pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
WORKERS' COMPENSATION OFFICE OF ADJUDICATION

CLAIM PETITION FOR WORKERS' COMPENSATION

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY (MM - DD - YYYY)

WCAIS CLAIM NUMBER

EMPLOYEE

First name _____

Last name _____

Date of birth _____

If deceased - Dependent/Guardian/Personal Representative

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 _____

County _____

Telephone _____ FEIN _____

NAIC code _____ or Insurer code _____

Insurer/TPA claim # _____

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 from LIBC-375).

2. If occupational disease, give the last date of employment (MM - DD - YYYY) and/or last date of exposure (MM - DD - YYYY) with this employer.

3. Give date of injury or onset of disease (MM - DD - YYYY).

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 (MM - DD - YYYY) in the following manner:

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

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 (MM - DD - YYYY).

10. Are you back to work with the same employer? ☐ Yes ☐ No If yes, ☐ Regular job ☐ Other job/give title

11. Are you back to work 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 ☐ 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 ☐ Week

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

☐ Loss of wages

☐ Partial disability from MM - DD - YYYY thru MM - DD - YYYY (date disability ends) or ☐ ongoing.

☐ Full disability from MM - DD - YYYY thru MM - DD - YYYY (date disability ends) or ☐ ongoing.

☐ Medical bills (Attach additional sheet giving name of health care provider, address, type of treatment and amount of bill).

☐ 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.

☐ Cancer as a firefighter under Act 46 of 2011.

15. Other _____

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

PLEASE ENTER MY APPEARANCE FOR PETITIONER:

Attorney's name _____

PA Attorney ID number _____

Firm name _____

Address _____

Address _____

City/Town _____ State _____ ZIP _____

Telephone _____

Date of petition MM - DD - YYYY

_____
Attorney's signature

Notice: This petition must be filled out as fully as possible. If not filing electronically, the original must be sent to the Workers' Compensation Office of Adjudication, 1010 N. Seventh St, Suite 202, Harrisburg, PA, 17102-1400. You must send a copy to all other parties, and on the attorneys of all other parties, if the attorneys are known. A Proof of Service must be attached. A Proof of Service is a signed statement signed by you verifying that you have sent a copy of the petition to all parties and their attorneys, if known. Questions regarding the completion of this form may be directed to the Bureau of Workers' Compensation Claims Information Services.

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).

Employer Information Services	**Claims Information Services**	**Hearing Impaired**	**Email**
717.772.3702	toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447	toll-free inside PA TTY: 800.362.4228 local & outside PA TTY: 717.772.4991	ra-li-bwc-helpline@pa.gov

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