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

PETITION FOR JOINDER OF ADDITIONAL DEFENDANT

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 _____

VS.

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 _____

376 1297-1

☐ Employee
☐ Employer _____ hereby petitions for joinder in connection with the pending _____ petition:

Additional Employer

Name _____

Street 1 _____

Street 2 _____

City/Town _____ State ___ Zip Code _____-_____

Additional Carrier

Name _____

Street 1 _____

Street 2 _____

City/Town _____ State ___ Zip Code _____-_____

Attorney (if known)

Name _____

Street 1 _____

Street 2 _____

City/Town _____ State ___ Zip Code _____-_____

Joinder is requested for the following reasons: _____

_____

_____

Attached are:
☐ Claim and/or other petitions
☐ All answers filed
☐ All exhibits
☐ The names/addresses of all parties and their counsel
☐ A statement of all hearings held or scheduled with dates

Date filed: _____/_____/_____
MM DD YYYY

(OVER)

I hereby certify that a copy of this petition and exhibits were served on the employers/insurance companies as identified above with copies to counsel for parties currently on record.

Petitioner

First Name ____________ Last Name ____________

____
SIGNATURE

Additional Employer	Additional Carrier	Attorney (if known)
Name ____________	Name ____________	Name ____________
Street 1 ____________	Street 1 ____________	Street 1 ____________
Street 2 ____________	Street 2 ____________	Street 2 ____________
City/Town ______ State ___ Zip Code _____-____	City/Town ______ State ___ Zip Code _____-____	City/Town ______ State ___ Zip Code _____-____

Additional Employer	Additional Carrier	Attorney (if known)
Name ____________	Name ____________	Name ____________
Street 1 ____________	Street 1 ____________	Street 1 ____________
Street 2 ____________	Street 2 ____________	Street 2 ____________
City/Town ______ State ___ Zip Code _____-____	City/Town ______ State ___ Zip Code _____-____	City/Town ______ State ___ Zip Code _____-____

Additional Employer	Additional Carrier	Attorney (if known)
Name ____________	Name ____________	Name ____________
Street 1 ____________	Street 1 ____________	Street 1 ____________
Street 2 ____________	Street 2 ____________	Street 2 ____________
City/Town ______ State ___ Zip Code _____-____	City/Town ______ State ___ Zip Code _____-____	City/Town ______ State ___ Zip Code _____-____

Date served: ____/____/________
MM DD YYYY

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.