

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  
TTY 800-362-4228  
www.dli.state.pa.us

**COMPROMISE AND  
RELEASE AGREEMENT BY  
STIPULATION PURSUANT  
TO SECTION 449 OF THE  
WORKERS'  
COMPENSATION ACT**

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	FEDIN	

**John T. Hofrichter & Associates**

**TO THE PARTIES: DO NOT SUBMIT THIS AGREEMENT TO THE BUREAU. SUBMIT IT TO THE ASSIGNED WORKERS' COMPENSATION JUDGE.**

**TO THE EXTENT THIS AGREEMENT REFERENCES AN INJURY FOR WHICH LIABILITY HAS NOT BEEN RECOGNIZED BY AGREEMENT OR BY ADJUDICATION, THE TERM "INJURY" AS USED IN THIS AGREEMENT SHALL MEAN "ALLEGED INJURY".**

**Insurer or Third Party Administrator (if self-insured)**

Name		
Street 1		
Street 2		
City/Town	State	Zip Code
County		
Telephone	Bureau Code	
Insurer/TPA Claim Number	FEDIN	

1. This is an agreement in the case of the above listed employee and the above listed employer, insurer, or third party administrator in regards to an injury or occupational disease.
2. State the date of injury or occupational disease \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY
3. State the average weekly wage of the employee, as calculated under Section 309. \$ \_\_\_\_\_ /wk
4. State the injury, the precise nature of the injury, and the nature of the disability, whether total or partial.
5. State the weekly compensation rate paid or payable. \$ \_\_\_\_\_ /wk
6. State the amount of indemnity benefits paid or due and unpaid to the employee or dependent up to the date of the stipulation or agreement or death. \$ \_\_\_\_\_
7. State the amount of the payment of indemnity benefits to be made at or after the date of the stipulation or agreement or death, and the length of time such payment of benefits is to continue. \$ \_\_\_\_\_ for \_\_\_\_\_