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

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
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.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5722

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.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 ● Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5675
www.wcc.sc.gov

Physician's Statement

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

Physician's Name: _____ Insurance Carrier: _____

Practice/Clinic: _____ SCWCC File No: _____

Preparer's Name: _____ Phone: _____

The undersigned physician has been authorized to evaluate or treat this Claimant for his or her work injury or illness pursuant to *South Carolina Code Sections 42*–15-60, 42-15-80, 42-1-172, or 42-11-10.

Date of injury: _____ Date of first office visit: _____ Date of last office visit: _____

The medical opinions below are stated to a reasonable degree of medical certainty.

Diagnosis or nature of injury or illness: _____

Body part(s) injured: _____ Body part(s) affected: _____

Date of **maximum medical improvement**: _____

Has the Claimant sustained **permanent physical impairment** as a result of the work injury? _____ Yes _____ No

If so, the permanent physical impairment is: _____ % medical impairment to the _____ (injured body part).

If there is a permanent physical impairment to other body part(s) as a result of the work injury, please indicate below:
_____ % medical impairment to the _____ (additional body part injured or affected).

The impairment rating(s) above are based upon the following:

_____ The AMA's *Guides to the Evaluation of Permanent Impairment* _____ Edition; or
_____ Other medical treatise: _____ or
_____ Other: _____

Does the Claimant have **permanent physical limitations** as a result of the injury? _____ Yes _____ No

If so, the permanent physical limitations are: _____

Does the Claimant **possess retained hardware** as a result of the injury? _____ Yes _____ No

If so, the retained hardware is: _____

Is there **medical, surgical, hospital or other treatment** that the Claimant needs as a result of the injury for an additional time that will tend to lessen the period of disability or maintain the current level of function: _____ Yes _____ No

If so, the medical care and treatment that is needed is/are:

*An indication or statement that future medical care "may be necessary" or "might be necessary" is not sufficient and will require further clarification.

I certify that I am a physician or other licensed healthcare provider, I have personally read and prepared this document, and the opinions reflected above are mine.

_____ _____

Treating or Evaluating Physician **Date**

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723

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

Claimant's Name: _____ 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 #: ( ) -

Date of injury: (m/d/yyyy) Date of Notice to Employer of Injury: (m/d/yyyy)

I. Payment of Temporary Compensation Check one: ☐ Initial period ☐ Additional period ☐ Corrected compensation rate
(choose A, B, or C)

☐ A. Temporary Total at the compensation rate of $ per week. For this period of disability, disability began on and the date of first payment was (m/d/yyyy). (m/d /yyyy)

☐ B. Temporary Partial at the compensation rate of $ per week. Note: When the Temporary Partial compensation rate will vary, report the first payment here. Supplement this report throughout the period of Temporary Partial compensation by filing a **Form 15S** with the **Form 18**, which shall be filed six months after the date of injury and each six months thereafter until the file is closed.
For this period of disability, disability began on (m/d/yyyy), and the date of first payment was (m/d/yyyy).

Calculation of Temporary Partial Rate:

	Average weekly wage before injury	$
–	Current weekly wage	$
=	Difference in wages before injury and now	$ 0.00
x	.6667	$ 0.00
	Temporary Partial Compensation Rate	**$** 0.00

☐ C. Salary in lieu of Temporary ☐ Total ☐ Partial (choose one) compensation in the amount of $ per week. For this period of disability, disability began on (m/d/yyyy) and the date of first payment of salary in lieu of temporary compensation was (m/d/yyyy).

THIS SECTION SHALL BE USED ONLY WITHIN 150 DAYS AFTER NOTICE TO EMPLOYER OF THE INJURY.
EMPLOYER'S REPRESENTATIVE MUST DOCUMENT THE REASON FOR TERMINATION BELOW.

II. Termination of Temporary Compensation Temporary compensation payments were stopped on (m/d/yyyy) for the following reason:

☐ Claimant has returned to work at least 15 days and no temporary partial compensation is due.
☐ Claimant agrees he/she is able to return to work and has signed a **Form 17**.
☐ Based on a good faith investigation, the claim is denied. Reason for denial: _____
☐ Claimant has been released to return to work without restrictions and employment has been offered.
☐ Claimant has been released to work at limited duty and employer has provided limited duty work consistent with the terms upon which the Employee has been released.
☐ Claimant has refused medical treatment, examination, or evaluation. Note: Benefits must be resumed if claimant accepts the treatment, examination, or evaluation. Additional report must be filed if compensation is resumed.

I certify that this form has been served on the claimant per R.67-211.

