COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501
(TOLL FREE) 800-482-2383
TTY 800-362-4228

CLAIM PETITION FOR WORKERS' COMPENSATION

EMPLOYEE SOCIAL SECURITY NUMBER

DATE OF INJURY
MONTH DAY YEAR

PA BWC CLAIM NUMBER (IF KNOWN)

EMPLOYEE

First Name
Last Name
If Deceased - Dependent or Guardian
First Name
Last Name
Address
Address
City/Town State Zip
County
Telephone ( )

EMPLOYER

Name
Address
Address
City/Town State Zip
County
Telephone ( ) FEIN

VS. **INSURER or THIRD PARTY ADMINISTRATOR** (if self insured)

Name
Address
Address
City/Town State Zip
Telephone ( ) Bureau Code
County
Claim # FEIN

1. Complete description of injury or illness including all parts of body affected. (If you are seeking additional compensation from the Subsequent Injury Fund for total disability as a result of a previous permanent loss, or loss of use of one hand, one arm, one foot, one leg or one eye, and a subsequent injury causing loss, or loss of use of, another hand, arm, foot, leg or eye, you must also submit form LIBC-375.)

2. If occupational disease, give the last date of employment MONTH DAY YEAR and/or last date of exposure MONTH DAY YEAR .

3. Give date of injury or onset of disease MONTH DAY YEAR .

4. How did the injury or disease happen?

5. Did injury or disease occur on employer's premises? ☐ Yes ☐ No Where? (Be specific.)

6. Notice of your injury or disease was served on your employer on MONTH DAY YEAR in the following manner:

7. What was your job title at the time of injury or disease?

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(OVER)

8. Were you working for more than one employer at the time of your injury? ☐ Yes ☐ No If Yes, list additional employers:

9. Did this problem cause you to stop working? ☐ Yes ☐ No If Yes, give date. MONTH DAY YEAR

10. Are you back to work with the same employer? ☐ Yes ☐ No If Yes, ☐ Regular Job ☐ Other Job/Give Title

11. Are you working with another employer? ☐ Yes ☐ No If Yes, give name and address of new employer:

12. What were your wages at the time of injury? $. ☐ Hour ☐ Day ☐ or Week

13. If you have returned to work since your injury or illness, are you earning ☐ More ☐ Same ☐ Less than you were at the time of injury? Current earnings $. ☐ Hour ☐ Day ☐ or Week

14. I am seeking payment for (check all that apply):

☐ Loss of Wages

☐ Partial disability from MONTH DAY YEAR to MONTH DAY YEAR

☐ Full disability from MONTH DAY YEAR to MONTH DAY YEAR

☐ Medical bills (give name of doctor/hospital, address, type of treatment and bill in space below).

☐ Counsel fees to be paid by the employer.

☐ Loss or loss of use of arm, hand, finger, leg, foot or toe.

☐ Disfigurement (scars) of head, face, or neck.

☐ Loss of sight.

☐ Loss of hearing.

15. Other _____

16. Is there other pending litigation in this case? ☐ Yes ☐ No If Yes, explain below:

PLEASE ENTER MY APPEARANCE FOR PETITIONER:

Attorney Name

PA Attorney ID Number

Firm Name

Address

Address

City/Town State Zip

Telephone ( )

Date of Petition

MONTH DAY YEAR

A copy of this petition has been sent to the employer.

Signature

☐ Employee ☐ Attorney

NOTICE: This Petition must be filled out as fully as possible. The original must be sent to the Bureau of Workers' Compensation, 1171 South Cameron Street, Room 103, Harrisburg, PA 17104-2501. A copy must be sent by you to the employer. Information on the completion of this form may be obtained by calling the Bureau of Workers' Compensation Helpline at 800-482-2383.

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

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, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).