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

## SUPPLEMENTAL AGREEMENT FOR COMPENSATION FOR DISABILITY OR PERMANENT INJURY

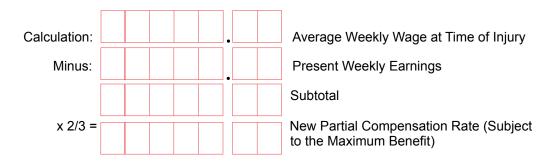
EMPL	OYEE	SOCIA	L S	ECUR	ITY NI	JME	BER				
			-			-					
DATE OF INJURY											
			-			-					
PA BW		YE.	AR								

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EMPLOYEE	EMPLOYER									
First Name	Name									
Last Name	Address									
Address	Address									
Address	City/Town			Sta	te		7	<u>Z</u> ip		
City/Town State Zip	-			Olu			_	iP		
County	County Telephone ( )				FEIN	J				
Telephone ( )	INSURER or THIRD	DADT	V A D				OP (	if col	finci	urod)
INJURY	Name	FANI	IAD	IVIII	VIO I	NAI	OK (	11 361	1 11150	ireu)
Body Part(s) affected	Address									
Type of Injury	Address									
Description of Injury	City/Town			Stat	te		Zip	o		
Decomption of injury	Telephone ( )				Bui	reau	Code			
	County									
Check if Occupational Disease	Claim #					FE	ΞIN			
agreed between parties hereto that the status of the disability of the said employee changed  on										
Said employer shall pay said employee compensation at the rate of \$ per week beginning on										
Compensation payable for weeks days;	or, if the future perio	d of d	isabi	ility	is u	ınce	rtain	, the	n to	continue
at said rate until further changed by supplemental agreemen	t, final receipt, or or	der of	a W	ork/	ers'	Co	mper	nsat	ion .	ludge, o
the Workers' Compensation Appeal Board.										
NOTICE: Agreement 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.										
NOTICE: Weekly wages must be computed in accordance										

Any individual filing misleading or incomplete information knowingly and with the 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).

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The employee's new partial compensation rate is based on the claimant's present weekly earnings and is calculated as follows:



Further matters agreed upon (list any previously unreported periods of compensation and/or actions in chronological order, as well as any additional information):

We, the undersigned, agree upon the facts represented by the above-named employee and their above-named employer:

SIGNATURE OF EMPLOYEE		IOM	NTH	_	DAY	_	YE	AR	
SIGNATURE OF CLAIMS REPRESENTATIVE	Claims Repro		tative )	e Na	ame _				

If you have any questions or need information on the completion of this form, please contact the Bureau of Workers' Compensation:

Employer Information Services 717.772.3702 Claims Information Services toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447 Only People with Hearing Loss toll-free inside PA TTY: 800.362.4228 local & outside PA TTY: 717.772.4991

DATE OF AGREEMENT

E-mail ra-li-bwc-helpline@ state.pa.us