II. EFFECTIVE USE OF INITIAL BUREAU OF WORKER'S COMPENSATION FORMS

A. Employer Report of Industrial Injury – LIBC-344

1. The Employer Report of Industrial Injury must be filed with the Bureau of Workers' Compensation, whenever the employee is absent for work for **one work shift or longer.**

2. The report of injury **must** be filed with the Bureau, within forty-eight (48) hours of Injury, resulting in death or within three (3) days after the date of injury. §438.

3. The insurer must file the Employer Report of Injury with the Bureau of Workers' Compensation and with its worker compensation Insurer. §438, 77 P.S. §256. It is customary to provide the employee a copy of the report.

4. The Employer's Report of Injury is not admissible as evidence against the Employer or Insurer in any worker compensation proceeding. §438.

5. The employer may record employee's version of events and note any disputed circumstances, i.e., "employee alleges," "employee asserts."

Pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

ELECTRONIC DATA INTERCHANGE
First Report of Injury

Transaction Title: (e.g. FROI)
Transaction Type: (e.g. Denial 04)

Jurisdictional Claim Number: (e,g.CLM-2012021312345)
Date Transaction Submitted to BWC: May 8 2012 01:30PM

Employee Information	
First Name:	Middle Name:
Last Name:	Last Name Suffix:
Employee ID:	ID Type:
Date of Birth:	Date of Death:
Number of Dependents:	Employee Marital Status Code:
Mailing City:	
Mailing State Code:	
Mailing Postal Code:	
Gender Code:	
Mailing Primary Address:	
Mailing Secondary Address:	
Mailing Country Code:	
Phone Number:	
Date Of Hire:	
Occupation Description:	

Claim Information	
Jurisdiction Claim Number:	Jurisdiction:
Initial Date Disability Began:	Claim Type Code:
Type of Loss:	
Death Result of Injury Code:	
Claim Status Code:	
Late Reason Code:	
Accident Site County/Parish:	
Initial Return to Work Date:	
Initial Date Last Day Worked:	
Employment Status Code:	
Employer Paid Salary In Lieu of Compensation Indicator:	
Date Employer Had Knowledge of Date of Disability:	
Return to Work Type Code:	

Injury Information
Date of Injury:
Nature of Injury Code:
Time of Injury:

Injury Information
Part of Body Injury Code:
Cause of Injury Code:
Accident/Injury Description Narrative:

Denial Information
Full Denial Reason Code:
Denial Reason Narrative:
Full Denial Reason Code:

Insurer Information	
Insured Report Number:	Insured FEIN:
Insurer FEIN:	
Insured Name:	
Insured Type Code:	
Insurer Name:	

Claim Administrator Information
Claim Administrator Name:
Claim Administrator FEIN:
Claim Administrator Postal Code:
Claim Administrator Claim Number:
Claim Administrator City:
Claim Administrator State Code:
Claim Administrator Information/Attention line:
Claim Administrator Primary Address:
Claim Administrator Secondary Address:
Claim Administrator County Code:

Employer Information	
Name:	Employer FEIN:
Physical Primary Address:	
Secondary Address:	
Physical City:	
Physical Postal Code:	
Physical Country Code:	

Employer Information
Contact Name:
Mailing Secondary Address:
Mailing City:
Mailing Postal Code:
Mailing State Code:
Mailing Country Code:
Mailing Information/Attention line:
Policy Number Identifier:
Contact Business Phone:

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program