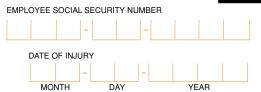
COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF LABOR AND INDUSTRY BUREAU OF WORKERS' COMPENSATION 1171 S. CAMERON STREET, ROOM 103 HARRISBURG, PA 17104-2501 (TOLL FREE) 800-482-2383 TTY (TOLL FREE) 800-362-4228

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE



	MONTH	DAY	YEAR
EMPLOYEE FIRST NAME			
ENDLOYEE LACT MANE			
EMPLOYEE LAST NAME			
STREET ADDRESS			
CITY	IP CODE		
CITY STATE Z	IP CODE	-	
COUNTY PHONE NUMBER			
	-		
EMPLOYEE: NUMBER OF DEPENDENTS DATE OF BIRTH			
MALE MARRIED			
FEMALE SINGLE MONTH DAY YEAR OCCUPATION OR JOB TITLE			
NCCI CLASS CODE (IF KNOWN) EMPLOYMENT STATUS FT - Full-time SI - Seasonal			
NCCI CLASS CODE (IF KNOWN) EMPLOYMENT STATUS FT = Full-time VO = Volunteer ZZ = Other			
ZZ = Oniei			
EMPLOYER			
STREET ADDRESS			, , , , , , , , , , , , , , , , , , ,
CITY STATE Z	IP CODE		
SIC CODE EMPLOYER FEIN PHONE NUMBER			
	-		
			1
COUNTY NAICS CODE			
FULL PAY FOR DAY OF INJURY? TIME EMPLOYEE BEGAN WORK TIME OF OCCURRENCE			
YES AM AM			
NOPMPM			
LAST DAY WORKED DATE DISABILITY BEGAN	344 1197-1		
MONTH DAY YEAR MONTH DAY YEAR			
DATE EMPLOYER NOTIFIED DATE RETURNED TO WORK D	ATE OF HIRE	1_1 1	
MONTH DAY YEAR MONTH DAY YEAR	MONTH DA	AY YE	EAR
CONTACT FIRST NAME CONTACT PHONE NUMBER			
	-		
CONTACT LAST NAME		1 1 1	1 1 1

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?		SAFEGUARDS OR SAFETY WERE SAFEGUARDS OR SAFETY JENT PROVIDED? EQUIPMENT USED?		
YES	YES	YES		
NO	NO .	NO		
ALL EQUIPMENT, MATERIALS, OR CH	HEMICALS EMPLOYEE WAS USING WHEN ACCID	ENT OR ILLNESS EXPOSURE OCCUR	RED	
LION IN HIRV OR HENDOWARD COM	U LIEATU CONDITION COCUIDDED DECODIDE	LIE OFOLIENOE OF EVENTO AND INO	ULUDE ANIX OD JEGTO OD GUIDOTANIGEG DIDEGTLY DEGDONGIDLE	
HOW INJURY OR ILLNESS/ABNORMA	AL HEALTH CONDITION OCCURRED. DESCRIBE I	HE SEQUENCE OF EVENTS AND INC	ELUDE ANY OBJECTS OR SUBSTANCES DIRECTLY RESPONSIBLE.	
IF FATAL ONE DATE OF DEATH			INITIAL TREATMENT:	
IF FATAL, GIVE DATE OF DEATH			NO MEDICAL TREATMENT	
MONTH PAY	VEAR		MINOR BY EMPLOYEE	
MONTH DAY	YEAR		CLINIC / HOSPITAL	
PHYSICIAN/HEALTH CARE PROVIDE	R		PANEL PHYSICIAN	
FIRST NAME:	LAST NAME:		EMPLOYEE PHYSICIAN	
STREET			EMERGENCY CARE	
CITY	STATE ZIP		HOSPITALIZED MORE THAN 24 HOURS	
			POLICY PERIOD FROM:	
HOSPITAL NAME:				
STREET			MONTH DAY YEAR	
CITY	STATE ZIP		POLICY PERIOD TO:	
OTT	SIMIL ZII			
POLICY/SELF INSURED NUMBER:			MONTH DAY YEAR	
WITNESS FIRST NAME		WITNESS PHONE NU	JMBER	
			-	
WITNESS LAST NAME				
PERSON COMPLETING THIS FORM:		INSURANCE CARRIER OR THIRD PA	RTY ADMINISTRATOR (IF SELF-INSURED)	
NAME:	NAME:			
TITLE:		STREET		
PHONE:		CITY	STATE ZIP	
		BUREAU CODE:	FEIN:	
ATE PREPARED				
MONTH DAY	YEAR			
			 	
A security adjusted to a filling at the large adjust-		nd with intent to		

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.