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

NOTICE OF CHANGE OF WORKERS' COMPENSATION DISABILITY STATUS

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

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

DATE OF THIS NOTICE: _____
MM DD YYYY

Attorney for Employee (if known)

Name

Firm Name

Street 1

Street 2

City/Town State Zip Code

Telephone PA Attorney ID Number

Attorney for Insurer/Employer (if known)

Name

Firm Name

Street 1

Street 2

City/Town State Zip Code

Telephone PA Attorney ID Number

Claim Representative

First Name Last Name

Telephone

SEE IMPORTANT INFORMATION ON REVERSE.

This notice should be clearly completed (preferably typed) and original mailed to the Bureau at the address in the upper left corner. A copy must be sent to the employee and the employee's counsel (if known).

(OVER)

As a result of an impairment rating evaluation (examination), your disability status has changed.

A change in disability status does not affect the amount of money you receive in your workers' compensation check. Partial disability status does, however, have a maximum period of 500 weeks of benefits.

The specifics of this change are listed as follows:

Claimant Name: _____

Social Security Number: _____

Date of Injury: _____
MM DD YYYY

Date you reached a total of 104 weeks of total disability: _____
MM DD YYYY

Date initially established for the examination: _____
MM DD YYYY

Actual Date of the Rating Examination: _____
MM DD YYYY

Impairment Examining Physician: _____

Impairment Rating Percentage: _____ %

This rating evaluation was conducted in accordance with Section 306(a.2) of the Pennsylvania Workers' Compensation Act.

☐ The above referenced Impairment Rating percentage has been used by your Insurance Carrier/Employer to change your workers' compensation status from total disability to partial disability status.

The effective date of this status change is _____ . (This effective date will be recorded on your claim record 60 days following the date of this notice)
MM DD YYYY

— OR —

☐ The result of this rating evaluation is that no change is occurring in your disability status.

You may appeal an adjustment in your workers' compensation status to a Workers' Compensation Judge *Petition for Review* by filing a with the Bureau of Workers' Compensation, 1171 S. Cameron Street, Room 103, Harrisburg, PA 17104-2501, which must include a qualified impairment rating physician's determination of impairment which is equal to or greater than 50%. If you have a question regarding this notice, please call or write the representative below.

Insurer/Employer Representative

First Name _____ Last Name _____

Signature _____

Street 1 _____

Street 2 _____

City/Town _____ State _____ Zip Code _____

Telephone _____ Bureau Code _____

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.