<u>Instructions for Completing the Employer's Report of Occupational Injury or Disease</u>
<u>(Form LIBC-344 Rev 1-02)</u>

- **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 *<u>not</u>* work information.
  - **There is <u>no need to complete any of the following codes</u>**: 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