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

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

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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

.

UNIFORM INFORMATION SERVICES, INC. **WC 8434j** (1-01)

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

PHYSICIAN/HEALTH CARE PROVIDER

FIRST NAME: LAST NAME:

STREET

CITY STATE ZIP 0000-00000

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 0000 YEAR

POLICY/SELF INSURED NUMBER:

WITNESS FIRST NAME

WITNESS PHONE NUMBER

( )

WITNESS LAST NAME

PERSON COMPLETING THIS FORM:

NAME:

TITLE:

PHONE:

RETURN COMPLETED FORM TO:
Susquehanna Conference UMC
303 Mulberry Drive
Mechanicsburg, PA 17050

OR EMAIL TO:
Christine Sims: csims@susumc.org

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.