pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

DISMEMBERMENT CHART SEC. 306(c) WORKERS' COMPENSATION ACT AS AMENDED

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 _____

INJURY INFORMATION

Part of body injured _____

Nature of injury _____

Accident/injury description narrative

_____

_____

Marked by _____ M.D.

Check if occupational disease ☐

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

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 # _____

DISMEMBERMENT CHART
Sec. 306(c) Workers' Compensation Act as Amended

The Left Foot (Dorsal surface)