EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

EMPLOYEE SOCIAL SECURITY NUMBER

DATE OF INJURY

MONTH DAY YEAR

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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.

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TYPE OF INJURY CODE	PART O	F BODY AFFE	ECTED CO	DE		CAUSE	OF INJU	RY COI	DE (ENTE	R CODI	ES, IF K	NOWN)					
YPE OF INJURY OR ILLNESS																	
ARTS OF BODY AFFECTED																	
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F FATAL, GIVE DATE OF DEATH MONTH DAY PHYSICIAN/HEALTH CARE PROVIDE FIRST NAME: STREET	YEAR ER	LAST NAI	 .ME:									INOR BY LINIC / H ANEL PH MPLOYE MERGEN	CAL TREA (EMPLOY IOSPITAL IYSICIAN E PHYSIC NCY CARE	YEE CIAN E			
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CITY									i		FULIC	Y PERIC	D FROM:				
HOSPITAL NAME:													D FROM: DAY			YEAR	
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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.