COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

EMPLOYEE VERIFICATION OF EMPLOYMENT, SELF-EMPLOYMENT OR CHANGE IN PHYSICAL CONDITION

Social Security Number _____ - _____ - _____

Date of Injury _____/_____/_____

PA BWC Claim Number _____

DATE OF THIS NOTICE _____/_____/_____

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 _____

INSTRUCTIONS TO EMPLOYEE:

DO NOT RETURN THIS FORM TO THE BUREAU OF WORKERS' COMPENSATION.

COMPLETED FORM MUST BE RETURNED TO THE PARTY WHO SENT THE FORM TO YOU WITHIN THIRTY (30) DAYS OF YOUR RECEIPT OF THIS FORM.

IF YOU DO NOT COMPLETE AND RETURN THIS FORM TO THE PARTY WHO SENT IT TO YOU WITHIN THIRTY (30) DAYS IT MAY RESULT IN A SUSPENSION OF YOUR COMPENSATION BENEFITS AS PROVIDED BY SECTION 311.1(g) OF THE WC ACT, AS WELL AS PROSECUTION FOR FRAUD UNDER ARTICLE XI OF THE WC ACT.

YOU MAY BE REQUIRED TO COMPLETE AND RETURN THIS FORM EVERY SIX (6) MONTHS.

INSTRUCTIONS TO EMPLOYEE: Section 311.1(d) of the Workers' Compensation Act requires employees who are receiving workers' compensation, or have filed a petition to receive workers' compensation, to verify employment, self-employment, wages and changes to physical condition.

1. Are you currently employed by any employer other than the employer listed above? ☐ Yes ☐ No

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

3. Have you been employed or self-employed at any time while receiving workers' compensation benefits? ☐ Yes ☐ No

(OVER)

4. Has your physical condition (caused by your injury) changed? ☐ Yes ☐ No

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

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

Name _____

Street 1 _____

Street 2 _____

City/Town _____ State _____ Zip Code _____-_____

Period of employment:

From _____/_____/_____ to _____/_____/_____
MM DD YYYY MM DD YYYY

AMOUNT OF WAGES $ _____ . ____

Name _____

Street 1 _____

Street 2 _____

City/Town _____ State _____ Zip Code _____-_____

Period of employment:

From _____/_____/_____ to _____/_____/_____
MM DD YYYY MM DD YYYY

AMOUNT OF WAGES $ _____ . ____

Name _____

Street 1 _____

Street 2 _____

City/Town _____ State _____ Zip Code _____-_____

Period of employment:

From _____/_____/_____ to _____/_____/_____
MM DD YYYY MM DD YYYY

AMOUNT OF WAGES $ _____ . ____

IF SELF-EMPLOYED

From _____/_____/_____ to _____/_____/_____
MM DD YYYY 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 _____

Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165 of 1994.

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