pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

# PHYSICIAN'S AFFIDAVIT OF RECOVERY

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY (MM - DD - YYYY)

WCAIS CLAIM NUMBER

## EMPLOYEE

First name _____

Last name _____

Date of birth _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____

## EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

This is to certify that the aforementioned employee has fully recovered from the following work injury:

_____

_____

_____

_____

_____

_____

which occurred on the date shown above, and is able to resume, without limitation, his/her previous occupation of

_____ on ___ - ___ - ____ .
MM DD YYYY

This affidavit is based upon an examination of aforementioned employee performed by the undersigned physician on

___ - ___ - ____ .
MM DD YYYY

I attest or affirm that the statements contained herein are true and correct to the best of my knowledge, information and belief.

SUBSCRIBED AND SWORN TO (OR AFFIRMED) BEFORE ME THIS

_____ DAY OF _____, _____

## PHYSICIAN

First name _____

Last name _____

Signature _____

___ - ___ - ____
MM DD YYYY

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

**Employer Information Services**
717.772.3702

**Claims Information Services**
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

**Hearing Impaired**
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

**Email**
ra-li-bwc-helpline@pa.gov

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