South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723 www.wcc.sc.gov

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ SSN: ___ - ___ - ____ Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) - _____ Work Phone: ( ) - _____ Insurance Carrier: _____

Preparer's Name: Law Firm: Preparer's Phone #: ( ) -

A claim for workers' compensation benefits is made based on the following grounds:

☐Injury ☐ Illness ☐ Repetitive Trauma ☐Occupational Disease ☐Physical Brain Injury ☐Concurrent Jurisdiction

1. The claimant sustained an injury to _____ (Part(s) of Body Injured) on _____ (Month/Day/Year) in _____ county, state of _____.
2. Body part(s) affected are: _____
   Briefly describe how the accident occurred. _____
3. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
4. The relationship of employer and employee existed at the time of injury.
5. At the time of the injury the claimant was performing services arising out of and in the course of employment.
6. Notice of the accidental injury was given to the Employer on _____ (Month/Day/Year) in the following manner:

☐7. Due to injury, the claimant is in need of (check one):

☐(a) medical examination and treatment for: _____

☐(b) additional medical examination and treatment for: _____

☐8. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:

☐9. Due to the injury, the Claimant has permanent disability of the following nature and extent (check one):

☐(1) General Disability: ☐Total ☐ Partial ☐(2) Specific Disability: ☐Total ☐ Partial ☐ (3) Wage Loss

9a. Claimant at MMI: ☐ Yes ☐ No

☐10. Due to the injury, the Claimant has a serious bodily disfigurement consisting of:

10a. At the time of the injury, the Claimant was paid weekly wages of $_____, and demands accounting of days worked and wages earned as provided by law.

10b. Give names and addresses of all employers for whom the Claimant has worked since the date of the accident:

11. Further grounds or unusual aspects of claim:

11a. List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident:

11b. To the best of your knowledge, did you have any prior permanent disability? _____
If yes, describe: _____

12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.

☐13. **I am filing a claim. I am not requesting a hearing at this time.** Estimated time needed for hearing: _____

☐14. **I am requesting a hearing. A $50 fee is required.**

☐ **Mediation**

- ☐a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
- ☐b. Mediation is required pursuant to Reg. 67-1802.
- ☐c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
- ☐d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to **mediation@wcc.sc.gov.**

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to_____

address_____ on the ___day of ____20__,by ☐ first class postage ☐certified mail ☐personal service ☐electronic service

I verify the contents of this form are accurate and true to the best of my knowledge.

_____ _____ _____ _____
Preparer's Signature Title Email Date

Questions about the use of this form should be directed to the Claims Department at 803.737.5723. Refer to Regulations 67-204 through 67-211 and Regulations 67-601 through 67-615 as well as Reg. 67-1801.

S.C. WORKERS' COMPENSATION COMMISSION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER | OSHA LOG NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION #

PHONE #

INDUSTRY CODE | EMPLOYER FEIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN | POLICY/SELF-INSURED NUMBER | ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | DATE HIRED | STATE OF HIRE

ADDRESS (INCL ZIP)

SEX

☐ Male
☐ Female
☐ Unknown

MARITAL STATUS

☐ Unmarried/Single/Divorced
☐ Married
☐ Separated
☐ Unknow

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

NCCI CLASS CODE

PHONE | # OF DEPENDENTS

RATE PER: ☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER:

DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ☐ AM (☐) CANNOT BE DETERMINED ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED
DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER | TYPE OF INJURY/ILLNESS | PART OF BODY AFFECTED

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE | PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK | IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)

INITIAL TREATMENT

0 ☐ No Medical Treatment
1 ☐ MINOR: BY EMPLOYER
2 ☐ MINOR CLINIC/HOSP
3 ☐ EMERGENCY CARE
4 ☐ HOSPITALIZED > 24 HOURS
5 ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER

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803-737-5722

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:
Enter all dates in MM/DD/YYYY format.

INDUSTRY CODE:
This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:
The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:
Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:
Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:
This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:
Indicate the employee's work status. The valid choices are:
Full-Time On Strike Unknown Volunteer
Part-Time Disabled Apprenticeship Full-Time Seasonal
Not Employed Retired Apprenticeship Part-Time Piece Worker

DATE DISABILITY BEGAN:
The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:
Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:
Briefly describe the nature of the injury or illness, (e.g. Lacerations to the forearm).

PART OF BODY AFFECTED:
Indicate the part of body affected by the injury/illness, (e.g. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:
(e.g. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

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EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(e.g. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(e.g. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (e.g. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

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Employer FEIN #: _____

Claimant's Name: _____ SSN: _____ Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Insurance Carrier: _____

Preparer's Name: _____ Law Firm: _____ Preparer's Phone #: _____

A claim for workers' compensation death benefits is made based on the following grounds:

The Claimant is _____ (relationship to employee) of _____ (employee's name)

1. The employee sustained an accidental injury to the _____ (Part of Body Hurt) on _____ (m/d/yyyy) in _____ County, State of _____.
2. Both the employee and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
3. The relationship of employer and employee existed at the time of injury.
4. At the time of the injury the employee was performing services arising out of and in the course of employment.
5. Notice of the accidental injury was given to the employer on _____ (m/d/yyyy) in the following manner:

_____

☐ 6. Due to injury, the employee received medical examination and treatment which remains unpaid by the employer.

☐ 7. Due to injury, the employee lost compensable time from work and wages for the periods of:

_____

☐ 8. The employee died on _____ (m/d/yyyy) as a result of the accidental injury, and death compensation is claimed.

9. At the time of the injury, the employee was paid weekly wages of $_____. The claimant demands an accounting of days worked and wages earned as provided by law.

10. Further grounds of claim:

_____

11. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.

☐ 12a. **I am filing a claim. I am not requesting a hearing at this time.**

☐ 12b. **I am requesting a hearing. A $50.00 fee is required.**

☐ **Mediation**

- ☐ a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
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I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to_____ address_____ on the _____day of _____20____, by ☐ first class postage ☐ certified mail ☐ personal service.

I verify the contents of this form are accurate and true to the best of my knowledge.

_____ _____ _____ _____
Preparer's Signature Title Email Date

Questions about the use of this form should be directed to the Judicial Department at 803.757.5675 or **judicial@wcc.sc.gov** or **mediation@wcc.sc.gov.** Refer to Regulations 67-205 through 67-211, 67-216, Regulations 67-601 through 67-615 and; Regulations 67-901 through 67-905 well as Reg. 67-1801.