North Carolina Industrial Commission

IC File #_____

Emp. Code #_____

Carrier Code #_____

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

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

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.

Social Security Number Disclosure Statement

The North Carolina Public Records Act (N.C. Gen. Stat. § 132-1.10) permits the North Carolina Industrial Commission to request a social security number from an individual when doing so is imperative to the performance of its duties and responsibilities. The purpose of requesting your social security number on this form is for the Industrial Commission to verify the correct employer with the North Carolina Department of Commerce, Division of Employment Security and to identify workers' compensation insurance coverage. The disclosure of a social security number by an individual to the Industrial Commission is voluntary. Social security numbers are confidential and exempt from public disclosure by the Industrial Commission. The Industrial Commission may not share your social security number unless otherwise permitted to do so pursuant to N.C. Gen. Stat. § 132-1.10.

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

Medical treatment received? ☐ Yes ☐ No Number of days out of work due to injury: _____

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 "3" 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 #_____

CLAIM BY EMPLOYEE, REPRESENTATIVE, OR DEPENDENT FOR BENEFITS FOR LUNG DISEASE

Emp. Code #_____

Carrier Code #_____

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

Social Security Number Disclosure Statement

The North Carolina Public Records Act (N.C. Gen. Stat. § 132-1.10) permits the North Carolina Industrial Commission to request a social security number from an individual when doing so is imperative to the performance of its duties and responsibilities. The purpose of requesting your social security number on this form is for the Industrial Commission to verify the correct employer with the North Carolina Department of Commerce, Division of Employment Security and to identify workers' compensation insurance coverage. The disclosure of a social security number by an individual to the Industrial Commission is voluntary. Social security numbers are confidential and exempt from public disclosure by the Industrial Commission. The Industrial Commission may not share your social security number unless otherwise permitted to do so pursuant to N.C. Gen. Stat. § 132-1.10.

Employee's Name	☐ M ☐ F / / Social Security Number Sex Date of Birth
Address	If Employee is deceased, list Personal Representative
City State Zip	Spouse's Name
( ) ( ) Employee's Home Telephone Work Telephone	Name of Attorney if represented

PRINT OR TYPE ALL ANSWERS

Notice is hereby given, as required by law, that the above-named employee sustained an occupational disease caused by exposure to: cotton dust ☐ ; silica ☐ ; asbestos ☐ ; or other substance ☐ and, if known, state substance:_____.
Date of diagnosis _____ By: Dr. _____ Attach diagnosing medical records.
Date of death, if applicable_____

Employer-Defendants
Attach additional pages if necessary

Employer Name: _____ Telephone: (___) _____ Dates of Employment _____
Address: _____ Location of Job(s) _____
City State Zip _____

Employer Name: _____ Telephone: (___) _____ Dates of Employment _____
Address: _____ Location of Job(s) _____
City State Zip _____

Employer Name: _____ Telephone: (___) _____ Dates of Employment _____
Address: _____ Location of Job(s) _____
City State Zip _____

IT IS REQUIRED THAT BOTH PAGES OF THIS FORM BE COMPLETED IN ORDER TO PROCESS THIS CLAIM

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

FORM 18B

Employment History, Beginning with Most Recent Employment (Attach additional pages if necessary):

Employer	From / To:	Employer's Type of Business	Employee's Job Title
If you were exposed to the listed substance(s) while working for this employer, describe in detail the exposures:			

Employer	From / To:	Employer's Type of Business	Employee's Job Title
If you were exposed to the listed substance(s) while working for this employer, describe in detail the exposures:			

Employer	From / To:	Employer's Type of Business	Employee's Job Title
If you were exposed to the listed substance(s) while working for this employer, describe in detail the exposures:			

List the names and addresses of all family physicians, treating physicians and hospitals that have provided medical services or treatment to you over a 20 year period prior to the filing of this claim.

