

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

[Empty box for equipment and materials used]

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES DIRECTLY RESPONSIBLE

[Empty box for description of injury/illness]

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:

MONTH - DAY - YEAR

POLICY PERIOD TO:

MONTH - DAY - YEAR

[Empty grid]

WITNESS FIRST NAME

[Empty grid]

WITNESS PHONE NUMBER

[Empty grid]

WITNESS LAST NAME

[Empty grid]

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.