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

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

EMPLOYEE SOCIAL SECURITY NUMBER

DATE OF INJURY
4/23/21
MONTH DAY YEAR

EMPLOYEE FIRST NAME
megha1644
megha1644

EMPLOYEE LAST NAME
makwana

STREET ADDRESS

CITY

Pennsylvan
STATE ZIP CODE

COUNTY

PHONE NUMBER

EMPLOYEE:
☑ MALE ☑ MARRIED
FEMALE SINGLE

NUMBER OF DEPENDENTS

DATE OF BIRTH
4/23/21
MONTH DAY YEAR

OCCUPATION OR JOB TITLE

NCCI CLASS CODE (IF KNOWN)

EMPLOYMENT STATUS
PT

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

EMPLOYER
Tender Touch Rehab

STREET ADDRESS
685 River Ave

CITY
Lakewood

STATE
PA

ZIP CODE
08701

SIC CODE

EMPLOYER FEIN
26-142-8616

PHONE NUMBER
732-987-3817

COUNTY

NAICS CODE

FULL PAY FOR DAY OF INJURY7
YES
NO

TIME EMPLOYEE BEGAN WORK
2021-04-23 16 AM PM

TIME OF OCCURRENCE
11/30/11 - 12:00 AM ☑ PM

LAST DAY WORKED
4/23/21
MONTH DAY YEAR

DATE DISABILITY BEGAN
4/23/21
MONTH DAY YEAR

DATE EMPLOYER NOTIFIED
4/23/21
MONTH DAY YEAR

DATE RETURNED TO WORK
4/30/21
MONTH DAY YEAR

DATE OF HIRE
4/23/21
MONTH DAY YEAR

CONTACT FIRST NAME
Joyce

CONTACT PHONE NUMBER
7329873817

CONTACT LAST NAME
Ginsberg

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)

meo,-IN_J_U-RY_C_O_DE------ PART OF BODY AFFECTED CODE ----- CAUSE OF INJURY CODE (ENTER CODE IF KNOWN) ----------

IGNORE I I

TYPE OF INJURY OR ILLNESS

Abrasion/Laceration

PARTS OF BODY AFFECTED

left anckle

CAUSE OF INJURY

RE

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

jj

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

POLICY/SELF INSURED NUMBER:

WITNESS FIRST NAME

WITNESS PHONE NUMBER

WITNESS LAST NAME

PERSON COMPLETING THIS FORM:
NAME: Joyce Ginsberg
TITLE: HR Benefits Manager
PHONE: 7329873817

NAME:
INSVRANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)
STREET
CITY STATE ZIP
BUREAU CODE: FEIN:

DATE PREPARED
4/23/21
MONTH DAY YEAR

344 1197-2

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.

SWIF REPORTING QUESTIONAIRE

When one of your employees has been injured, early reporting is the most important step you can take in controlling the cost of the injury and the time lost from work. Immediately report ALL injuries to SWIF, no matter how minor the injury may seem. If you have posted a panel of physicians, secure the injured employee's signature on the Employee Notification Form. This form should already have been signed at the time of hire.

Much confusion exists surrounding the proper completion of the LIBC-344. For your convenience, SWIF has implemented a toll-free Reporting Hotline. In order to alleviate any confusion and reporting delays, the following is an item-by-item explanation of the LIBC-344 form. To expedite the claims reporting process, please refer to this questionnaire when calling SWIF's injury hotline.

1. Policy number – Active S.W.I.F. policy number

   policy #: 06284769

2. Employee's Social Security number - Injured employee's

3. Employee's last & first name - Injured employee's

   megha1644 makwana

4. Marital status – Self-explanatory

   ☐ Married ☐ Single

5. Gender – Self-explanatory

   Male Female

6. Date of birth – Self-explanatory

   4/23/21

7. If fatal, give date of death - Month, day, year

8. Street address – Injured employee's home address.

A) city, state, zip code & county

Pennsylvan

9. Phone number - Injured employee's home phone number including area code

10. Date of injury - Be precise

    4/23/21

11. Time of occurrence - Be precise

11/30/11 - 12:00 AM ☐ PM

12. Type of injury or illness - Nature of injury or illness i.e.: break, fracture

Abrasion/Laceration

13. Parts of body affected – Part(s) of the body affected by the illness or injury (i.e.: wrist, hand, finger, etc.)

left anckle

14. Address of employer – Where the employer is located, not where the injury occurred

685 River Ave Lakewood PA 08701

15. Occupation or job title - Injured employee

16. Employment status - Full time, part time, seasonal, volunteer, other

PT

17. Date of hire / State of hire - Date injured employee hired by employer

Date of Hire: 4/23/21 State of Hire:

18. Full pay for day of the injury -Yes or No

Yes No

19. Last day worked - Month, day & year

20. Date returned to work - Date employee returned to work. If no absence is incurred, date of injury. Also if the first day employee is able to work is a scheduled day off, that is the day he/she could return.

21. Date employer notified – Date injured employee notified employer.

4/23/21

22. Time employee began work – Self-explanatory

2021-04-23 16:45 AM ☐ PM

23. Did the injury or illness occur on the employer's premises? - Yes or No

☐ Yes ☐ No

24. If out of state, specify state of injury

25. Were safeguards and/or safety equipment provided? Yes or No

Yes ☐ No / Does Not Apply

26. Where safeguards and/or safety equipment used? Yes or No

Yes ☐ No/Does Not Apply

27. How injury or illness / abnormal health condition occurred? - Describe sequence of events and include any objects or substances directly responsible. Describe details fully!

jj

28. Witness name and phone number - If applicable, first & last name & phone number of a person or people who witnessed the injury.

29. Initial treatment – No medical treatment, minor by employee, clinic/hospital, panel physician, employee physician, emergency care, hospitalized more than 24 hours.

No Medical treatment	Minor By Employee	Clinic/Hospital
Panel Physician	Employee Physician	☐ Emergency Care

30. Physician / health care provider – Name & address of doctor or hospital

31. Contact Person / first & last name – Employer contact person

Joyce Ginsberg

32. Phone number – Phone number of the employer's contact person (include area code)

7329873817

33. Would the policyholder be interested in receiving information about setting up a panel of physicians? - Yes or No

☐ Yes ☑ No

34. Name of person reporting the claim - Self-explanatory

35. Title of person reporting the claim - Self-explanatory

36. Phone number of person reporting the claim - Self-explanatory