

Commonwealth of Pennsylvania Department of Labor and Industry Bureau of Workers' Compensation 1171 S. Cameron St. Room 103 Harrisburg, PA 17111 Telephone 717-783-5421 Long Distance (toll-free) 800-482-2383	<b>EMPLOYER'S REPORT          OF          OCCUPATIONAL INJURY          OR DISEASE</b>	_____-_____-_____ EMPLOYEE Social Security # ____/____/_____ <b>DATE OF INJURY (mmdyy)</b>
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<b>EMPLOYEE FIRST NAME</b>		<b>EMPLOYEE LAST NAME</b>	
<b>STREET ADDRESS</b>			
<b>CITY</b>		<b>STATE</b>	<b>ZIP</b>
<b>COUNTY</b>	<b>HOME PHONE</b> ( ) _____-_____	<input type="checkbox"/> <b>MALE</b> <input type="checkbox"/> <b>FEMALE</b>	<b>DATE OF BIRTH</b> ____/____/_____
<b>OCCUPATION OR JOB TITLE</b>		<b>EMPLOYMENT STATUS</b>	FT= FULL TIME      VO= VOLUNTEER PT= PART TIME      ZZ= OTHER SL= SEASONAL

<b>EMPLOYER: EAST STROUSDBURG UNIVERSITY</b>			
200 PROSPECT STREET	EAST STROUDSBURG	PA	18301 <b>COUNTY: MONROE</b>

<b>TIME EMPLOYEE BEGAN WORK:</b> ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM	<b>TIME OF OCCURANCE:</b> ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<b>FULL PAY FOR DAY OF INJURY?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>DATE DISABILITY BEGAN:</b> ____/____/_____
<b>LAST DAY WORKED:</b> ____/____/_____	<b>DATE RETURNED TO WORK:</b> ____/____/_____
<b>DATE EMPLOYER NOTIFIED:</b> ____/____/_____	<b>DATE THIS REPORT PREPARED:</b> ____/____/_____
<b>NAME OF PERSON COMPLETING THIS FORM:</b>	<b>WORK EXTENSION:</b>

<b>TYPE OF INJURY:</b>	
<b>PART(S) OF BODY AFFECTED:</b>	
<b>CAUSE OF INJURY:</b>	
<b>DID INJURY OCCUR ON EMPLOYER'S PREMISES?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>IF OUT OF STATE, SPECIFY STATE</b>	
<b>WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>WERE SAFEGUARDS OR SAFETY EQUIPMENT USED?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>EQUIPMENT, MATERIALS OR CHEMICALS IN USE WHEN ACCIDENT OR ILLNESS OCCURRED:</b>	
HOW INJURY/ILLNESS OCCURRED- sequence and any objects or substances directly responsible:	
<b>IF FATAL, GIVE DATE OF DEATH:</b> ____/____/_____	
<b>WITNESS NAME:</b>	<b>WITNESS PHONE NUMBER:</b>

<b>INITIAL TREATMENT:</b> <input type="checkbox"/> no medical treatment <input type="checkbox"/> minor by employee <input type="checkbox"/> clinic/hospital <input type="checkbox"/> panel physician <input type="checkbox"/> employee physician <input type="checkbox"/> emergency care <input type="checkbox"/> hospitalized more than 24 hours	<b>PROVIDER NAME:</b> (if known)  <b>PROVIDER ADDRESS:</b> (if known)
<b>INSURANCE ADMINISTRATOR:</b> Inservco Claims Service Office PO Box 3899 Harrisburg, PA 17105-3899 <b>Bureau Code:</b> 1260 <b>FEIN:</b> 23-2145732	<b>HOSPITAL NAME:</b> (if known)  <b>HOSPITAL ADDRESS:</b> (if known)