Pennsylvania Conference of Seventh-day Adventists
Worker's Compensation Incident Report
Liberty Mutual Insurance
WCJ-291-528466-022

Employee Name ____
First Name Middle Initial Last Name Suffix

Injury/Incident Date ____________________ Time ___________ Did anyone die? Y/N _____

Days of work missed other than day of accident? ________ Day of accident paid? Y/N ______

If applicable, enter first day of missed work _________________________ Paid? Y/N ______

And last day of missed work _________________________ Paid? Y/N ______

Home Address of Employee ____

Employee Phone Number ______________________________

Number of days worked per week _________ Average hours worked per week ___________

Body part most affected (pick one):

- ☐ Abdomen
- ☐ Ankle
- ☐ Artificial appliance
- ☐ Body Systems
- ☐ Brain
- ☐ Buttocks
- ☐ Chest, ribs or sternum
- ☐ Disc in low or middle back
- ☐ Disc in neck
- ☐ Ear(s)
- ☐ Elbow
- ☐ Eye(s)
- ☐ Facial bones
- ☐ Facial soft tissue
- ☐ Finger(s)
- ☐ Foot
- ☐ Great toe
- ☐ Hand
- ☐ Head
- ☐ Heart
- ☐ Hip
- ☐ Internal organs
- ☐ Knee
- ☐ Larynx
- ☐ Low back
- ☐ Lower arm
- ☐ Lower extremities
- ☐ Lower leg
- ☐ Lungs
- ☐ Mouth
- ☐ Multiple body parts
- ☐ Neck
- ☐ Neck soft tissue
- ☐ No physical injury
- ☐ Nose
- ☐ Pelvis
- ☐ Tailbone (sacrum or coccyx)
- ☐ Shoulder
- ☐ Skull
- ☐ Spinal cord (low or middle)
- ☐ Spinal cord (neck)
- ☐ Teeth
- ☐ Thigh
- ☐ Thumb
- ☐ Toe(s)
- ☐ Trunk
- ☐ Upper arm
- ☐ Upper back
- ☐ Upper extremities
- ☐ Vertebrae in neck
- ☐ Wrist
- ☐ Wrist(s) and hand(s)

Nature of injury/illness (pick one):

- ☐ Amputation
- ☐ Burn
- ☐ Cancer
- ☐ Chemical poisoning
- ☐ Contagious diseases
- ☐ Contusion
- ☐ Crushing
- ☐ Cumulative injury
- ☐ Dermatitis
- ☐ Dislocation
- ☐ Surgical removal of _______________
- ☐ Foreign body
- ☐ Fracture
- ☐ Infection
- ☐ Inflammation
- ☐ Injury
- ☐ Laceration
- ☐ Metal poisoning
- ☐ Occupational disease
- ☐ Puncture
- ☐ Radiation
- ☐ Sprain
- ☐ Strain
- ☐ Vascular

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Describe the injury/illness:

____

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Where was medical treatment first provided?

- ☐ No medical treatment
- ☐ Minor onsite
- ☐ Physician/Clinic
- ☐ Emergency room treated and released
- ☐ Hospitalized > 24 hours
- ☐ Hospitalized < 24 hours

What type of provider performed the treatment?

- ☐ Clinic
- ☐ Hospital
- ☐ Physician

Provider or organization name ____

City, state ____

Nature of accident (pick one):

- ☐ Burn or scald – heat or cold exposure
- ☐ Caught in or between
- ☐ Injured by cut, puncture, scrape
- ☐ Fall or slip injury
- ☐ Motor vehicle
- ☐ Strain or injury by _______________
- ☐ Striking against or stepping on ________________
- ☐ Struck or injured by _______________
- ☐ Miscellaneous causes
- ☐ Rubbed or abraded by _______________

Describe the accident: ____

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What caused the injury: ____

Accident Location (address): ____

Was anyone else injured in the accident? ________

Any witnesses? _______ If yes, please provide name and phone number:

____

Please complete each item on the report to the best of your knowledge.

____ ________________________________

Employee Signature Date

Submit to the Human Resources Department as soon as possible after treatment is administered.
Fax: 610-374-9331 or Email: llanda@paconference.org