

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) 800-382-4228

# 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

NCCI CLASS CODE (IF KNOWN)

8 8 6 8

EMPLOYMENT STATUS

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

EMPLOYER

L e h i g h U n i v e r s i t y

STREET ADDRESS

6 1 6 B r o a d h e a d A v e n u e

CITY

STATE

ZIP CODE

B e t h l e h e m P A 1 8 0 1 5 - 3 0 5 4

SIC CODE

EMPLOYER FEIN

PHONE NUMBER

8 2 2 1 2 4 0 7 9 5 4 4 5 6 1 0 - 7 5 8 - 3 8 9 9

COUNTY

NAICS CODE

N o r t h a m p t o n

FULL PAY FOR DAY OF INJURY?

YES   
NO

TIME EMPLOYEE BEGAN WORK

AM   
PM

TIME OF OCCURRENCE

AM   
PM



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

L y n n

CONTACT PHONE NUMBER

6 1 0 - 7 5 8 - 3 8 9 9

CONTACT LAST NAME

C h e r m a n s k y

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.

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? IF OUT OF STATE, SPECIFY STATE OF INJURY WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE SAFEGUARDS OR SAFETY EQUIPMENT USED?

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: 07-01-20 MONTH DAY YEAR

POLICY PERIOD TO: 07-01-20 MONTH DAY YEAR

POLICY/SELF INSURED NUMBER: 20074864963A

WITNESS FIRST NAME WITNESS PHONE NUMBER WITNESS LAST NAME

PERSON COMPLETING THIS FORM: NAME: TITLE: PHONE: SUPERVISOR SIGNATURE: DATE PREPARED: INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED) NAME: PMA INSURANCE GROUP P.O. BOX 231 JANESVILLE, WI 53547-5231 BUREAU CODE: FEIN: 23-1642962

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.