COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501
(TOLL FREE) 800-482-2383

EMPLOYEE REPORT OF WAGES AND PHYSICAL CONDITION

Social Security Number: _____ - _____ - _____

Date of Injury: _____/_____/_____ (MM DD YYYY)

PA BWC Claim Number: _____ (IF KNOWN)

Employee

First Name _____ Last Name _____

Street 1 _____

Street 2 _____

City/Town _____ State _____ Zip Code _____-_____

County _____ Telephone (____) _____-_____

Employer

Name _____

Street 1 _____

Street 2 _____

City/Town _____ State _____ Zip Code _____-_____

County _____

Telephone (____)_____- _____ FEIN _____

Insurer or Third Party Administrator (if self-insured)

Name _____

Street 1 _____

Street 2 _____

City/Town _____ State _____ Zip Code _____-_____

Telephone (____)_____- _____ Bureau Code _____

County _____

Claim Number _____ FEIN _____

FAILURE TO COMPLETE THIS FORM MAY SUBJECT YOU TO ARTICLE XI OF THE WC ACT RELATING TO FRAUD.

YOU MUST COMPLETE AND RETURN THIS FORM WITHIN THIRTY (30) DAYS OF BEGINNING EMPLOYMENT OR SELF-EMPLOYMENT.

1. Are you now employed? ☐ Yes ☐ No

2. Are you now self-employed? ☐ Yes ☐ No

3. Have you been employed or self-employed at any time while receiving workers' compensation benefits?
   ☐ Yes ☐ No
   If you answered Yes to one of the questions, please complete the following:

   Occupation(s): _____

4. Has your physical condition (caused by your work injury) changed? ☐ Yes ☐ No
   If Yes, attach medical report.

5. Is there any other information you are aware of that is relevant in determining your entitlement to, or amount of compensation? ☐ Yes ☐ No

   If Yes, please explain: _____

_____

_____

(OVER)