North Carolina Industrial Commission

IC File #_____

Emp. FEIN_____

Carrier FEIN_____

Carrier File #_____

EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

To the Employer:
A copy of this Form 19 accompanied by a blank Form 18 must be given to the employee. It does not satisfy the employee's obligation to file a claim. The filing of this report is required by law.
This form MUST be transmitted to the Industrial Commission through your Insurance Carrier.

To the Employee:
This Form 19 is not your claim for workers' compensation benefits. To make a claim, you must complete and sign the enclosed **Form 18** and mail it to Claims Administration, N.C. Industrial Commission, 1235 Mail Service Center, Raleigh, NC 27699-1235 within two years of the date of your injury or last payment of medical compensation. For occupational diseases, the claim must be filed within two years of the date of disability or the date your doctor told you that you have a work-related disease, whichever is later.

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Employee's Name		Employer's Name		( ) - Telephone Number
Address		Employer's Address	City	State Zip
City	State Zip	Insurance Carrier	Policy Number	
( ) - Home Telephone	( ) - Work Telephone	Carrier's Address	City	State Zip
- - Social Security Number	☐ M ☐ F Sex / / Date of Birth	( ) - Carrier's Telephone Number	( ) - Fax Number	

Employer	1.	Give nature of employer's business
Time And Place	2.	Location of plant where injury occurred County Department State if employer's premises
	3.	Date of injury / / 4. Day of week Hour of day : ☐ A.M. ☐ P.M.
	5.	Was employee paid for entire day 6. Date disability began / /
	7.	Date you or the supervisor first knew of injury / / 8. Name of supervisor
Person Injured	9.	Occupation when injured
	10.	(a) Date employment began (b) Wages per hour $
	11.	(a) No. hours worked per day (b) Wages per day $ (c) No. of days worked per week (d) Avg. weekly wages w/ overtime $ (e) If board, lodging, fuel or other advantages were furnished in addition to wages, estimated value per day, week or month. $ per
Cause And Nature Of Injury	12.	Describe fully how injury occurred and what employee was doing when injured: (Statement made without prejudice and without vouching for correctness of information)
	13.	List all injuries and specify body part involved (e.g. right hand or left hand):
	14.	Date & hour returned to work / / at : .M. 15. If so, at what wages $ per
	16.	At what occupation 17. Employee's salary continued in full?
	18.	Was employee treated by a physician
Fatal Cases	19.	Has injured employee died 20. If so, give date of death (Submit Form 29) / /

Employer name _____ Date Completed / /

Signed by _____ Official Title _____

OSHA 301 Information:

Case Number from Log:	Date Hired: / /	Time Employee began work on date of incident: : ☐ A.M. ☐ P.M.	If off-site medical treatment provided, answer entire next line.
Name of facility:		Address: Street/City/Zip/Telephone	ER visit? ☐ Yes ☐ No / Overnight stay? ☐ Yes ☐ No

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

FOR IC USE ONLY
RESEARCHER:_____
CC:_____
EC:_____
DATA ENTRY:_____

FORM 19

SELF-INSURED EMPLOYER OR CARRIER, FILE AS **FROI** VIA **EDI: HTTP://WWW.IC.NC.GOV/EDIFORM19.HTML**

UNINSURED EMPLOYERS OR LUNG DISEASE CLAIMS:
E-MAIL TO: FORMS@IC.NC.GOV OR MAIL TO: NCIC - CLAIMS SECTION, 1235 MAIL SERVICE CENTER, RALEIGH, NC 27699-1235
MAIN TELEPHONE: (919) 807-2500 HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

IMPORTANT INFORMATION FOR EMPLOYER

Employer must furnish a copy of this form, as completed, to the employee or the employee's representative when submitted to the Insurance Carrier or Claims Administrator for transmission to the Commission. Every question must be answered. This Form 19 must be transmitted to the Commission through your insurance carrier/claims administrator, and is required by law to be filed within 5 days after knowledge of accident. Employer must also give employee a blank Form 18.

