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

EMPLOYEE REPORT OF WAGES AND PHYSICAL CONDITION

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: University of Pittsburgh

Street 1: 1826 Cathedral of Learning

Street 2: _____

City/town: Pittsburgh State: PA Zip Code: 15260

County: Allegheny

Telephone: 4126241198 FEIN: 25-0965591

Insurer or Third Party Administrator (if self-insured)

Name: UPMC Benefits Management Svcs., Inc.

Street 1: DBA UPMC Work Partners

Street 2: PO Box 2971

City/Town: Pittsburgh State: PA Zip Code: 15230

Telephone: 8006331197 Bureau Code: 0908

County: Allegheny

Claim Number: _____ FEIN: 251769564

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 THIRTY (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: _____

(OVER)

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

Name
Street I
Street 2
City/Town State Zip Code
Period of Employment:
From MM DD YYYY TO MM DD YYYY
Amount of Wages $

Name
Street I
Street 2
City/Town State Zip Code
Period of Employment:
From MM DD YYYY TO MM DD YYYY
Amount of Wages $

Name
Street 1
Street 2
City/town State Zip Code
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 THIS NOTICE: MM DD YYYY

Section 31 1.1 (A) of the Workers' Compensation Act requires employees who are receiving workers' compensation, or who have filed 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 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.