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

PETITION FOR PENALTIES

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

Injury

Description of Injury and Cause of Death

Check if Occupational Disease ☐

John T. Hofrichter & Associates

PLEASE ENTER MY APPEARANCE FOR PETITIONER:

Attorney

Name

Firm Name

Street 1

Street 2

City/Town State Zip Code

Telephone ( ) - PA Attorney ID Number

Counsel for Respondent (if known)

Name

Firm Name

Street 1

Street 2

City/Town State Zip Code

Telephone ( ) - PA Attorney ID Number

NOTICE: This petition should be clearly completed (preferably typed) and original mailed to the Bureau at the address in the upper left corner.