IMPORTANT INFORMATION FOR EMPLOYEE

Reporting an Injury

If you do not agree with the description or time of the accident given on this form, you should make a written report of injury to the employer within thirty (30) days of the injury.

Making A Claim

To be sure you have filed a claim, complete a Form 18, Notice of Accident, within two years of the date of the injury and send a copy to the Industrial Commission and to your employer. The employer is required by law to file this Form 19, but the filing of the Form 19 does not satisfy the employee's obligation to file a claim. The employee must file a Form 18 even though the employer may be paying compensation without an agreement, or the Commission may have opened a file on this claim. A claim may also be made by a letter describing the date and nature of the injury or occupational disease. This letter must be signed and sent to the Industrial Commission and to your employer.

FOR ASSISTANCE OR TO OBTAIN A FORM 18 FROM THE INDUSTRIAL COMMISSION, YOU MAY CALL (800) 688-8349

USE YOUR I.C. FILE NUMBER (IF KNOWN) OR SOCIAL SECURITY NUMBER ON
ALL FUTURE CORRESPONDENCE WITH THE COMMISSION

[SPANISH TRANSLATION]

INFORMACIÓN IMPORTANTE PARA LOS EMPLEADOS

Reporte de una Lesión (Reporting an Injury)

Si usted no está de acuerdo con la descripción o la hora del accidente que aparece en el formulario, debe hacer un reporte de la lesión por escrito y dárselo a su empleador dentro de un período de treinta (30) días a partir de la fecha de la lesión.

Cómo Presentar una Reclamación (Making a Claim)

Para ceriorarse de que ha presentado una reclamación, complete el Formulario 18 Notificación de Accidente dentro de un período de dos años a partir de la fecha de la lesión y envíe una copia a la Comisión Industrial y una copia a su empleador. Por ley, el empleador debe presentar el Formulario 19, sin embargo, el presentar el Formulario 19 no cumple con la obligación que tiene el empleado de presentar una reclamación. El empleado debe presentar el Formulario 18 aunque el empleador esté pagando compensación sin tener un acuerdo o si la Comisión ha creado un expediente con respecto a esta reclamación. También se puede presentar una reclamación por medio de una carta explicando la fecha y la naturaleza de la lesión o la enfermedad ocupacional. Esta carta se debe firmar y enviar a la Comisión Industrial así como al empleador.

PARA RECIBIR ASISTENCIA O PARA OBTENER EL FORMULARIO 18 DE LA COMISIÓN INDUSTRIAL, USTED PUEDE HABLAR AL (800) 688-8349

EN TODA LA CORRESPONDENCIA QUE ENVÍE A LA COMISIÓN INDUSTRIAL POR FAVOR ESCRIBA
EL NÚMERO DE CASO DESIGNADO POR LA COMISIÓN *[I.C. FILE NUMBER]* (SI LO SABE)
O SU NÚMERO DE SEGURO SOCIAL.

FORM 19

SELF-INSURED EMPLOYER OR CARRIER, FILE AS **FROI** VIA **EDI:**
HTTP://WWW.IC.NC.GOV/EDIFORM19.HTML

UNINSURED EMPLOYERS OR LUNG DISEASE CLAIMS:
E-MAIL TO: **FORMS@IC.NC.GOV** OR MAIL TO: **NCIC - CLAIMS SECTION, 1235 MAIL SERVICE CENTER, RALEIGH, NC 27699-1235**
MAIN TELEPHONE: **(919) 807-2500** HELPLINE: **(800) 688-8349**
WEBSITE: **HTTP://WWW.IC.NC.GOV/**

