

**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: MARRIED
MALE
FEMALE SINGLE
NUMBER OF DEPENDENTS DATE OF BIRTH
MONTH DAY YEAR
OCCUPATION OR JOB TITLE

EMPLOYMENT STATUS

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

EMPLOYER

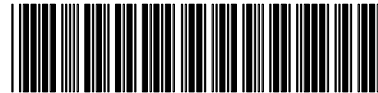
STREET ADDRESS

CITY STATE ZIP CODE

COUNTY PHONE NUMBER

CHURCH / DISTRICT

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

(OVER)

TYPE OF INJURY CODE PART OF BODY AFFECTED CODE CAUSE OF INJURY CODE (ENTER CODES, IF KNOW)

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
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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
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POLICY PERIOD TO:

MONTH	DAY	YEAR
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POLICY/SELF INSURED NUMBER:

WITNESS FIRST NAME

WITNESS PHONE NUMBER

WITNESS LAST NAME

<p>PERSON COMPLETING THIS FORM:</p> <p>NAME:</p> <p>TITLE:</p> <p>PHONE:</p>	<p>RETURN COMPLETED FORM TO:</p> <p>Susquehanna Conference UMC 303 Mulberry Drive Mechanicsburg, PA 17050</p> <p>OR EMAIL TO:</p> <p>Jason Mackey - jmackey@susumc.org</p>
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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.