

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2601
(TOLL FREE) 800-482-2383
TTY (TOLL FREE) 800-362-4228

Inservco claim number:

**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?

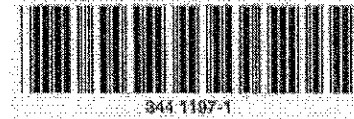
YES
NO

TIME EMPLOYEE BEGAN WORK

AM
PM

TIME OF OCCURRENCE

AM
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?

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 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

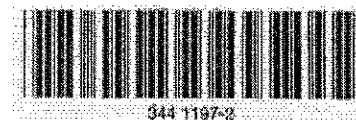
WITNESS LAST NAME

PERSON COMPLETING THIS FORM:
NAME:
TITLE:
PHONE:

INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)
NAME:
STREET
CITY STATE ZIP
BUREAU CODE: FEIN:

DATE PREPARED

MONTH DAY YEAR



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.