_____ _____
Signature of Claims Administrator Date (m/d/yyyy)

III. Notice to Injured Worker or Legal Representative when Temporary Compensation Has Been Stopped:
If the employer's representative has terminated or suspended temporary compensation during the first 150 days after the employer received notice of the injury pursuant to Section 42-9-260, the claimant may request a hearing to dispute the termination or suspension of temporary compensation by signing below and filing the form pursuant to Reg. 67-207.

BY SIGNING BELOW I SWEAR OR AFFIRM THAT:
1) I HAVE RECEIVED THE FORM 15, SEC. II ABOVE TERMINATING OR SUSPENDING MY COMPENSATION; AND
2) I AM REQUESTING A HEARING TO DISPUTE THE TERMINATION OR SUSPENSION OF TEMPORARY COMPENSATION PURSUANT TO REG. 67-504(C).

_____ _____
Signature of Claimant or Legal Representative Date (m/d/yyyy)

Employer's representative must complete and file **Form 15** with Claims Department within ten days after compensation begins or is terminated. Employer's representative must serve the **Form 15** on the claimant when compensation begins per R.67-211. Employer's representative must prepare and serve **Form 20** within thirty days of beginning compensation per R.67-1603. Employer's representative must serve per R.67-211 the **Form 15** on claimant immediately on termination of compensation with documentation of the reason for the termination. Injured worker may contest termination of compensation within 150 days from the date of notice of the injury by completing section III of the **Form 15** and filing it with Judicial Department.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723

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 #: _____

Date of injury: _____
(m/d/yyyy)

Supplemental Report of Varying Temporary Partial Payments

From _____ through _____, Claimant was paid $_____ per week as temporary partial compensation. The weekly wage before the injury was $_____. The weekly wage for this period was $_____.

From _____ through _____, Claimant was paid $_____ per week as temporary partial compensation. The weekly wage before the injury was $_____. The weekly wage for this period was $_____.

From _____ through _____, Claimant was paid $_____ per week as temporary partial compensation. The weekly wage before the injury was $_____. The weekly wage for this period was $_____.

From _____ through _____, Claimant was paid $_____ per week as temporary partial compensation. The weekly wage before the injury was $_____. The weekly wage for this period was $_____.

From _____ through _____, Claimant was paid $_____ per week as temporary partial compensation. The weekly wage before the injury was $_____. The weekly wage for this period was $_____.

From _____ through _____, Claimant was paid $_____ per week as temporary partial compensation. The weekly wage before the injury was $_____. The weekly wage for this period was $_____.

From _____ through _____, Claimant was paid $_____ per week as temporary partial compensation. The weekly wage before the injury was $_____. The weekly wage for this period was $_____.

From _____ through _____, Claimant was paid $_____ per week as temporary partial compensation. The weekly wage before the injury was $_____. The weekly wage for this period was $_____.

From _____ through _____, Claimant was paid $_____ per week as temporary partial compensation. The weekly wage before the injury was $_____. The weekly wage for this period was $_____.

From _____ through _____, Claimant was paid $_____ per week as temporary partial compensation. The weekly wage before the injury was $_____. The weekly wage for this period was $_____.

In an ongoing period of temporary partial, when the compensation rate varies from week to week, the employer's representative shall report the first payment on a Form 15 according to R.67-503. Supplemental payments shall be reported on a Form 15S, to be filed with the document stopping that period of temporary partial compensation or with the Form 18, which shall be filed six months after the date of injury and each six months thereafter until the file is closed. R.67-503.

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: _____ Employer's Name: _____

Address: _____ Address: _____

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

Home Phone: _____ Work Phone: _____ Carrier: _____

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

This form is only applicable to injuries by accident occurring on or after July 1, 2007 pursuant to Title 42-15-60 (A) as amended. The execution of this document is an agreement between the parties relating to a Workers' Compensation claim under §§42-1-160, 42-1-172 or 42-11-10.

Date of Injury or Illness_____

The above parties agree to pay and accept compensation based on the following facts:
A compensable ☐ Injury ☐ Illness ☐ Repetitive Trauma occurred on: _____ (month/day/year).

The injury was to _____ body part(s) injured and also the injury affected other body part(s).
_____

The authorized treating physician has released the Claimant from his or her care and has found maximum medical improvement on _____ (month/day/year).
with an impairment rating of_____.

