Completion Instructions
for the
Employer’s Report of Occupational Injury or Disease
(Form LIBC-344 Rev 1-01)

• General Information:
  • The injured employee’s direct supervisor is to complete the injury report and not
the injured employee.
  • Type or hand-write using blue or black ink. If typing, no need to put one letter
per box. Stay within the range of boxes and avoid typing or writing in the
margins.
  • Employee’s address, phone number, etc at the top of the form should be the
employee’s home information and not work information.
  • There is no need to complete any of the following codes: NCCI Class Code,
SIC Code, NAICS Code, Type of Injury Code, Part of Body Affected Code, or the
Cause of Injury Code

• Dates:
Enter all dates as MMDDCCYY. (Correct example: 01/01/2002)

• Phone Numbers:
Phone numbers must include area code. (Correct example: 412-624-1198)

• Times:
Enter all times as HHMM, checking the AM or PM box, as appropriate. Do not use
military time. (Correct example: 08:30 AM)

• Date Returned To Work:
If employee has NOT lost any time, please enter the same date as the day of injury.

• Contact Name and Number:
This should be the name and campus number of the injured worker’s direct
supervisor.

• Type of Injury or Illness:
Briefly describe the nature of the injury of illness. (Correct example: contusion,
fracture, sprain, strain)

• Parts of Body Affected:
Indicate the part(s) of the body affected by the injury or illness. (Correct example:
neck, upper or lower back, left or right wrist)

• Cause of Injury:
Briefly indicate how the employee incurred the injury or illness. (Correct example:
cut from broken glass, fell from ladder, strain from lifting)

Revised: October 9, 2002
# EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

**Employee Information**

- **Employee First Name**
- **Employee Last Name**
- **Street Address**
- **City**
- **State**
- **Zip Code**
- **County**
- **Telephone Number**

**Employee Details**

- **Gender**
  - Male
  - Female
- **Civil Status**
  - Married
  - Single
- **Occupation or Job Title**

**NCCI Class Code (If Known)**

**Employment Status**

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

**Employer Information**

- **Employer Name**
- **Street Address**
- **City**
- **State**
- **Zip Code**
- **SIC Code**
- **Employer's FEIN**
- **Telephone Number**

**County**

**NAICS Code**

**Full Pay for Day of Injury?**

- Yes
- No

**Time Employee Began Work**

- AM
- PM

**Time of Occurrence**

- AM
- PM

**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 Last Name**

**Contact Telephone Number**

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**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)**