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
(TOLL FREE) 800-482-2383
TTY (TOLL FREE) 800-362-4228

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

EMPLOYEE SOCIAL SECURITY NUMBER

DATE OF INJURY

MONTH DAY YEAR

EMPL	OYEE	FIRST	NAME				1	1	1	1		1		I																		
EMPL	OYEE	LAST	NAME																													
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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 C(ODE (ENTER CODES, IF KNOWN)	
TYPE OF INJURY OR ILLNESS				u por
PARTS OF BODY AFFECTED				
CAUSE OF INJURY				
DID INJURY OR ILLNESS OCCUR ON EMPLOYER'S PREMISES?			WERE SAFEGUARDS OR SAFETY EQUIPMENT USED?	
YES NO	YES NO			
HOW INJURY OR ILLNESS/ABNORM.	AL HEALTH CONDITION OCCURRED. DESCRIBE T	THE SEQUENCE OF EVENTS /	AND INCLUDE ANY OBJECTS OR SUBSTANCES DIRECTLY RESPO	
IF FATAL, GIVE DATE OF DEATH	YEAR		INITIAL TREATMENT: NO MEDICAL TREATMENT MINOR BY EMPLOYEE CLINIC / HOSPITAL PANEL PHYSICIAN	
FIRST NAME:	LAST NAME:		PANEL PHYSICIAN EMPLOYEE PHYSICIAN	
STREET				
CITY	STATE ZIP		HOSPITALIZED MORE THAN 24 HOURS	
HOSPITAL NAME:			POLICY PERIOD FROM:	
STREET			MONTH DAY YEAR	l ł
CITY	STATE ZIP		POLICY PERIOD TO:	1
POLICY/SELF INSURED NUMBER:			MONTH DAY YEAR	
]	
WITNESS FIRST NAME		WITNESS PH		
WITNESS LAST NAME				
PERSON COMPLETING THIS FORM		INSURANCE CARRIER OR TH	THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)	
TITLE:		STREET		
PHONE:			STATE ZIP	
		BUREAU CODE:	STATE ZIF	
DATE PREPARED	Ι	BUREAU CODE.		
	YEAR	and with intent to	344 1197-2	

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.