Average weekly wage $_____ Compensation rate $_____

By agreement of the parties, the following award has been referred to the Commission for approval:

____	Percentage loss of use to: _____	(body part(s) injured).	_____weeks
0.00	Percentage loss of use to: 0.00	(body part(s) affected).	0.00 weeks
____	Percentage loss of use to: whole person		_____weeks
	Disfigurement to: _____		_____weeks
	Wage Loss: $_____amount		_____weeks
	Total and Permanent Disability: _____		_____weeks
	Other: _____		_____weeks

Estimated award (number of weeks times compensation rate) $ _____
The estimated award is subject to verification by the Commission

Additionally, the Employer's Representative agrees to pay and the Claimant accepts the following medical care and treatment as recommended by the authorized treating physician pursuant to the attached physician's statement, **Form 14B**

Additional medical ordered: ☐ **Yes** ☐ **No** ☐
See attached 14B physician's statement dated: _____

This agreement is binding on approval by the Commission. A claim for additional compensation based on a worsening of the Claimant's condition **must be filed no later than one (1) year from the date of the last payment of compensation.** Only medical care specifically detailed herein will be paid under this agreement. If a dispute arises with regard to continued medical treatment, either party may request a hearing before the Commission pursuant to 42-15-60(B) 3 and (C).

_____	_____	_____
Claimant's Signature	Date Agreement Signed	Attorney/Witness/Translator
_____	_____	_____
Employer's Representative	Attorney for Carrier	Email
_____	_____	_____
Claims Mediator	Date Agreement Approved	Jurisdictional Commissioner

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723

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

Claimant's Name: _____ 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 #: _____

Date of injury: _____ (m/d/yyy)

1. Temporary Compensation Paid:

Number of Weeks	From	To	Amount
			$
			$
			$
			$
			$

2. The claimant returned to work on _____ (m/d/yyyy)
☐ With restrictions but at a salary not less than before the injury.
☐ Without restrictions.

3. The claimant agrees he or she was able to return to work on _____. (m/d/yyyy)

I agree that I was disabled for the period(s) indicated and I was paid compensation as shown above. **I UNDERSTAND THAT MY WEEKLY TEMPORARY COMPENSATION CHECKS WILL STOP; HOWEVER, I GIVE UP NO RIGHTS TO COMPENSATION FOR FUTURE DISABILITY, FOR PERMANENT DISABILITY, DISFIGUREMENT OR MEDICAL CARE.** The effect of this form has been fully explained to me, and I have received a copy of it. I understand that I should not sign this form until 15 days after I have returned to work or agree I was able to return to work.

_____ _____

Claimant's Signature Employer's Representative Signature

_____

(Check one) ☐ Witness ☐ Claimant's Attorney Date Agreement Signed

File this form with the Claims Department no later than 31 days from the date the claimant returned to work to terminate temporary compensation after the first 150 days after employer's notice of the injury according to R.67-505. Within the 150 period, obtain Form 17 to document that claimant agrees he or she is able to return to work.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723

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

Claimant's Name: _____ 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 #: ( ) -

1. Date of injury: _____ (m/d/yyyy) 2. Total Weeks Compensation Paid: _____

3. Type of Compensation Paid (TP or TT)/Periods of Payment:

		(m/d/yyyy)		(m/d/yyyy)
Type: _____	From: _____		To: _____	
Type: _____	From: _____		To: _____	
Type: _____	From: _____		To: _____	
Type: _____	From: _____		To: _____	

4. Date of First Payment: _____ (m/d/yyyy)

5. Total Amount Paid
   (a) Compensation: $ _____
   (b) Medical (Include Nursing, Hospital, Drugs, Etc.): $ _____

_____ ( ) - _____
Employer's Representative Phone Date

Type or print all information. File this form six months after the alleged injury date and each six months until the Commission's File is closed. Form 18 must be filed whether or not compensation is ongoing. Refer to R.67-413, and R.67-804 for further information.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723

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

Claimant's Name: _____ 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 #: _____

Compensation Paid:	Number of Weeks	From (m/d/yyyy)	To (m/d/yyyy)	Amount
1. Number of Weeks T.T.				$
2. Number of Weeks T.P.				$
3. Number of Weeks P.P.				$
4. Disfigurement				$
5. Agreement and Final Release				$
Total Compensation Paid				$
6. Total Medical Benefits* Paid				$
7. Funeral Benefits				$

☐ Case Denied

Date of Injury: _____ (m/d/yyyy)

By signing this receipt, I acknowledge that I have received the compensation shown above.

By: _____ By: _____ _____

Claimant | Employer's Representative | Date (m/d/yyyy)

_____

Print or type the name of the person, other than the claimant, receiving benefits and sign below.