Year	**Name**	**Address (City)**	**Purpose for which treated (if known)**

I hereby authorize the above named medical sources to disclose medical records (including images such as x-rays, CT scans, MRIs, sonograms, etc.) regarding my treatment, hospitalization, and/or outpatient care for any condition during the period(s) identified above to all parties (including insurance companies) or State agencies that may review my application for compensation. I also hereby authorize that a photocopy of this authorization be accepted with the same authority as this original. The information disclosed will be used in connection with my claim for benefits under the Workers' Compensation Act.

I understand this authorization will automatically expire when my application for benefits is finally decided.

_______________________________________ ( ) ____________________

Signature of (Check One) ☐ Employee, ☐ Attorney, ☐ Representative, or ☐ Dependent

Telephone Number

____

Address City State Zip Date Completed

Employee should return original of this form to the Industrial Commission, furnish his/her employer with one signed copy and retain a copy.

FORM 18B

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

North Carolina Industrial Commission

IC File #_____

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

Emp. FEIN_____

Carrier FEIN_____

Carrier File #_____

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 #_____

DENIAL OF WORKERS' COMPENSATION CLAIM (G.S. §97-18(c) AND G.S. §97-18(d))

Emp. Code #_____

Carrier Code #_____

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

Carrier File #_____

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
XXX-XX- Last 4 Digits of SSN	☐ M ☐ F Sex	/ / Date of Birth	( ) - Carrier's Telephone Number	( ) - Fax Number	
Date of Injury:					

TO EMPLOYEE (TO DEPENDENT(S) OR NEXT OF KIN IN CASE OF DEATH):

This is to inform you that the claim for the
☐ injury on _____, or
☐ occupational disease as of _____, or
☐ death on _____

is **DENIED** for the following reasons:

		/ /
SIGNATURE EMPLOYER OR CARRIER/ADMINISTRATOR	**TITLE**	**DATE**

Employer/Insurance Carrier must provide a detailed statement of the grounds for denying compensability of the claim or liability for the claim where payments have previously been made without prejudice under N.C. Gen. Stat. § 97-18(d). Failure to specify a particular ground may preclude asserting certain defenses at a later date pursuant to N.C. Gen. Stat. § 97-18(f).

Employee: If you disagree with this denial, you are entitled to request a hearing by submitting a Form 33. If you need assistance you may contact the Industrial Commission at the address below or telephone the Industrial Commission at (800) 688-8349.

Employer: A copy of this form shall be sent to the employee and employee's attorney of record, if any, and all known health care providers which have submitted bills to the employer/carrier. The original of this form shall be sent to the Industrial Commission at the address below.

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

FORM 61

CONTACT INFORMATION:
NCIC- CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

North Carolina Industrial Commission

IC File #_____

EMPLOYER'S ADMISSION OF EMPLOYEE'S RIGHT TO COMPENSATION (G.S. § 97-18(b))

Emp. Code #_____

Carrier Code #_____

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

Carrier File #_____

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
XXX-XX- Last 4 Digits of SSN	☐ M ☐ F Sex	/ / Date of Birth	( ) - Carrier's Telephone Number	( ) - Fax Number	

TO DEFENDANTS: Describe with particularity the body part(s) or condition(s) for which you are admitting liability and compensability.
TO EMPLOYEE: Your employer admits your right to compensation for an

☐ injury by accident on __/__/____ (date) (Specify body part(s) involved):

☐ occupational disease on __/__/____ (date) (Specify condition(s) and body part(s) involved):

THE FOLLOWING ITEMS 1 THROUGH 4 ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY AND DO NOT CONSTITUTE AN AGREEMENT:

1. The description of the injury or occupational disease, including body parts involved is:

2. The employee was paid for the entire day of injury. ☐ Yes ☐ No
3. The employee's average weekly wage, subject to verification, including overtime and all allowances, was $_____, which results in a weekly compensation rate of $_____.
   - ☐ a. Temporary total compensation is being paid at the compensation rate above.
   - ☐ b. Temporary partial compensation is being paid in the amount of $_____.
   - ☐ c. Other: _____
4. The disability resulting from the injury began on __/__/____ (date), and compensation commenced on __/__/____ (date).

