Instructions for Completing the Employer’s Report of Occupational Injury or Disease
(Form LIBC-344 Rev 1-02)

- **General Information:**
  - Working together, the injured employee and his/her direct supervisor must complete the injury report form.
  - Type or hand-write using blue or black ink. *If typing, there is no need to put one letter per box on the form.* Stay within the range of boxes and avoid typing or writing in the margins.
  - Employee’s address, phone number, etc., at the top of the form should be the employee’s home information and *not* work information.
  - **There is no need to complete any of the following codes:** NCCI Class Code, SIC Code, NAICS Code, Type of Injury Code, Part of Body Affected Code, or the Cause of Injury Code.

- **Dates:**
  Enter all dates as MMDDCCYY. *(for example: 01012002)*

- **Phone Numbers:**
  Phone numbers must include area code. *(for example: 4126241198)*

- **Times:**
  Enter all times as HHMM, checking the AM or PM box, as appropriate. **Do not use military time.** *(for example: 0830 AM)*

- **Date Returned to Work:**
  If employee has NOT lost any time, please enter the same date as the day of the injury.

- **Contact Name and Number:**
  This should be the name and campus number of the Lehigh University Workers’ Compensation administrator.

- **Type of Injury or Illness:**
  Briefly describe the nature of the injury or illness. *(for example: contusion, fracture, sprain, strain, etc.)*

- **Parts of Body Affected:**
  Indicate the part(s) of the body affected by the injury or illness. *(for example: neck, upper or lower back, left or right wrist, etc.)*

- **Cause of Injury:**
  Briefly indicate how the employee incurred the injury or illness. *(for example: cut from broken glass, fell from ladder, strain from lifting)*
• All Equipment, materials…. and How Injury/Illness Occurred:
  Provide brief narrative of any equipment being used and/or how the injury occurred.

• Initial Treatment:
  Check applicable box(es)

• Physician/Health Care Provider:
  Include this information if treatment was provided before a completed injury report
  form was submitted to the Risk Management Office.

• Policy Number/Policy Period:
  For Risk Management Use Only

• Witness Name/Phone Number:
  Provide this information if applicable

• Person Completing This Form; Supervisor Signature:
  Supervisor and/or Injured Employee’s name, title and phone number; Supervisor
  signs/dates the form

• SUBMIT THE FORM IMMEDIATELY TO THE RISK MANAGEMENT
  OFFICE:
  - Fax copy to Risk Management at 610-758-5855
  - Send the original/signed form to the Risk Management Office via Campus Mail