By: _____

Report of Additional Fees and Recoupment

A. Carrier Reimbursement by Third Party $ _____

B. Attorney's Fee Paid by Employer $ _____

C. Attorney's Fee Paid by Claimant (Non-contingent fees only) $ _____

File this form with the Claims Department according to R.67-414 and R.67-1204. A person, other than the claimant, receiving benefits should sign on the line provided. * Do not include as medical costs fees paid for expert testimony, fees for determining carrier's liability, costs of autopsy, birth and death certificates and impartial examination. Form 19 must be filed within 16 days of final payment of compensation. Form 19 must be filed when a claim is denied.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723

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

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

Address: _____ Address: _____

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

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

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

Date of Injury: _____
month day year

A. Total Wages Paid

1. Check Applicable Method:
   - ☐ Report of earnings of injured employee based on four completed quarters.
   - ☐ Report of earnings of injured employee who did not complete four quarters based on actual time worked.
   - ☐ Report of earnings of similar employee. Injured employee did not work sufficient time before alleged injury. Hire date: _____
   - ☐ Report of earnings of injured employee based on alternative method because Form 20 results in a compensation rate that is not fair and just (attach documentation to show how average weekly wage and compensation rate were calculated).

2. List total wages paid as reported to the Employment Security Commission on the Employer Quarterly Contribution and Age Reports during the four quarters immediately preceding the quarter in which the injury occurred. Do not include the quarter during which the injury occurred.

Quarter	Ending Date	Total Wages Paid
1st		$
2nd		$
3rd		$
4th		$

Total Paid 2. $ _____

3. List total value of other allowances of any character made in lieu of wages during four quarters above. 3. $ _____

4. Add lines 2 and 3. **TOTAL WAGES PAID:** 4. $ _____

5. List total number of weeks paid to employee during the four quarters immediately preceding the quarter in which the injury occurred. 5. _____

B. Average Weekly Wage

6. To calculate average weekly wage, divide total wages (line 4) by total weeks paid (line 5).

AVERAGE WEEKLY WAGE: 6. $ _____

C. Compensation Rate

7. The general rule for calculating the compensation rate is to multiply average weekly wage (line 6) by .6667. Estimate compensation rate by multiplying average weekly wage (line 6) by .6667. See part 8 below to determine the actual compensation rate. 7. $ _____

8. The compensation rate is as follows (choose one):
   - ☐ When average weekly wage (line 6) is less than $75.00, the compensation rate is the average weekly wage. Enter average weekly wage on line 8.
   - ☐ When the estimated compensation rate (line 7) is less than $75.00 and average weekly wage (line 6) is more than $75.00, the compensation rate is $75.00. Enter $75.00 on line 8.
   - ☐ When the estimated compensation rate (line 7) is more than the maximum compensation rate for the year in which the injury occurred, enter the maximum compensation rate for the year in which the injury occurred on line 8.
   - ☐ Employee is within the exceptions listed in S.C. Code Ann. Section 42-7-65. List applicable exception here and enter appropriate compensation rate on line 8. _____
   - ☐ The calculated compensation rate (line 7) applies. Enter amount from line 7 on line 8.

WEEKLY COMPENSATION RATE: 8. $ _____

Employer's representative shall prepare a Form 20 and serve per R.67-211 a copy on the claimant within thirty days of beginning temporary compensation. See R.67-1603 when no temporary compensation is paid. NOTE: Average weekly wage represents average gross pay before taxes and other deductions. WHEN THE CLAIMANT DOES NOT AGREE WITH THE COMPENSATION RATE ON LINE 8, HE OR SHE SHOULD CONTACT THE EMPLOYER'S REPRESENTATIVE TO TRY TO REACH AN AGREEMENT AS TO THE COMPENSATION RATE. IF NO AGREEMENT CAN BE REACHED, THE CLAIMANT SHOULD CONTACT THE CLAIMS DEPARTMENT AT (803)737-5723.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737.5675 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 #: (___) ___-_____

The date of injury reported on Form 12A is: _____ (m/d/yyyy)

Check appropriate section(s). The Employer's Representative requests a hearing to:

I. ☐ **Stop payment of compensation.** Claimant has reached maximum medical improvement and Claimant continues to receive temporary compensation payments. The employer's representative requests a hearing pursuant to § 42-9-260(D) to stop payment of temporary compensation. A hearing requested pursuant to this section must be held within sixty days of the date of the request.

Claimant reached maximum medical improvement on_____ (m/d/yyyy) (copy of medical report must be attached).
Compensation payments are current as of _____ (m/d/yyyy) and shall continue until otherwise ordered or until Form 17 is signed by the claimant.
A Form 17 was offered and refused on _____ (m/d/yyyy).

II. ☐ **Address suspension, termination, or reduction of temporary disability payments for any cause.**

☐ a. At any time pursuant to § 42-9-260(E).