_____ / /

SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR **TITLE** **DATE**

EMPLOYER: Failure to file Form 28B, Report of Compensation and Medical Compensation Paid, within 16 days after last payment pursuant to an agreement or award subjects employer or carrier/administrator to a penalty pursuant to N.C. Gen. Stat. § 97-18(h). Form 30 must be used for compensable injuries resulting in death. A copy of this Form 60 shall be provided to the employee and the employee's attorney of record, if any, and the original provided to the Industrial Commission at the address below.

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03/2020
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FORM 60

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

CONTACT INFORMATION:
NCIC-CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

North Carolina Industrial Commission

IC File # _____

Emp. Code # _____

Carrier Code # _____

Carrier File # _____

NOTICE TO EMPLOYEE OF PAYMENT OF COMPENSATION WITHOUT PREJUDICE (G.S. § 97-18(d)) OR PAYMENT OF MEDICAL BENEFITS ONLY WITHOUT PREJUDICE (G.S. § 97-2(19) & § 97-25)

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
XXX-XX- Last 4 Digits of SSN	☐ M ☐ F Sex	/ / Date of Birth	( ) - Carrier's Telephone Number	( ) - Fax Number	

TO EMPLOYEE (TO DEPENDENT(S) OR NEXT OF KIN IN CASES OF DEATH):

This is to inform you with regard to your claim for

☐ injury on __/__/____ (date) (Specify body part(s) involved):

☐ occupational disease as of __/__/____ (date) (Specify condition(s) and body part(s) involved):

☐ death on __/__/____ (date)

TO EMPLOYER/CARRIER: FILL OUT ONLY THE APPLICABLE SECTION 1 OR 2 BELOW
NOTE: THE FOLLOWING ARE FOR INFORMATIONAL PURPOSES ONLY AND DO NOT CONSTITUTE AN AGREEMENT

SECTION 1: INDEMNITY BENEFITS

☐ Payments of workers' compensation benefits, both indemnity (money) and medical, will be made without prejudice to later deny your claim or Defendants' liability. Compensation may be continued during the investigation of your claim. The investigation may take up to 90 days, with a possible 30 day extension. During this period, Defendants may admit liability; contest your claim or Defendants' liability; or by Defendants' lack of action, waive the right to contest your claim.

The date on which Defendants first had written or actual notice of this claim was __/__/____(date)

Disability began on __/__/____(date) and the first payment of compensation is being mailed on__/__/____ (date)

Subject to verification, employee's average weekly wage was $_____, which results in a weekly compensation rate of $_____.

SECTION 2: MEDICAL BENEFITS ONLY (PAID WITHOUT PREJUDICE, NOT SUBJECT TO 90-DAY REQUIREMENT IN SECTION 1 ABOVE)

☐ Payment of medical compensation is expressly being made without prejudice to Defendants to later deny the compensability of your claim. In the event you miss more than 7 days of work, you must notify your employer or carrier because you may be entitled to additional benefits. Completion of this section (Section 2) does not constitute an agreement to pay indemnity (money) benefits to you under G.S. § 97-18(d).

The date on which Defendants first had written or actual notice of this claim was __/__/____(date).

SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR	**TITLE**	/ / **DATE**

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

CONTACT INFORMATION:
NCIC-CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

North Carolina Industrial Commission

IC File # _____

Emp. Code # _____

Carrier Code # _____

Carrier File # _____

NOTICE OF REINSTATEMENT OR MODIFICATION OF COMPENSATION (G.S. § 97-32.1 OR § 97-18(b))

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
XXX-XX- ☐ M ☐ F	/ /		( ) -	( ) -	
Last 4 Digits of SSN Sex	Date of Birth		Carrier's Telephone Number	Fax Number	
Date of Injury:					

Compensation in the amount of $. _____ per week was reinstated or modified on _____ pursuant to ☐ N.C. Gen. Stat. § 97-32.1

or

☐ N.C. Gen. Stat. § 97-18(b).

Give reason for reinstatement or modification:

The employee's average weekly wage, including overtime and all allowances, was $. _____, which results in a weekly compensation rate of $. _____.

