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
PT = Part-time
SL = Seasonal
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?
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

DATE OF HIRE
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 EMPLOYER'S 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

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 PHYSICAN
- ○ EMERGENCY CARE
- ○ HOSPITALIZED MORE THAN 24 HOURS

POLICY PERIOD FROM:
MONTH DAY YEAR

POLICY PERIOD TO:
MONTH DAY YEAR

WITNESS FIRST NAME

WITNESS LAST NAME

WITNESS PHONE NUMBER

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

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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.