EMPLOYEE SOCIAL SECURITY NUMBER

HARRISBURG PA 17104-2501
(TOLL FREE; 800-482-2383
TTY (TOLL FREE) 800-362-4228

INJURY OR DISEASE

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 SL = Seasonal
PT = Part-time VO = Volunteer
ZZ = Other

EMPLOYER

STREET ADDRESS

CITY STATE ZIP CODE

SIC CODE EMPLOYER FEIN PHONE NUMBER

COUNTY

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

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.

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(OVER)

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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 EMPLOYERS 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

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

POLICY/SELF INSURED NUMBER:

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:

STREET

CITY STATE ZIP

BUREAU CODE: FEIN:

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.

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