North Carolina Industrial Commission

IC File #_____

NOTICE OF ACCIDENT TO EMPLOYER AND CLAIM OF EMPLOYEE, REPRESENTATIVE, OR DEPENDENT

Emp. Code #_____

Carrier Code #_____

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Employee's Name

Address

City State Zip

( ) -
Home Telephone

- - ☐ M ☐ F / /
Social Security Number Sex Date of Birth

Employer's Name ( ) - Telephone Number

Employer's Address City State Zip

Insurance Carrier Policy Number

Carrier's Address City State Zip

( ) - ( ) -
Carrier's Telephone Number Carrier's Fax Number

EMPLOYEE – This form must be filed with the Industrial Commission within two years of the date of injury or occupational disease or your claim may be barred. Notice shall be given to the employer immediately after the accident or as soon as practicable and within 30 days. (This form should also be used for occupational disease claims; however, for asbestosis, silicosis and byssinosis, Form 18B is to be used.)

Notice is hereby given, as required by law, that the above-named employee sustained an injury or contracted an occupational disease, described as follows: _____ (Time of Injury) on ____/__/____ (Date (required)) at _____ (City and County). Describe the injury or occupational disease, including the specific body part involved (e.g., right hand, left hand) _____

Describe how the injury or occupational disease occurred: _____

Occupation when injured: _____ Nature of employer's business: _____

Number of days out of work due to injury:

Medical treatment received? ☐Yes ☐No

Weekly wage: $_____ Number of hours worked per day: _____ Days worked per week: _____

NOTE: If employee is unable to sign this form, another may sign for him. This form should be typed or printed by hand in black ink, if possible. Employee should retain one signed copy of this notice, mail one signed copy to the Industrial Commission at the address below, and provide one signed copy to employer.

Signature of (Check One) ☐ Employee, ☐ Attorney, ☐ Representative, or ☐ Dependent | Printed Name of Signer | E-mail Address | ( ) - Telephone Number

Address | City | State | Zip Code | / / Date Completed

EMPLOYER: This notice is being sent to you in compliance with requirements of the North Carolina Workers' Compensation Act, in order that the medical services prescribed by the Act may be obtained; and, if disability extends beyond 7 days duration, or if death ensues, compensation may be paid according to law.

FOR IC USE ONLY

RESEARCHER: _____
CC: _____
EC: _____
DATA ENTRY: _____

FORM 18

ATTORNEYS: FILE WITH AN **IC FILE NUMBER** VIA **EDFP**
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML OR
IF NO IC FILE NUMBER, FOLLOW EMPLOYEE FILING OPTIONS.
EMPLOYEES: E-MAIL TO: **FORMS@IC.NC.GOV**
OR MAIL TO: **NCIC - CLAIMS SECTION**
1235 MAIL SERVICE CENTER
RALEIGH, NC 27699-1235
MAIN TELEPHONE**: (919) 807-2500** HELPLINE: **(800) 688-8349**
WEBSITE: **HTTP://WWW.IC.NC.GOV/**

GENERAL INFORMATION ON THE FORM 18

1. What does a Form 18 do?

A Form 18 establishes a legal claim of injury on your behalf if filed within two years of the date of injury or occupational disease, and gives the required written notice to the employer if a copy is submitted to the employer within 30 days of the injury. The employer is required by law to file a Form 19 if the employee misses more than one day of work due to the injury or if the medical bills exceed $4,000.00. However, the employer's filing of a Form 19 does not satisfy the employee's obligation to file a claim. In order to ensure the employee's rights are protected, the employee must file a Form 18 even though the employer may be paying compensation or the Industrial Commission may have opened a file for the injury.

2. To whom should the Form 18 be sent?

The original Form 18 should be submitted to the Industrial Commission. The injured worker should keep one copy for his or her records and one copy should be submitted to the employer at the time of the injury.

3. What numbers do I write in the upper right corner?

You do not need to fill in the spaces on the upper right corner of the Form 18. If you know that your employer has already filed a report of injury, (Form 19) and you know what your I.C. (Industrial Commission), File Number is, you may write the number in the "I.C. File No." space. If you do not already have an I.C. File Number, the Industrial Commission will assign one upon receipt of the Form 18. The other two spaces "Emp. Code No." and "Carrier Code No." are for internal use only.

