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

PLEASE Complete HIGHLIGHTED items and forward to Amy in the Business Office

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
Bald Eagle Area School Dist

STREET ADDRESS
751 S Eagle Valley Rd

CITY
Wingate

STATE
PA

ZIP CODE
16823-

SIC CODE

EMPLOYER FEIN
24-6002157

PHONE NUMBER
814-355-5516

COUNTY
Centre

NAICS CODE
110118

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
Amy

CONTACT PHONE NUMBER
814-355-5516

CONTACT LAST NAME
McBride

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

INITIAL TREATMENT:
- ☐ NO MEDICAL TREATMENT
- ☐ MINOR BY EMPLOYEE
- ☐ CLINIC / HOSPITAL
- ☐ PANEL PHYSICIAN
- ☐ EMPLOYEE PHYSICIAN
- ☐ EMERGENCY CARE
- ☐ HOSPITALIZED MORE THAN 24 HOURS

PHYSICIAN/HEALTH CARE PROVIDER

FIRST NAME: LAST NAME:
STREET
CITY STATE ZIP

HOSPITAL NAME:
STREET
CITY STATE ZIP

POLICY PERIOD FROM: 07 - 01 - 2023
MONTH DAY YEAR

POLICY PERIOD TO: 07 - 01 - 2024
MONTH DAY YEAR

POLICY/SELF INSURED NUMBER: EIG4552755000

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: Employers/Conduent
STREET PO Box 14791
CITY Lexington STATE KY ZIP 40512-4791
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.