DEPARTMENT OF LABOR & INDUSTRY
WORKERS' COMPENSATION OFFICE OF ADJUDICATION

PETITION FOR PHYSICAL EXAMINATION OR EXPERT INTERVIEW OF EMPLOYEE (SECTION 314)

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 ______
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 # ______

INJURY INFORMATION

Provide the following information if Employer has accepted liability for this injury:

Part of body injured ______

Nature of injury

Accident/injury description narrative

Check if occupational disease ☐

NOTICE TO EMPLOYEE: Employer must indicate whether "physical examination" or "expert interview" is required by checking the appropriate boxes. Employee's answer must be filed with the Workers' Compensation Judge within twenty (20) days.

1. The **insurer/employer alleges** that it requested the employee to submit to a ☐ physical examination ☐ expert interview by ______ (HEALTH CARE PROVIDER'S/EXPERTS NAME AND ADDRESS AND FIELD OF SPECIALTY OR EXPERTISE), for the purposes of ______ (IME/IRE/EXPERT INTERVIEW) on __ - __ - ____ (MM DD YYYY), and the employee refused or failed to appear at such examaination or interview.

2. The **date of last** ☐ physical examination of the employee by the health care provider chosen by the insurer/employer or ☐ expert interview of the employee by the expert chosen by the insurer/employer was on __ - __ - ____ (MM DD YYYY).

3. If the petition is for the purpose of an IRE, the date of the request was on __ - __ - ____ (MM DD YYYY).

4. Wherefore the **insurer/employer petitions the Workers' Compensation Judge to order** the employee to submit to ☐ a physical examination ☐ an expert interview by ______ (HEALTH CARE PROVIDER'S/EXPERTS NAME) or by such health care provider(s)/expert(s) as may be designated by the Workers' Compensation Judge at such time and place as may be set and determined ______ (IME/IRE/EXPERT INTERVIEW).

Identify documents previously filed with the Bureau of Workers' Compensation:

☐ Notice of Compensation Payable dated __ - __ - ____ (MM DD YYYY)
☐ Other ______ dated __ - __ - ____ (MM DD YYYY)
☐ Supplemental Agreement dated __ - __ - ____ (MM DD YYYY)
☐ Petition ______ dated __ - __ - ____ (MM DD YYYY)

5. This is an Act 46 (firefighter cancer) claim ☐

CLAIMANT MUST BE SERVED

PLEASE ENTER MY APPEARANCE FOR PETITIONER

Attorney's name __________

PA Attorney ID number __________

Firm name __________

Address __________

Address __________

City/Town __________ State ____ ZIP ______

Telephone __________

COUNSEL FOR RESPONDENT (if known)

Attorney's name __________

PA Attorney ID number __________

Firm name __________

Address __________

Address __________

City/Town __________ State ____ ZIP ______

Telephone __________

____

Petitioner or representative's signature

Date of petition

__ __ - __ __ - __ __ __ __

MM DD YYYY

____

Petitioner or representative's name (typed/printed)

NOTE: 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 7th Street, Suite 202, Harrisburg, PA, 17102-1400. You must send a copy to all other parties, and to 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 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
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
PA Relay 7-1-1

Email
ra-li-bwc-helpline@pa.gov

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