

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

EMPLOYEE SOCIAL SECURITY NUMBER

DATE OF INJURY

MONTH DAY YEAR

EMPLOYEE FIRST NAME

EMPLOYEE LAST NAME

STREET ADDRESS

CITY

STATE

ZIP CODE

COUNTY

PHONE NUMBER

EMPLOYEE:

MALE  MARRIED

FEMALE  SINGLE

NUMBER OF DEPENDENTS

DATE OF BIRTH

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

STREET ADDRESS

CITY

STATE

ZIP CODE

SIC CODE

EMPLOYER FEIN

PHONE NUMBER

COUNTY

FULL PAY FOR DAY OF INJURY?

YES

NO

TIME EMPLOYEE BEGAN WORK

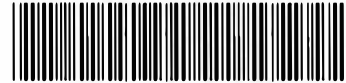
AM

PM

TIME OF OCCURRENCE

AM

PM



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LAST DAY WORKED

MONTH

DAY

YEAR

DATE DISABILITY BEGAN

MONTH

DAY

YEAR

DATE EMPLOYER NOTIFIED

MONTH

DAY

YEAR

DATE RETURNED TO WORK

MONTH

DAY

YEAR

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.

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 EMPLOYERS PREMISES?

YES

NO

IF OUT OF STATE SPECIFY  
STATE OF INJURY

WERE SAFEGUARDS OR SAFETY  
EQUIPMENT PROVIDED?

YES

NO

WERE SAFEGUARDS OR SAFETY  
EQUIPMENT USED?

YES

NO

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

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HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES DIRECTLY RESPONSIBLE

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IF FATAL, GIVE DATE OF DEATH

MONTH                      DAY                      YEAR

PHYSICIAN/HEALTH CARE PROVIDER

FIRST NAME:	LAST NAME:
STREET	
CITY	STATE                      ZIP

HOSPITAL NAME:
STREET
CITY                      STATE                      ZIP

POLICY/SELF INSURED NUMBER:

INITIAL TREATMENT

- NO MEDICAL TREATMENT
- MINOR BY EMPLOYEE
- CLINIC / HOSPITAL
- PANEL PHYSICIAN
- EMPLOYEE PHYSICIAN
- EMERGENCY CARE
- HOSPITALIZED MORE THAN 24 HOURS

POLICY PERIOD FROM:

MONTH                      DAY                      YEAR

POLICY PERIOD TO:

MONTH                      DAY                      YEAR

WITNESS FIRST NAME

WITNESS PHONE NUMBER

WITNESS LAST NAME

<p>PERSON COMPLETING THIS FORM:</p> <p>NAME:</p> <p>TITLE:</p> <p>PHONE:</p>	<p>INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)</p> <p>NAME:</p> <p>STREET</p> <p>CITY                      STATE                      ZIP</p> <p>BUREAU CODE:                      FEIN:</p>
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DATE PREPARED

MONTH                      DAY                      YEAR



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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.