4. What if I do not know who my employer's insurance carrier is?

If you do not know who the employer's insurance carrier is you may either ask your employer for the information, call the Industrial Commission's Claims Administration Section at (800) 688-8349 then press "1" after the prompt, or simply leave the line blank.

5. When listing the number of days out of work, do I count partial days?

Yes, you include partial as well as whole calendar days not worked. However, the days do not need to be consecutive.

6. What happens after I file the Form 18?

The Industrial Commission will mail an acknowledgement letter to you after your Form 18 is processed. Processing time varies according to current workload. The Industrial Commission will mail a copy of the acknowledgement letter to the employer or its workers' compensation insurance carrier asking them to contact you and inform you if compensation will be paid to you voluntarily.

North Carolina Industrial Commission

IC File # _____

Emp. Code # _____

Carrier Code # _____

Employer FEIN _____

AVISO DE ACCIDENTE Y RECLAMO DEL EMPLEADO, REPRESENTANTE Ó DEPENDIENTE *(G.S. 97-22 HASTA 24)*

(Notice of Accident to Employer and Claim of Employee, Representative, or Dependent [*G.S. 97-22 through 24*])

El uso de esta forma se requiere bajo las provisiones de la Ley de Compensación Laboral para empleados.

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

Nombre del empleado

Nombre del empleador ( ) Número de telefóno

Domicilio

Domicilio del patrón

Ciudad Estado Código Postal

Ciudad Estado Código Postal

( ) Teléfono en el hogar

( ) Teléfono en el trabajo

Portador de Aseguranza

Número de Seguro Social ☐M ☐F Sexo / / Fecha de Nacimiento

EMPLEADO – Esta Forma debe ser enviada a la Comisión Industrial dentro los dos años siguiendo la fecha del la lesión o enfermedad laboral o su reclamo será excluído. Deberá avisarle a su empleador immediatamente después del accidente o tan pronto sea posible dentro de 30 días. (Esta Forma debe ser usada también para reportar una enfermedad de oficio; sin embargo, para asbestosis, silicosis y byssinosis, La Forma 18B debe ser usada.)

Aviso se da por este medio, segun los requisitos de la ley, que el empleado sufrió una lesión ó contrajo una enfermedad de oficio descrito como sigue: _____ el_____ en _____. Describa la lesión ó enfermedad
Hora de la lesión Fecha (Requerido) Ciudad y Condado
incluyendo la parte del cuerpo específicamente envuelta (e.g.mano derecha, mano izquierda)

Describe cómo ocurrió la lesión ó la enfermedad de oficio:_____

Ocupación el día del accidente:_____ Naturaleza del negocio del empleador:_____

Número de días fuera del trabajo debido a la lesión:

Recibió tratamiento medico: Si No

Compensación semanal:_____Número de horas que trabaja cada dia:_____Dias que trabaja por semana:_____

EMPLEADOR: Este aviso se le envia conforme con los requisitos del Acta de Compensación Laboral de Carolina del Norte; para poder obtener los servicios médicos prescritos por el Acta; y, si está incapacitado más de 7 días, o si resulta en la muerte, la indemnización puede ser pagada según la ley.

Firma (Check One) ☐ Empleado, ☐ Abogado, ☐ Representante, ó ☐ Dependiente

( ) Número telefónico

Domicilio Ciudad Estado Código postal Fecha Completado

AVISO – Si el lesionado no puede firmar esta forma, entonces otra persona puede firmar por él. Esta forma debe ser llenada a máquina si es posible, o con su letra en tinta negra. El trabajador debe quedarse con una copia, envie el original a la Comisión Industrial a la dirección que esta escrita en el mismo formulario, y envie una copia a su empleador.

