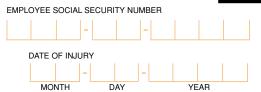
COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF LABOR AND INDUSTRY BUREAU OF WORKERS' COMPENSATION 1171 S. CAMERON STREET, ROOM 103 HARRISBURG, PA 17104-2501 (TOLL FREE) 800-482-2383 TTY (TOLL FREE) 800-362-4228

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE



				MONTH	DAY	YEAR
EMPLOYEE FIRST NAME						
EMPLOYEE LACT NAME						
EMPLOYEE LAST NAME						
STREET ADDRESS						
CITY			CTATE	ZIP CODE		
CITY			STATE	ZIP CODE	-	
COUNTY		PI	HONE NUMBER			
				-		
EMPLOYEE: NUMBEI	R OF DEPENDENTS D	ATE OF BIRTH				
MALE MARRIED		-	-			
FEMALE SINGLE COCCUPATION OR JOB TITLE		MONTH DAY	YEAR			
NCCI CLASS CODE (IF KNOWN)	EMPLOYMEN	T STATUS				
NOCI CLASS CODE (IF KNOWN)	EMPLOTMEN	1 1 = 1	ull-time SL = Seasonal VO = Volunteer ZZ = Other			
			ZZ = Other			
EMPLOYER						
STREET ADDRESS					1 1 1	
CITY			STATE	ZIP CODE		
					-	
SIC CODE EMPLOYER FEIN		P	HONE NUMBER			
			- -	-		
COUNTY		NAIO	0005			
		NAIC:	S CODE			
FULL PAY FOR DAY OF INJURY? TIME EMPLO	YEE BEGAN WORK	TIME OF OCCURRE	NCE			
YES	AM _		АМ			
NO	PM _		PM PM			
LAST DAY WORKED	DATE DISABIL	ITY BEGAN	1 1 1	344 1197-1		
MONTH DAY YEAR	MONTH	DAY	YEAR			
DATE EMPLOYER NOTIFIED	DATE RETURN			DATE OF HIRE		
DATE EMPLOYER NOTIFIED	DATE RETURN	- -		JATE OF HIRE	-	
MONTH DAY YEAR	MONTH	DAY	YEAR	MONTH D.	AY YE	EAR
CONTACT FIRST NAME		C	ONTACT PHONE NUMBER	1 1 1	1 1 1	I
			-	-		
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.

			LIDO	344 ر				
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?			E SAFEGUARDS OR SAFETY IPMENT USED?					
YES NO	YES NO	YES NO						
ALL EQUIPMENT, MATERIALS, OR CHEM	MICALS EMPLOYEE WAS USING WHEN ACCID	ENT OR ILLNESS EXPOSURE OCCU	JRRED					
HOW INJURY OR ILLNESS/ABNORMAL I	HEALTH CONDITION OCCURRED. DESCRIBE	THE SEQUENCE OF EVENTS AND IN	NCLUDE ANY OBJECTS OR SUBSTANCES DIRECTLY RESPONSIB	LE.				
			INITIAL TOPATMENT					
IF FATAL, GIVE DATE OF DEATH			INITIAL TREATMENT: NO MEDICAL TREATMENT					
MONTH DAY	YEAR		MINOR BY EMPLOYEE					
PHYSICIAN/HEALTH CARE PROVIDER		CLINIC / HOSPITAL						
FIRST NAME:	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 YEAR					
CITY	STATE ZIP		POLICY PERIOD TO:					
POLICY/SELF INSURED NUMBER:			MONTH DAY YEAR					
POLICY/SELF INSURED NUMBER.			MONTH DAY YEAR					
MITNECO FIDOT MAME		WITNESS BUONE	NUMBER					
WITNESS FIRST NAME		WITNESS PHONE I	NUMBER					
WITNESS LAST NAME								
PERSON COMPLETING THIS FORM:		INSURANCE CARRIER OR THIRD F	PARTY ADMINISTRATOR (IF SELF-INSURED)					
NAME:		NAME:						
TITLE:		STREET						
PHONE:		CITY	STATE ZIP					
		BUREAU CODE:	FEIN:					
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.