PA WORKERS’ COMPENSATION INFORMATION

To All Employees:

The PA Workers’ Compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

Benefits are required to be paid by your employer if self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers’ compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place. It is also required to be posted in any areas used for treatment of injured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your employer. Your benefits could be delayed or denied if you do not notify your employer immediately.

If your claim is denied by your employer, you have the right to request a hearing before a PA Workers’ Compensation Judge.

The PA Bureau of Workers’ Compensation cannot provide legal advice. However, you may contact the PA Bureau of Workers’ Compensation for additional general information:

   PA Bureau of Workers’ Compensation
   651 Boas Street, 8th Floor
   Harrisburg, Pennsylvania 16121-0750
   Toll free inside PA: 1-800-482-2383
   Local calls from outside PA: 717-772-4447
   Hearing impaired individuals or those who have difficulty speaking may contact the PA Dept of Labor and Industry’s Bureau of WC by dialing 7-1-1 and providing the relay service with the bureau’s phone number.
   https://www.dli.pa.gov

For a complete list of panel physicians, please refer to https://www.risk.pitt.edu/pennsylvania-workers-compensation. Please contact Workpartners at 1-800-633-1197 with any additional questions.

I, ________________________________, employee of the University of Pittsburgh, hereby certify that I have been provided with, read, and understood the information set forth above consistent with the requirements of the Pennsylvania Workers’ Compensation Act.

Employee Signature: ____________________________ Date: __________________

Revised: 7/1/23