For IC use ONLY
Nature_____
Body_____
Cause_____
SIC_____
Coder

FORMA 18

MAIL TO: NCIC - CLAIMS ADMINISTRATION
1235 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-1235
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

Informacion General Del Formulario 18

1. Qué es la Forma 18?

La forma 18 establece un reclamo legal al reportar heridas que hayan resultado de un accidente de trabajo. Debe ser sometida dentro de 2 años de la fecha de accidente o diagnóstico de la enfermedad de oficio. También satisface el requisito de notificarle al patrón por escrito, que ha ocurrido un accidente en el trabajo. Esta notificación debe ser entregada al patrón dentro de 30 días del acontecimiento o puede notificarlo verbalmente. El patrón tiene la obligación por ley de someter una Forma 19 si usted pierde un día de trabajo por resultado del accidente o si los gastos médicos exceden $4,000. Sin embargo, la Forma 19 no satisface la obligación del trabajador a someter una reclamación. El trabajador debe someter la Forma 18 para protejer sus derechos aunque esté recibiendo benficios o aunque la Comisión Industrial tenga un expediente abierto de su accidente.

2. **A quién se le debe enviar la Forma 18?**

La forma original debe ser enviada a la Comisión Industrial a la dirección que está en el mismo papel. El trabajador lesionado debe mantener una copia y otra copia debe ser entregada al patrón cuando ocurre la lesión.

3. Qué números debo escribir en la esquina superior derecha?

Usted no tiene que escribir nada en la esquina superior derecha en la Forma 18. Si Ud. sabe que su empleador ya sometió el reporte de la lesión (Forma 19) y usted sabe cuál es el número de archivo de IC (de la Comisión Industrial) usted puede escribir ese número en el espacio que dice “IC File #”. Si usted no tiene todavía un número de IC, entonces la Comisión Industrial le asignará un número cuando la forma sea procesada. Los otros tres espacios “Emp. Code No.,” “Carrier Code No.,” y “Employer FEIN” son para uso interno solamente.

4. Qué pasa si yo no sé cuál es el portador de seguro que tiene mi patrón?

Si usted no sabe quién es el portador de seguro, le puede preguntar a su patrón o puede llamar a la Comisión Industrial para obtener información al 1-800-688-8349 o puede dejar esa línea en blanco.

5. Cuando se lista el número de días fuera del trabajo, cuentan los días parciales?

Si, Ud. debe incluir tanto el tiempo parcial como los días calendarios completos que no haya trabajado. Sin embargo, los días no necesitan ser consecutivos.

6. Qué pasa después que yo envié la Forma 18?

La Comisión Industrial le enviará una carta de reconocimiento después que la Forma 18 sea procesada. El período de procesamiento puede variar de acuerdo al cargo de trabajo. La Comisión Industrial también le va a enviar una copia de reconocimiento al portador de seguro, pidiéndole a ellos que lo contacten y le informen si le van a pagar los beneficios voluntariamente.

North Carolina Industrial Commission

IC File # _____

Emp. Code # _____

Carrier Code # _____

EMPLOYEE'S APPLICATION FOR ADDITIONAL MEDICAL COMPENSATION (G.S. § 97-25.1)

CONTRACTED ON OR AFTER 5 JULY 1994)

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Employee's Name	Employer's Name ( ) Telephone Number
Address	Employer's Address City State Zip
City State Zip	Insurance Carrier
( ) Home Telephone ( ) Work Telephone	Carrier's Address City State Zip
XXX-XX- Last 4 Digits of SSN ☐ M ☐ F Sex / / Date of Birth	( ) Carrier's Telephone Number ( ) Fax Number

SECTION A. TO BE COMPLETED BY EMPLOYEE:

1. The above-named employee claims additional medical compensation as a result of an injury by accident or an occupational disease which occurred on or by _____ (Date) because _____

   _____
   (Reason for Additional Medical Compensation)
2. Additional medical and/or other supporting documentation ☐ is / ☐ is not attached (*optional*).
   (Place your I.C. File # on each attachment.)