☐ a. Temporary total compensation is being paid at the compensation rate above.

☐ b. Temporary partial compensation is being paid in the amount of $. _____.

☐ c. Other: _____.

SIGNATURE EMPLOYER OR CARRIER/ADMINISTRATOR	TITLE	/ / DATE

Employer: The original of this form must be sent to the Industrial Commission at the address below. A copy shall be provided to the employee and the employee's attorney of record, if any.

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

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FORM 62

CONTACT INFORMATION:
NCIC-CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

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.

North Carolina Industrial Commission

REPORT OF EARNINGS

IC File #_____

Emp. Code #_____

Carrier Code #_____

Carrier File #_____

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

(EMPLOYER/INSURANCE CARRIER TO COMPLETE THIS SECTION)

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

To Employees: The Employer/Insurance Carrier periodically needs to verify your continuing eligibility for workers' compensation benefits and to update their records. **You are required to complete Page 2 of this Report of Earnings and return it to the insurer or employer address provided on page 2 of this form within 15 days after receipt of this form, even if you have no earnings.**

****YOUR WORKERS' COMPENSATION BENEFITS MAY BE SUSPENDED IF YOU FAIL TO COMPLETE THIS REPORT IN A TIMELY MANNER.****

NOTICE TO EMPLOYEES RECEIVING WORKERS' COMPENSATION

When you are receiving weekly workers' compensation benefits, YOU MUST REPORT ANY EARNINGS YOU RECEIVE TO THE INSURANCE CARRIER (OR EMPLOYER IF THE EMPLOYER IS SELF-INSURED) THAT IS PAYING YOU THE BENEFITS. "Earnings" include any cash, wages or salary received from self-employment or from any employment other than the employment where you were injured. Earnings also include commissions, bonuses, and the cash value for all payments received in any form other than cash (e.g., a building custodian receiving a rent-free apartment). Commissions, bonuses, etc., earned before your disability do not constitute earnings that must be reported.

You must report any work in any business, even if the business lost money or if profits or income were reinvested or paid to others.

Your endorsement on a benefit check or deposit of the check into an account is your statement that you are entitled to receive workers' compensation benefits. Your signature on a benefit check is a further affirmation that you have made no false claims or statements or concealed any material fact regarding your right to receive workers' compensation benefits.

MAKING FALSE STATEMENTS FOR THE PURPOSE OF OBTAINING WORKERS' COMPENSATION BENEFITS MAY RESULT IN CIVIL AND CRIMINAL PENALTIES.

TIME PERIOD COVERED BY THIS REPORT: _____ to _____

(Employer/Insurance Carrier must complete)

FORM 90

NORTH CAROLINA INDUSTRIAL COMMISSION
1240 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-1240
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

EMPLOYEE: COMPLETE SECTION BELOW

(1) Did you receive earnings from work during the time period indicated on Page 1? ☐ YES ☐ NO

(2) Did you work for a business or any person during that time period? ☐ YES ☐ NO

(3) If you answered **NO** to both questions 1 and 2, **sign and return** the form to the insurance carrier or to the individual identified by the insurance carrier or employer listed below.

(4) If you answer **YES** to either question, **complete item 5 below,** sign and return the form to the insurance carrier or to the individual identified by the insurance carrier or employer listed below. For the purposes of this statement, "Gross Earnings" include all pre-tax earnings, bonuses, commissions, and/or the cash value of any payment received in any form other than cash.

(5) 1st Employer or Business Name (include self-employment):

Location: _____
Dates worked: _____
Gross Earnings: _____

Next Employer or Business Name (include self-employment):

Location: _____
Dates worked: _____
Gross Earnings: _____

Attach additional page(s) if necessary.

Employee Signature: _____ **Date:** _____.
(Required)

NOTICE TO EMPLOYEE:

Failure to report earnings as defined herein may subject you to criminal prosecution and civil liability including the suspension or forfeiture of your benefits. The Form 90 must be signed and returned to the insurance carrier listed below even if you have no earnings.

