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

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)

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

26-142-8616

PHONE NUMBER

COUNTY

NAICS CODE

FULL PAY FOR DAY OF INJURY7
YES ☐
NO ☐

TIME EMPLOYEE BEGAN WORK
AM ☐
PM ☐

TIME OF OCCURRENCE
AM ☐
PM ☐

344 1197-1

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

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 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 ☐

A I I 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

PHYSICIAN/HEALTH CARE PROVIDER

FIRST NAME: LAST NAME:

STREET

CITY STATE ZIP

STREET

CITY STATE ZIP

POLICY/SELF INSURED NUMBER:

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

WITNESS FIRST NAME

WITNESS PHONE NUMBER

WITNESS LAST NAME

PERSON COMPLETING THIS FORM:

NAME:

TITLE:

PHONE: ( )

DATE PREPARED

MONTH DAY YEAR

NAME:

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

STREET

CITY STATE ZIP

BUREAU CODE: FEIN:

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

4. Marital status – Self-explanatory

☐ Married ☐ Single

5. Gender – Self-explanatory

☐ Male ☐ Female

6. Date of birth – Self-explanatory

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

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

A) city, state, zip code & county

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

10. Date of injury - Be precise

11. Time of occurrence - Be precise

☐ AM ☐ PM

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

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

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

15. Occupation or job title - Injured employee

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

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

Date of Hire: 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.

22. Time employee began work – Self-explanatory

☐ 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!

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

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

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