

# NOTICE OF ABILITY TO RETURN TO WORK

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 _____		

DATE OF THIS NOTICE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

## 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 _____	

Section 306(b)(3) of the Pennsylvania Workers' Compensation Act requires insurers to notify the employee when they receive medical evidence indicating the ability to return to work in some capacity.

Receipt of medical evidence indicates your present physical condition or change of condition is:

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Attached are all documents supporting these allegations.

### YOU SHOULD ALSO KNOW

- You have an obligation to look for available employment.
- Proof of available employment may jeopardize your right to receive ongoing benefits.
- You have the right to consult with an attorney in order to obtain evidence to challenge the insurer's contentions.

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.

Auxiliary aids and services are available upon request to individuals with disabilities.  
 Equal Opportunity Employer/Program