

**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: NUMBER OF DEPENDENTS DATE OF BIRTH
MALE MARRIED
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

STREET ADDRESS

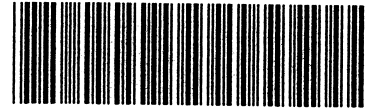
CITY STATE ZIP CODE

SIC CODE EMPLOYER FEIN PHONE NUMBER

COUNTY NAICS CODE

FULL PAY FOR DAY OF INJURY? TIME EMPLOYEE BEGAN WORK TIME OF OCCURRENCE

YES AM AM
NO PM PM



LAST DAY WORKED DATE DISABILITY BEGAN
MONTH DAY YEAR MONTH DAY YEAR

DATE EMPLOYER NOTIFIED DATE RETURNED TO WORK DATE OF HIRE

MONTH DAY YEAR MONTH DAY YEAR 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.

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 EMPLOYER'S PREMISES?	IF OUT OF STATE, SPECIFY STATE OF INJURY	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?	WERE SAFEGUARDS OR SAFETY EQUIPMENT USED?
YES		YES	YES
NO		NO	NO

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

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

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

PERSON COMPLETING THIS FORM:

NAME:
TITLE:
PHONE:

INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)

NAME: MRM WC Pooled Trust
STREET 1603 Carmody Court, Blaymore II, Ste. 403
CITY Sewickley STATE PA ZIP 15143
BUREAU CODE: 5500 FEIN: 25-1687566

DATE PREPARED

MONTH DAY YEAR



344 1197-2

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.