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

OCCUPATIONAL DISEASE CLAIM PETITION MONTHLY COMPENSATION FOR DISABILITY UNDER SECTION 301(i) ONLY

EMPLOYEE

First name _____

Last name _____

Date of birth _____

Address _____

Address _____

City/Town _____ State____ ZIP _____

County _____

Telephone _____

VS

Commonwealth of Pennsylvania
Department of Labor & Industry
c/o Office of Chief Counsel
1171 South Cameron Street
Harrisburg, PA 17104-2501

INJURY INFORMATION

Part of body injured _____

Nature of injury _____

_____

_____

Accident/injury description narrative _____

_____

_____

Check if occupational disease ☐

1. My last date of employment or self-employment in any occupation was ☐☐ - ☐☐ - ☐☐☐☐.
   MM DD YYYY
2. I became totally disabled on ☐☐ - ☐☐ - ☐☐☐☐ as a result of:
   MM DD YYYY
   ☐ Coal Workers' Pneumoconiosis ☐ Silicosis ☐ Anthraco-Silicosis ☐ Asbestosis
3. My total disability is a result of employment in a hazardous occupation having a:
   ☐ Coal hazard ☐ Asbestos hazard ☐ Silica hazard
4. I was employed in the Commonwealth of Pennsylvania at least two years preceding the above date of the disability, as follows:
   (List all employment in the hazardous occupation.)

NAME OF EMPLOYER IN PENNSYLVANIA	ADDRESS	DATES OF EMPLOYMENT FROM MM-DD-YYYY	TO MM-DD-YYYY

5. If you have filed a claim previously under the Occupational Disease Act or the Workers' Compensation Act, complete the following:

   (a) Date of filing ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY)

   (b) Claim petition: ☐ Pending ☐ Dismissed ☐ Withdrawn

   (c) Claim filed under: ☐ Occupational Disease Act ☐ Workers' Compensation Act

6. I ☐ have ☐ have not filed for benefits under the Federal Health and Coal Mine Safety Act of 1969.

Therefore, I hereby petition the Department of Labor & Industry to award monthly compensation to me at the rate set forth under the provisions of Section 301 (i) of the 1939 Occupational Disease Act, as amended.

_____
Petitioner/Employee signature

Date of petition
☐☐ - ☐☐ - ☐☐☐☐
MM DD YYYY

PLEASE ENTER MY APPEARANCE FOR PETITIONER:
Attorney's name _____
PA Attorney ID number _____
Firm name _____
Address _____
Address _____
City/Town _____ State _____ ZIP _____
Telephone _____

_____
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 serve a copy to all other parties, and on the attorneys of all other parties, if the attorneys are known. Questions regarding the completion of this form may be directed to the Bureau of Workers' Compensation Claims Information Services.

INSTRUCTIONS TO CLAIMANT

Failure to comply with these instructions will necessitate the return of your petition.

Employee must **sign this document**.

Attach two recent photographs. Place your signature and last four digits of Social Security Number on the reverse side of each photograph.

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