

**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   
OCCUPATION OR JOB TITLE  
NUMBER OF DEPENDENTS DATE OF BIRTH  
MONTH DAY YEAR

NCCI CLASS CODE (IF KNOWN) EMPLOYMENT STATUS  
FT = Full-time SL = Seasonal  
PT = Part-time VO = Volunteer  
ZZ = Other

EMPLOYER

STREET ADDRESS

CITY STATE ZIP CODE

SIC CODE EMPLOYER FEIN PHONE NUMBER

COUNTY

FULL PAY FOR DAY OF INJURY? YES  NO   
TIME EMPLOYEE BEGAN WORK AM  PM   
TIME OF OCCURRENCE AM  PM



LAST DAY WORKED DATE DISABILITY BEGAN  
MONTH DAY YEAR MONTH DAY YEAR

DATE EMPLOYER NOTIFIED DATE RETURNED TO WORK  
MONTH DAY YEAR MONTH DAY YEAR

CONTACT FIRST NAME CONTACT PHONE NUMBER

CONTACT LAST NAME

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 EMPLOYERS 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 text 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 text box for description of injury/illness]

IF FATAL, GIVE DATE OF DEATH

MONTH DAY YEAR

PHYSICIAN/HEALTH CARE PROVIDER

Form for Physician/Health Care Provider with fields for First Name, Last Name, Street, City, State, and ZIP.

Form for Hospital Name with fields for Hospital Name, Street, City, State, and 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 YEAR

POLICY/SELF INSURED NUMBER:

WITNESS FIRST NAME

WITNESS PHONE NUMBER

WITNESS LAST NAME

Form for Person Completing This Form and Insurance Carrier/Third Party Administrator with fields for Name, Title, Phone, Street, City, State, ZIP, Bureau Code, and FEIN.

DATE PREPARED

MONTH DAY YEAR



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