COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501
(TOLL FREE) 800-482-2383
TTY 800-362-4228

NOTICE OF TEMPORARY COMPENSATION PAYABLE

EMPLOYEE SOCIAL SECURITY NUMBER

DATE OF INJURY
MONTH DAY YEAR

PA BWC CLAIM NUMBER (IF KNOWN)

DATE OF NOTICE
MONTH DAY YEAR

EMPLOYEE

First Name
Last Name
Address
Address
City/Town State Zip
County
Telephone

EMPLOYER

Name
Address
Address
City/Town State Zip
County
Telephone FEIN

INJURY INFORMATION

Body Part(s) affected
Type of Injury
Description of Injury

Check if Occupational Disease

INSURER or THIRD PARTY ADMINISTRATOR (if self insured)

Name
Address
Address
City/Town State Zip
Telephone Bureau Code
County
Claim # FEIN

NOTICE TO EMPLOYER: In wage loss claims, a copy of this Notice is to be sent to the injured employee with the first payment of **temporary** compensation, the original to be filed with the Department of Labor & Industry. In wage loss claims, 90 days begins on the first day of disability. The employer's/insurer's failure to file a notice as provided in Section 406.1(d)(5) of the Act advising the employee that the employer is ceasing temporary compensation shall be deemed an admission of liability, and this notice shall be converted to a Notice of Compensation Payable.
NOTICE TO EMPLOYEE: This Notice of **temporary** compensation payments is for a period of up to 90 days and **is not** an admission by your employer that it is responsible for your injury. If any questions arise, contact the representative at the bottom of this Notice. If you need further information, call the Bureau at 800-482-2383.

Compensation is payable as follows:

Check only if compensation for medical treatment **(medical only, no loss of wages)** will be paid subject to the Workers' Compensation Act. Compensation for medical treatment is payable from date of injury. If Employer stops temporary compensation in accordance with the Act, employer will not pay for treatment received on or after the stoppage date.
For compensation for medical treatment only, you should not complete numbers 1 or 3.

1. Weekly compensation rate $

   Based on an average weekly wage of $ (A statement of wages must accompany this form.)

2. Ninety-day period
   begins on MONTH DAY YEAR and ends on MONTH DAY YEAR

3. Payments will hereafter be made: Weekly Biweekly Other (Specify)
   until payments cease or the ninety-day maximum period for temporary compensation expires.

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Name of Claims Representative _____ Phone Number ( ) _____

_____
Signature of Claims Representative

(OVER)