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

EMPLOYEE FIRST NAME

REPORT NUMBER

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 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?
YES
NO

TIME EMPLOYEE BEGAN WORK
AM
PM

TIME OF OCCURENCE
AM
PM


344 1197-1

LAST DAY WORKED

DATE DISABILITY BEGAN

DATE EMPLOYER NOTIFIED

DATE RETURNED TO WORK

DATE OF HIRE

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.

CARRIER CLAIM #

LIBC-344 REV 1-01

(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		YES	YES
NO		NO	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 RESPONSIBL

IF FATAL, GIVE DATE OF DEATH

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

PHYSICIAN
DATA:

HOSPITAL
DATA:

POLICY PERIOD FROM:

POLICY PERIOD TO:

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)

BUREAU CODE:

DATE PREPARED

CARRIER CLAIM #

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 penalities through Pennsylvania Act 165.