

EMPLOYER'S REPORT
 OF
 OCCUPATIONAL INJURY
 OR DISEASE

INJURED'S SOCIAL SECURITY NUMBER _____
 EMPLOYER'S UC REPORTING NUMBER _____
 INSURANCE POLICY NUMBER _____

DATES	1 DATE OF REPORT	2 DATE OF INJURY AND TIME AM PM	3 NORMAL STARTING TIME AM PM	4 IF EMPLOYEE BACK TO WORK GIVE DATE	5 AT SAME WAGE? YES <input type="checkbox"/> NO <input type="checkbox"/>	00 NOT WRITE IN THIS COLUMN	
	6 IF FATAL INJURY - GIVE DATE OF DEATH	7 DATE EMPLOYER KNEW OF INJURY	8 DATE DISABILITY BEGAN	9 LAST FULL DAY PAID - DATE	DATE		
EMPLOYER	10 EMPLOYER			11 PERSON MAKING THIS REPORT (SUPERVISOR)		HOURS WORKED	
	12 ADDRESS - INCLUDE COUNTY AND ZIP CODE			13 EMPLOYER TELEPHONE NUMBER (INCLUDE AREA CODE)		REPORT LAG	
	14 MAILING ADDRESS - IF DIFFERENT THAN ABOVE		15 NATURE OF BUSINESS - TYPE OF MFG . TRADE . CONSTRUCTION SERVICE, ETC				DISABILITY
EMPLOYEE	16 EMPLOYEE FIRST MIDDLE LAST		17 MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	18 EMPLOYEE TELEPHONE NUMBER (INCLUDE AREA CODE)		INDUSTRY	
	11 ADDRESS - INCLUDE COUNTY AND ZIP CODE			20 MARRIED YES <input type="checkbox"/> NO <input type="checkbox"/>	21 NUMBER OF CHILDREN UNDER 18		SEX
	22 DATE OF BIRTH	23 AGE	24 IF UNDER 16. CERTIFICATE NUMBER	25 OCCUPATION FDA WHICH ISSUED			AGE
	26 OCCUPATION		27 DEPARTMENT OF DIVISION REGULARLY EMPLOYED		26 HOW LONG EMPLOYED		
	29 PLACE OF INJURY EMPLOYER'S PREMISES YES <input type="checkbox"/> NO <input type="checkbox"/>		30 IF NO EXACT LOCATION - STREET, CITY, COUNTY AND STATE				OCCUPATION
OCCURRENCE	31 WHAT WAS EMPLOYEE DOING WHEN (INJURED BE SPECIFIC. IF USING TOOLS OR EQUIPMENT OR HANDLING MATERIAL NAME THEM AND TELL WHAT HE WAS DOING WITH THEM)					COUNTY	
	32 HOW DID INJURY OCCUR? (DESCRIBE FULLY THE EVENTS WHICH RESULTED IN INJURY OR DISEASE TELL WHAT HAPPENED AND HOW IT HAPPENED NAME ANY OBJECTS OR SUBSTANCES INVOLVED AND TELL HOW THEY WERE INVOLVED. GIVE FULL DETAILS ON ALL FACTORS WHICH LED OR CONTRIBUTED TO INJURY OR DISEASE.)					ACCIDENT TYPE	
						OCCUPATIONAL DISEASE	
						UNSAFE ACT	
	DID INJURY OR DISEASE OCCUR BECAUSE OF _____		33 MECHANICAL DEFECT <input type="checkbox"/> NO <input type="checkbox"/> YES (DESCRIBE ABOVE)	34 UNSAFE ACT <input type="checkbox"/> NO <input type="checkbox"/> YES (DESCRIBE ABOVE)	35 CHECK IF AMPUTATION <input type="checkbox"/>		INSURANCE
36 MATURE AND LOCATION OF INJURY OR DISEASE - DESCRIBE FULLY - INCLUDING PARTS OF BODY AFFECTED					PAYMENT LAG		
37 ATTENDING PHYSICIAN AND ADDRESS (IF HOSPITAL INVOLVED - INDICATE)					COMPENSATION RATE		

EMPLOYER INSTRUCTIONS AND WAGE INFORMATION ON REVERSE SIDE

DISTRIBUTION OF THIS REPORT:

1. ORIGINAL MUST BE SENT IMMEDIATELY TO WORKMEN'S COMPENSATION INSURANCE CARRIER
2. COPY TO BUREAU SEE INSTRUCTIONS
3. EMPLOYER'S COPY RETAIN AS RECORD
4. MEDICAL COPY MUST BE SENT IMMEDIATELY TO TREATING PHYSICIAN OR DELIVERED BY INJURED EMPLOYEE
5. CHANGE OF STATUS REPORT - SEE INSTRUCTIONS
6. INJURED EMPLOYEE'S COPY

WORKMEN'S COMPENSATION INSURANCE COMPANY AND ADDRESS
 (Preprint or Stamp- Include Bureau Code)

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Inservco Insurance Services, Inc.
 3461 Market St., Suite 201
 P.O. Box 8898
 Camp Hill, PA 17001-8898

 SIGNATURE OF PERSON IN 11 ABOVE (Supervisor)

 OFFICIAL POSITION