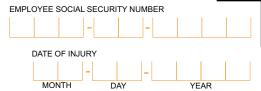
COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF LABOR AND INDUSTRY BUREAU OF WORKERS' COMPENSATION 1171 S. CAMERON STREET, ROOM 103 HARRISBURG, PA 17104-2501 (TOLL FREE) 800-482-2383

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE



	WONTH	DAT	TEAR
EMPLOYEE FIRST NAME			
EMPLOYEE LAST NAME			
STREET ADDRESS			
CITY STATE :	ZIP CODE		
SIAIE 2	ZIF GODE		
COUNTY PHONE NUMBER			
	1 1.1		
EMPLOYEE: NUMBER OF DEPENDENTS DATE OF BIRTH MALE MARRIED DATE OF BIRTH	1		
FEMALE SINGLE 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	1 1 1	1 1 1	
STREET ADDRESS			
CITY STATE	ZIP CODE		
		-	
SIC CODE EMPLOYER FEIN PHONE NUMBER			
COUNTY			
FULL PAY FOR DAY OF INJURY? TIME EMPLOYEE BEGAN WORK TIME OF OCCURRENCE			
YES AM AM AM PM PM			
	344 1107		
LAST DAY WORKED DATE DISABILITY BEGAN	5 11 1131	- 1	
MONTH DAY YEAR MONTH DAY YEAR			
DATE EMPLOYER NOTIFIED DATE RETURNED TO WORK			
MONTH DAY YEAR MONTH DAY YEAR			
CONTACT FIRST NAME CONTACT PHONE NUMBER			
	1 1.1		
CONTACT LAST NAME	= [
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	
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?			RE SAFEGUARDS OR SAFETY JIPMENT USED?		
YES	YES [
NO	NO	NO			
ALL EQUIPMENT, MATERIALS, OR	CHEMICALS EMPLOYEE WAS USING WHEN AC	CIDENT OR ILLNESS EXPOSURE OCC	CURRED		
HOW INJURY OR ILLNESS/ABNOR	MAL HEALTH CONDITION OCCURRED. DESCR	IBE THE SEQUENCE OF EVENTS AND	INCLUDE ANY OBJECTS OR SUBSTANCES DIRECTLY RES	PONSIBLE	
IF FATAL, GIVE DATE OF DEATH			INITIAL TREATMENT:		
MONTH DAY	VEAD		NO MEDICAL TREATMENT MINOR BY EMPLOYEE		
	YEAR		CLINIC / HOSPITAL		
PHYSICIAN/HEALTH CARE PROVI	LAST NAME:		PANEL PHYSICIAN		
STREET			EMPLOYEE PHYSICIAN EMERGENCY CARE		
CITY	STATE	ZIP	HOSPITALIZED MORE THAN 24 HOURS		
			POLICY PERIOD FROM:		
HOSPITAL NAME:					
STREET			MONTH DAY YE	AR	
CITY	STATE	ZIP	POLICY PERIOD TO:		
POLICY/SELF INSURED NUMBER:			MONTH DAY YE	EAR	
			DAI		
WITNESS FIRST NAME		WITNESS PHON	E NUMBER		
WITNESS LAST NAME					
PERSON COMPLETING THIS FOR	M:	INSURANCE CARRIER OR THIRD	PARTY ADMINISTRATOR (IF SELF-INSURED)		
NAME:		NAME:			
TITLE:		STREET			
PHONE:		CITY	STATE ZIP		
		BUREAU CODE:	FEIN:		
DATE PREPARED					
MONTH DAY YEAR					
			 		
			J T1 1131-∠		

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.