



# 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**  
toll-free inside PA TTY: 800.362.4228  
local & outside PA TTY: 717.772.4991

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



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