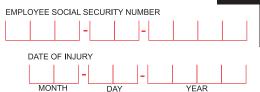
COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF LABOR AND INDUSTRY BUREAU OF WORKERS' COMPENSATION 1171 S. CAMERON STREET, ROOM 103 HARRISBURG, PA 17104-2501 (TOLL FREE) 800-482-2383 TTY (TOLL FREE) 800-362-4228

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE



	MONTH	DAY	YEAR
EMPLOYEE FIRST NAME			
EMPLOYEE LAST NAME			
STREET ADDRESS			
	1 1 1		1 1 1
CITY STATE ZIP	CODE		
		- -	
COUNTY PHONE NUMBER			
	_		
EMPLOYEE: NUMBER OF DEPENDENTS DATE OF BIRTH MALE MARRIED MARRIED DIT NUMBER OF DEPENDENTS DATE OF BIRTH			
FEMALE SINGLE			
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			
EMPLOYER	1 1 1		
STREET ADDRESS			
CITY STATE ZIP	CODE	1 11 1	1 1 1
DUONE NUMBER			
SIC CODE EMPLOYER FEIN PHONE NUMBER	1 1 1		
COUNTY NAICS CODE			
	_		
FULL PAY FOR DAY OF INJURY? TIME EMPLOYEE BEGAN WORK TIME OF OCCURRENCE			
YES AM AM AM AM			
NO D PMD PMD PMD			
	344 1107 1		
LAST DAY WORKED DATE DISABILITY BEGAN	344 1197-1		
MONTH PAY			
MONTH DAY YEAR MONTH DAY YEAR			
DATE EMPLOYER NOTIFIED DATE RETURNED TO WORK DAT	E OF HIRE		
	- -	-	
MONTH DAY YEAR MONTH DAY YEAR M	IONTH DA'	Y YE	AR
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.

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.