KenCrest
Your Dreams. Our Mission.

WORKERS' COMPENSATION PANEL LIST DECLARATION FORM - PA

I hereby acknowledge that I have again been informed of and that I understand my rights and duties under the Pennsylvania Workers' Compensation Act and KenCrest Services Procedures. I have received a copy of the "KenCrest Services Notice to Employees regarding Pennsylvania Procedures for work-related injury or illness." Treatment was available and I choose: (please check one).

To seek medical treatment _____
(I understand that by signing to seek medical treatment, I must be seen by a panel physician for the first 90 days of treatment).

(Or)

To decline medical treatment _____ (I have been presented with the opportunity to see a panel physician and have declined treatment at this time. I will notify my supervisor if my situation changes and I wish to seek treatment at a later date).

_____ _____
Employee Signature Date

Signed by employee upon reporting a work-related injury. Please forward signed copy to Human Resources Department, Minyette Brown at Minyette.Brown@kencrest.org 215-260-1110 (cell) or Fax: 610-825-8514