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
TTY (TOLL FREE) 800-362-4228

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

HR OFFICE USE	
POLICY PERIOD	
From 7/1/2023	To 7/1/2024
DATE REPORT SUBMITTED:	
EMPLOYEE DATE OF HIRE:	
DATE CLAIM FILED:	
CLAIM NUMBER:	

EMPLOYER	INSURER
Cairn University, 200 Manor Ave., Langhorne PA 19047 Phone: 215-702-4545 or 215-702-4314; Fax: 215-702-4841 SIC CODE: 8221 FEIN : 23-0973290 NAICS CODE : 611300	AmTrust North America, P.O. Box 94405, Cleveland, OH 44101 Phone : 888-239-3909 Policy Number: TWC4274498

EMPLOYEE-PROVIDED INFORMATION

FIRST NAME | LAST NAME | DATE OF BIRTH (mm/dd/yyyy) | SOCIAL SECURITY NUMBER

EMPLOYEE HOME ADDRESS NUMBER and STREET | CITY | STATE | ZIP CODE | COUNTY

PRIMARY PHONE NUMBER | ALTERNATE PHONE NUMBER | SEX: Male ☐ Female ☐ | MARITAL STATUS: Single ☐ Married ☐ | NUMBER OF DEPENDENTS

OCCUPATIONAL OR JOB TITLE | EMPLOYMENT STATUS (check one of the above): Full-time ☐ Part-time ☐ Seasonal ☐ Volunteer ☐ Other ☐

INJURY INFORMATION - PROVIDED BY OR ON BEHALF OF EMPLOYEE

DATE AND TIME EMPLOYEE BEGAN WORK ON THE DAY OF INJURY (a.m./ p.m.)

APPROXIMATELY WHAT TIME DID THE INJURY OR ILLNESS OCCUR? (a.m./ p.m.)

WHAT WAS THE EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED? Describe the activity, as well as the tools, equipment, or material the employee was using. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."

WHAT HAPPENED? Describe how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; Worker developed soreness in wrist over time."

WHAT WAS THE INJURY OR ILLNESS? Name the part(s) of the body affected and how; be more specific than "hurt", "pain", or "sore". *Examples*: "strained lower section of back"; "chemical burn on left hand and forearm"; "developed carpal tunnel syndrome in both wrists".

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? Yes ☐ No ☐ WERE SAFEGUARDS OR SAFETY EQUIPMENT USED? Yes ☐ No ☐

DID THE INJURY OCCUR ON CAIRN'S CAMPUS? IF SO, AT WHAT LOCATION? (Provide building, room number, or describe exact area.)

IF THE INJURY DID NOT OCCUR ON CAIRN'S CAMPUS, PLEASE PROVIDE THE LOCATION OF THE PLACE WHERE THE INJURY/ILLNESS OCCURRED. Include the address and a description of your work-related activity at the time.

NAME INDIVIDUAL(S) WHO WITNESSED THE INCIDENT AND INCLUDE THEIR PHONE NUMBER(S)

EMPLOYER'S REPORT
OF OCCUPATIONAL
INJURY OR DISEASE

EMPLOYER-PROVIDED INFORMATION

REPORT OF MEDICAL SERVICES

INITIAL TREATMENT (check all that apply)

No medical treatment	Minor care, employee-provided	First aid provided on site	Non -emergency clinic or hospital*	Hospital emergency room*	Panel physician*	Employee's physician*	Hospitalized more than 24 hours*

*PHYSICIAN/HEALTH CARE PROVIDER INFORMATION:

_____	_____	_____	_____
PHYSICIAN, CLINIC, OR HOSPITAL NAME	LOCATION ADDRESS	PHONE NUMBER	CONTACT PERSON

REPORT OF STATUS OF CLAIM AND EMPLOYEE DISABILITY

_____	_____	_____	_____	_____
DATE EMPLOYER WAS NOTIFIED	DID EMPLOYEE RECEIVE FULL PAY FOR DATE OF INJURY?	LAST DAY WORKED	DATE DISABILITY BEGAN	DATE RETURNED TO WORK