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
11/17/2021
MONTH DAY YEAR

EMPLOYEE FIRST NAME
asdf

EMPLOYEE LAST NAME
asdf

STREET ADDRESS
sadfasdf

AK
STATE ZIP CODE

CITY
asdfadf

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)

EMPLOYMENT STATUS
FT
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
05:30
☐ AM ☑ PM

TIME OF OCCURRENCE
☐ AM ☐ PM

344 1197-1

LAST DAY WORKED
11/23/2021
MONTH DAY YEAR

DATE DISABILITY BEGAN
MONTH DAY YEAR

DATE EMPLOYER NOTIFIED
11/17/2021
MONTH DAY YEAR

DATE RETURNED TO WORK
MONTH DAY YEAR

DATE OF HIRE
MONTH DAY YEAR

CONTACT FIRST NAME
Joyce

CONTACT PHONE NUMBER
732-987-3817

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

TYPE OF INJURY OR ILLNESS

Concussion

PARTS OF BODY AFFECTED

asdasd

CAUSE OF INJURY

RE

DID INJURY OR ILLNESS OCCUR ON EMPLOYER'S PREMISES?	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?	WERE SAFEGUARDS OR SAFETY EQUIPMENT USED?	IF OUT OF STATE SPECIFY STATE OF INJURY
YES	YES ■	YES ■	
NO ■	NO	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

sada

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, HR Benefits Manager

TITLE: HR Benefits Manager

PHONE 732-987-3817

NAME:

INSVRANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)

STREET

CITY STATE ZIP

BUREAU CODE: FEIN:

DATE PREPARED

11/17/2021

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.

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