☐ b. After the one-hundred-fifty day period has expired pursuant to § 42-9-260(F), R.67-505 and R.67-506.

The basis for the termination/ suspension is _____

III. ☐ **Determine if compensation is due** pursuant to § 42-9-10, § 42-9-20 or § 42-9-30 and, if so, in what amount, based on the following grounds:

_____

Claimant reached maximum medical improvement on_____ (m/d/yyyy) (copy of medical report must be attached).

IV. ☐ **Request Credit for Overpayment of temporary compensation pursuant to § 42-9-210.**

V. ☐ **Determine amount of compensation for claims involving a fatality.**

☐ a. Payment of unpaid balance of compensation when employee dies pursuant to § 42-9-280.

☐ b. Amount of compensation for death of employee due to accident pursuant to § 42-9-290.

VI. ☐ **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.

Failure to respond pursuant to Reg. 67-208 B in writing may result in ordered mediation pursuant to Reg. 67-1801 B.
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. A $50.00 filing fee and updated Form 18 is required.**

Preparer's Signature _____ Title _____ Email _____ Date _____

Questions about the use of this form should be directed to the Judicial Department at 803-737-5675, or **judicial@wcc.sc.gov** or **mediation@wcc.sc.gov**
Refer to Regulations 67-211, 67-504, 67-505, 67-506; and 67-510.

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.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5675 www.wcc.sc.gov

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

Claimant's Name: _____ SSN: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Date of Injury: _____

Employer's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Insurance Carrier: _____

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

Date of Injury or Illness: _____ **Estimated time for hearing:** _____

Complete each information blank. Clearly specify when contentions are admitted in part and denied in part. The Employer/Carrier in answer to the claim, respectfully shows:

1. It is ☐ **Admitted** ☐ **Denied** the employee sustained an injury or illness on or about the date set forth in the Form 50. The reasons for denial are:

2. It is ☐ **Admitted** ☐ **Denied** both the employer and employee were subject to the Workers' Compensation Act at the time in question. The reasons for denial are:

3. It is ☐ **Admitted** ☐ **Denied** the relationship of employer and employee existed at the time in question. The reasons for denial are:

4. It is ☐ **Admitted** ☐ **Denied** at the time in question the employee was performing services arising out of and in the course of employment. The reasons for denial are:

5. It is ☐ **Admitted** ☐ **Denied** notice of injury was given the employer. The reasons for denial are:

6. It is ☐ **Admitted** ☐ **Denied** the employee ☐ **Needs** ☐ **Is Entitled to Additional** medical care as a result of injury or illness. The reasons for denial are:

7. It is ☐ **Admitted** ☐ **Denied** the employee is entitled to temporary total disability for the period(s) of : _____

8. It is ☐ **Admitted** ☐ **Denied** the employee is permanently disabled. The reasons for denial are:

9. It is ☐ **Admitted** ☐ **Denied** the employee has serious disfigurement.

10. It is contended that an average weekly wage of **$** _____ applies, according to attached Form 20 as provided by law.

11. Further contentions, grounds of defense, or unusual aspects are:

☐ **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 _____

Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615. Refer to R. 67-1801 for mediation. Questions about the use of this form may be directed to the Commission's Judicial Department at 803-737-5675 or **judicial@wcc.sc.gov** or **mediation@wcc.sc.gov**. Pursuant to R.67-606, a Form 20 must be filed with the Claims Department at least 30 days from the date of filing this form.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5675 www.wcc.sc.gov

PRE-HEARING BRIEF
WCC File No:_____

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

Address: _____ Address: _____

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

Home Phone: _____ Work Phone: _____ Carrier: _____

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

A claim for workers' compensation benefits is made based on the following grounds:
☐ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: _____ 2. AWW: $_____ **Date of Injury:** _____
3. Type of injury and body part(s): _____
4. Facts in controversy:

5. Legal issues involved:

0.00

6. Unusual aspects: 0.00
7. Witnesses (designate if expert):*

0.00

8. Exhibits:

9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance):

10. Name, address, and specialty, if any, of the treating physician:

11. Impairment rating(s); body part(s); physician and date of opinion:
12. I am amending my Form 50/51 in the following manner:

☐ **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.

Signature: _____ Email: _____

Date of hearing: _____ Time needed for hearing: _____

Questions about the use of this form should be directed to the Jurisdictional Commissioner. Refer to Regulations 67-204 through 67-211 and Regulations 67-601 through 67-615; as well as Regulation 67- 1801. File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports. * Commissioners reserve the right to admit expert witnesses at hearings.