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.

2a. ☐ Cancer as a firefighter under Act 46 of 2011.

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):

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

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

☐ Medical bills

☐ 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.

☐ Other ____

15. 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).