_____
SIGNATURE OF EMPLOYEE DATE COMPLETED

Name and address of employee's attorney, if any: _____

_____

EMPLOYEE: SEND THE ORIGINAL OF THIS FORM AND ANY SUPPORTING DOCUMENTATION TO THE INDUSTRIAL COMMISSION AS INSTRUCTED AT THE BOTTOM OF THIS FORM AND SEND A COPY TO THE EMPLOYER OR CARRIER/ADMINISTRATOR.

SECTION B. TREATING PHYSICIAN'S STATEMENT (OPTIONAL) :

This is to certify that:

1. I am the above-named employee's treating physician. My area of medical practice is _____, and my treatment of the employee began on _____. (mo/day/yr)
2. In my opinion, there is a substantial risk that the employee will need the following additional medical care or monitoring (including medical, surgical, hospital, nursing, rehabilitation services, medicines, sick travel, replacement of artificial members, medical and surgical supplies, and other treatment): _____.

   The need for this medical treatment results from the injury by accident or occupational disease as set forth in Section A. above.

_____
SIGNATURE OF TREATING PHYSICIAN PRINTED NAME DATE

_____
ADDRESS CITY STATE ZIP

ATTORNEYS/CARRIERS:
FILE VIA ELECTRONIC DOCUMENT FILING PORTAL
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML

EMPLOYEE FILING OPTIONS:
E-MAIL TO EXECSEC@IC.NC.GOV
FAX TO (919) 715-0282
MAIL TO NCIC-EXECUTIVE SECRETARY
1236 MAIL SERVICE CENTER
RALEIGH, NC 27699-1236

HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

FORM 18M

North Carolina Industrial Commission

IC File # _____

STATEMENT OF DAYS WORKED AND EARNINGS OF INJURED EMPLOYEE

Emp. Code # _____

Carrier Code # _____

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Carrier File # _____

Employee's Name

Address

City State Zip

( ) - ( ) -
Home Telephone Work Telephone

XXX-XX- ☐ M ☐ F / /
Last 4 Digits of SSN Sex Date of Birth

Date of Injury: / /

( ) -
Employer's Name Telephone Number

Employer's Address City State Zip

Insurance Carrier

Carrier's Address City State Zip

( ) - ( ) -
Carrier's Telephone Number Fax Number

Year: **20**	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Amount Earned
Jan.																																
Feb.																																
Mar.																																
Apr.																																
May																																
June																																
July																																
Aug.																																
Sept.																																
Oct.																																
Nov.																																
Dec.																																
																														Total		

Was this employee given free rent, lodging, or board or other allowances made in lieu of wages? _____

If so, state weekly value thereof: $ _____ .

FORM 22

FILE VIA ELECTRONIC DOCUMENT FILING PORTAL
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML

The undersigned employer of _____,
(Name of Employee)

who alleges an injury on the _____ of _____, **20**__
(Day) (Month) (Year)

while in the employment of the undersigned, does hereby certify that the above is a true and correct statement of days worked and earnings of this employee during the 52 weeks immediately preceding the injury (or during the above weeks and parts thereof, if employed for less than 52 weeks) and while engaged in the occupation in which the employee was allegedly injured.

_____
Employer

By _____
Authorized Signature

/ /20__
Date Signed

To Employer: Making a false statement for the purpose of denying workers' compensation benefits may result in civil or criminal penalties.

INSTRUCTIONS

This form must be completed and filed with the Commission in all cases resulting in death unless maximum compensation rate is stipulated. It must also be filed in any other case if there is a disagreement about earnings or if the Commission requests it.

In preparing this form, place an X in the proper squares to indicate days paid in full. Days the employee is on paid vacation leave and/or paid sick leave should be marked with an X. Leave blank squares to indicate days not paid in full for any reason. Total earnings for each pay period should be placed in the proper column. If the employee's job or pay rate was changed during the reported period, this should be noted, with an indication as to the nature of the change.

The employer code number and the carrier code number, if any, must be inserted in the proper place at the upper right-hand corner of the form.