Allentown Fire Department

REPORT OF OCCUPATIONAL INJURY OR DISEASE NOTIFICATION

EMPLOYEE SOCIAL SECURITY NUMBER

DATE OF INJURY (MM/DD/YYYY)

EMPLOYEE FIRST NAME	MIDDLE INITIAL

EMPLOYEE LAST NAME

STREET ADDRESS

CITY	STATE	ZIP CODE

COUNTY	PHONE NUMBER (AC-XXX-XXXX)

EMPLOYEE				NO OF DEPENDENTS	DATE OF BIRTH (MM/DD/YYYY)
MALE		MARRIED			
FEMALE		SINGLE			

OCCUPATION OR JOB TITLE

FULL PAY FOR DAY OF INJURY?		TIME EMPLOYEE BEGAN WORK			TIME OF OCCURRENCE		
YES			AM			AM	
NO			PM			PM	

LAST DAY WORKED (MM/DD/YYYY)	DATE DISABILITY BEGAN (MM/DD/YYYY)

DATE EMPLOYER NOTIFIED (MM/DD/YYYY)	DATE RETURNED TO WORK (MM/DD/YYYY)

SHADED AREA FOR CITY USE ONLY

EMPLOYER:	CONTACT:
CITY OF ALLENTOWN **435 HAMILTON STREET, ROOM 224** **ALLENTOWN, PA 18101-1699** **SIC CODE - 9131 EMPLOYER FEIN: 23-6003116** **POLICY/SELF-INSURED NUMBER 946**	**PATRICIA VENNINGER** **PHONE: 610-437-7619**

POLICY PERIOD FROM: 0701		TO: 0603	
	YEAR		YEAR

TYPE OF INJURY CODE	PART OF BODY AFFECTED CODE	CAUSE OF INJURY CODE

(OVER)

TYPE OF INJURY OR ILLNESS

PARTS OF BODY AFFECTED

CAUSE OF INJURY

DID INJURY OR ILLNESS OCCUR ON EMPLOYER'S PREMISES?	IF OUT OF STATE, SPECIFY STATE OF INJURY	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?	WERE SAFEGUARDS OR SAFETY EQUIPMENT USED?
YES		YES	YES
NO		NO	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 (MM/DD/YYYY)

PHYSICIAN/HEALTH CARE PROVIDER

FIRST NAME		LAST NAME			
STREET					
CITY		STATE		ZIP	

INITIAL TREATMENT

- [ ] NO MEDICAL TREATMENT
- [ ] MINOR BY EMPLOYEE
- [ ] CLINIC/HOSPITAL
- [ ] PANEL PHYSICIAN
- [ ] EMPLOYEE PHYSICIAN
- [ ] EMERGENCY CARE
- [ ] HOSPITALIZED MORE THAN 24 HOURS

HOSPITAL

STREET					
CITY		STATE		ZIP	

WITNESS FIRST NAME	WITNESS PHONE NUMBER (AC-XXX-XXXX)

WITNESS LAST NAME

PERSON COMPLETING THIS FORM:		SUPERVISOR COMPLETING THIS FORM:	
NAME:		NAME:	
TITLE		TITLE	
PHONE (AC-XXX-XXXX)		PHONE (AC-XXX-XXXX)	
DATE PREPARED (MM/DD/YYYY)		DATE (MM/DD/YYYY)	

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.

- [ ] COPY TO EMPLOYEE