Diocese of Scranton

# REPORTING OF OCCUPATIONAL INJURIES & DISEASE

The Bureau of Workers Compensation requires that all employees report occupational injuries and/or disease within 7 (seven) days of loss. To ensure compliance, we are requesting that you report any injury and/or disease to the Risk Management Department within 5 (five) days of the loss or within 5 days after you have been informed of the injury. Failure to comply with the above may jeopardize our self-insured status.

**Reporting**:
The attached Employers Report of Occupational Injury or Disease form (LIBC-344) is the official state document and needs to be completed and faxed to the Risk Management Department (570-558-4311). The form is self-explanatory and should be completed in detail by a supervisor or manager; **NOT** the injured party. Management should investigate the alleged accident in order to 1.) determine if the incident actually took place on our premise and 2.) determine if any corrective measures need to be taken in order to prevent similar incidents. If you have any concerns over the incident, attach a note to the first report listing those concerns and they will be addressed during our investigation.

The Risk Management Department will complete the NCCI Class Code, SIN, NAICS, Employer FEIN, Type of Injury, Part of the Body and Cause sections. You are responsible for and must complete the brief description.

The attached Workers Compensation Injury Medical Authorization form should be completed by the employee who suffered the injury. Once completed, this form should be forwarded to the Risk Management Department along with the EROID form.

**The 21-Day Rule**:
Pennsylvania State Law mandates that a claim must be accepted and paid within 21 (twenty-one) days and the Commonwealth of Pennsylvania Bureau of Workers Compensation tracks for compliance to this rule. Failure to comply can jeopardize the Diocese's self-insured status as well as any and all defenses to the pending claim.

If you have any questions, please call the Risk Management Department at 570-558-4310 or fax same to 570-558-4311.

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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

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
PT = Part-time
SL = Seasonal
VO = Volunteer
ZZ = Other

EMPLOYER

STREET ADDRESS

CITY

STATE

ZIP CODE

SIC CODE

EMPLOYER FEIN

PHONE 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 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.

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 ☐

ALL 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

INITIAL TREATMENT:
☐ NO MEDICAL TREATMENT
☐ MINOR BY EMPLOYEE
☐ CLINIC / HOSPITAL
☐ PANEL PHYSICIAN
☐ EMPLOYEE PHYSICIAN
☐ EMERGENCY CARE
☐ HOSPITALIZED MORE THAN 24 HOURS

PHYSICIAN/HEALTH CARE PROVIDER
FIRST NAME: LAST NAME:
STREET
CITY STATE ZIP

HOSPITAL NAME:
STREET
CITY STATE ZIP

POLICY PERIOD FROM:
MONTH - DAY - YEAR

POLICY PERIOD TO:
MONTH - DAY - YEAR

POLICY/SELF INSURED NUMBER:

WITNESS FIRST NAME

WITNESS PHONE NUMBER

WITNESS LAST NAME

PERSON COMPLETING THIS FORM:
NAME:
TITLE:
PHONE:

INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)
NAME:
STREET
CITY STATE ZIP
BUREAU CODE: FEIN:

DATE PREPARED
MONTH - DAY - YEAR

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.

# WORKERS COMPENSATION
# INJURY MEDICAL AUTHORIZATION

## Authorization for Medical Records
## And Communication Release

By this form or copy thereof, I ______________________, hereby authorize any licensed physician, chiropractor, medical practitioner, hospital, clinic or other related medical or medically related facility, insurance company or other organization, institution, or person, that has any records or knowledge of my mental, physical health, history, condition or well being, to supply such information to my employer, it's insurer, claims administrator, rehabilitation or medical management consultant or attorneys.

I specifically authorize any treating physician or medical care provider to communicate orally or in writing with my employer, it's insurer, claims administrator, rehabilitation or medical management consultant or attorneys as to my care and treatment and as to any other issues including but not limited to diagnosis, prognosis, causal connection of care and treatment to my work injury or duties and ability to work. In conjunction with this, I authorize any treating physician or medical provider to review any additional medical records provided to them.

I understand that by signing this authorization for medical records and communication release that my applicable medical provider will be releasing information subject to the HIPPA restrictions. I specifically waive any rights or protections that I may have under the HIPPA regulation and request that the medical providers release the requested information.

A photo copy of this authorization shall be valid as the original. This release shall remain valid for the length of my claim.

______________________________
Name (Please Print)

______________________________
Address (Street, City/Town, Zip Code)

______________________________
Signature

______________________________
Date Signed

TWR05 08/08