐ PM ☐

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

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.

LIBC-344 REV 11-97

(OVER)

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

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 ☐ NO ☐		YES ☐ NO ☐	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

FIRST NAME: LAST NAME:

STREET:

CITY   STATE   ZIP

HOSPITAL NAME: LAST 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

PERSON COMPLETING THIS FORM:

NAME:

TITLE:

PHONE:

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

NAME: Inservco Claims Service Office

STREET P.O. Box 198

CITY Pittsburgh   STATE PA   ZIP 15230-0198

DATE PREPARED

MONTH   DAY   YEAR

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