

**WORKERS' COMPENSATION INFORMATION**

To All Employees:

The Workers' Compensation law provides some replacement wages and medical benefits to employees who cannot work, or who need medical care, because of a work related injury.

Employers are required to post the name of the company responsible for paying workers' compensation benefits in a prominent and easily accessible place, including, areas used for the treatment of injured employees or for the administration of first aid. Penn State's Workers' Compensation coverage is provided through the Pennsylvania Manufacturers' Association (PMA).

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

If your claim is denied by PMA, then you have the right to request a hearing before a Workers' Compensation Judge.

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

**Bureau of Workers' Compensation**  
**1171 South Cameron Street, Room 103**  
**Harrisburg, Pennsylvania 17104-2501**  
**Telephone No. within Pennsylvania: 800-482-2383**  
**Telephone No. outside of this Commonwealth: 717-772-4447**  
**TTY – 800-362-4228 (for hearing and speech impaired only);**  
**[www.state.pa.us](http://www.state.pa.us), pa keyword: workers' comp.**

In addition, you can contact your human resources representative or the University's Workers' Compensation Office (814-865-0424) if you have any questions about Penn State's policies.

Also attached to this sheet is a complete list of panel physicians and medical providers for your reference.

I, \_\_\_\_\_, employee of The Pennsylvania State University, 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: \_\_\_\_\_

EMPLOYEE NAME (PRINTED): \_\_\_\_\_

EMPLOYER REPRESENTATIVE: \_\_\_\_\_ DATE: \_\_\_\_\_