pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

EMPLOYEE REPORT OF WAGES AND PHYSICAL CONDITION

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 _____

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 # _____

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 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:

6. Names of employers for whom you have worked since your date of injury:

Name ______________________
Address ______________________
Address ______________________
City/Town ____________ State ____ ZIP ________
Period of employment:
From [MM]-[DD]-[YYYY]
To [MM]-[DD]-[YYYY]
Amount of wages $ ____________

Name ______________________
Address ______________________
Address ______________________
City/Town ____________ State ____ ZIP ________
Period of employment:
From [MM]-[DD]-[YYYY]
To [MM]-[DD]-[YYYY]
Amount of wages $ ____________

Name ______________________
Address ______________________
Address ______________________
City/Town ____________ State ____ ZIP ________
Period of employment:
From [MM]-[DD]-[YYYY]
To [MM]-[DD]-[YYYY]
Amount of wages $ ____________

IF SELF-EMPLOYED

From [MM]-[DD]-[YYYY]
To [MM]-[DD]-[YYYY]
Amount of wages $ ____________

I verify that this information is true and correct based upon my knowledge, information and belief. I understand false statements are subject to the penalties of 18 Pa. C.S. §4904 relating to unsworn falsification to authorities.

Employee

First name ______________________
Last name ______________________
Signature ______________________

DATE OF NOTICE
[MM]-[DD]-[YYYY]

Section 311.1(A) of the Workers' Compensation Act requires employees who are receiving workers' compensation, or who have filled a petition to receive workers' compensation, to report earnings from employment or self-employment. You must complete and return this form to the sender within thirty (30) days of beginning such employment or self-employment.

EMPLOYEE IS TO RETURN THIS COMPLETED FORM TO THE INSURER OR THIRD PARTY ADMINISTRATOR SHOWN ON THE FRONT.

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