NOTICE TO PARTIES:

11 NCAC 23A .0903(c) provides that if the employee fails to complete and return the Form 90 within 30 days of receipt of the form, a Form 24 Application may be filed to request suspension of compensation being paid pursuant to G.S. 97-29.

11 NCAC 23A .0903(d) provides that if compensation is suspended pursuant to 11 NCAC 23A .0903(c) and the employee subsequently completes and returns the Form 90, the employee's compensation shall be reinstated with back payment unless the Form 90 indicates the employee is not eligible for continuing disability compensation. If the Form 90 indicates continuing eligibility for temporary partial disability compensation, payment of compensation pursuant to G.S. 97-30 shall be made with back payment within 14 days of receipt of documentation establishing the amount of compensation due. If payment of compensation is not reinstated following submission of the completed Form 90 and the employee claims entitlement to ongoing disability compensation, the employee may seek reinstatement by filing a Form 23 Application or Form 33 hearing request.

Insurance carrier or Employer must list the name and address below of the person to whom this form must be returned.
11 NCAC 23A .0903(b) provides that the Form 90 shall be sent to the employee by certified mail, return receipt requested, and shall include a self-addressed stamped envelope for the return of the form. When the employee is represented by an attorney, the Form 90 shall be sent only to the attorney for the employee and shall be sent by any method of transmission that provides proof of receipt, including electronic mail, facsimile, or certified mail, return receipt requested.

Name: _____.

Address: _____.
City State Zip

FORM 90

NORTH CAROLINA INDUSTRIAL COMMISSION
1240 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-1240
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

NOTICE TO INSURER OR EMPLOYER:
Any person who willfully makes a false statement or representation of a material fact for the purpose of denying or assisting another in denying any benefit or payment under the Workers' Compensation Act shall be guilty of a Class 1 misdemeanor if the amount at issue is less than $1000. Violation is a Class H felony if the amount at issue exceeds $1000. Any person who threatens an employee with criminal prosecution under the provisions of the Act for the purpose of coercing or attempting to coerce an employee into agreeing to compensation under the Act shall be guilty of a Class H felony.

FORM 90

NORTH CAROLINA INDUSTRIAL COMMISSION
1240 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-1240
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

North Carolina Industrial Commission

IC File #_____

RETURN TO WORK REPORT

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

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

Employer: The use of this form is not appropriate when an employee has returned to work on a trial return to work basis pursuant to N.C. Gen. Stat. § 97-32.1, in which case Form 28T must be used. By using this form you are stating that this case is not a trial return to work and that one of the exclusions contained in NCIC Rule 404A(7) applies.

Important Notice To Employee: Your disability compensation has been stopped because you have returned to work. You are entitled to a trial return to work for a period not to exceed nine months, unless you have been released by an authorized treating physician to unrestricted work, in which case your trial return to work may be limited to 45 days. During your trial return to work, you may be entitled to partial disability compensation if, because of your on-the-job injury, you earn less wages now than before your injury. If your trial return to work is unsuccessful, you should complete form 28U in order to request that your compensation be reinstated.

THE EMPLOYER OR CARRIER/ADMINISTRATOR MUST COMPLETE THE FOLLOWING WHEN EMPLOYEE RETURNS TO WORK OTHER THAN ON A TRIAL RETURN TO WORK BASIS.

SECTION A. COMPLETE THE FOLLOWING:

1. Date of injury: _____
2. Date disability began: _____
3. Date returned to work: _____

SECTION B. COMPLETE IF EMPLOYEE RETURNED TO WORK FOR REDUCED WAGES:

Employee is being paid at the rate of $ _____ weekly.

SECTION C. COMPLETE IF EMPLOYEE RETURNED TO WORK FOR A DIFFERENT EMPLOYER:

1. Name of that employer: _____
2. Address: _____
3. Telephone: _____

SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR **TITLE** **DATE**

Employer: The original of this form shall be sent to the address below, and a copy sent to the employee and the employee's attorney of record, if any. A Form 28B must be filed to report the amount and last date compensation and/or medical compensation were paid.

FORM 28

ATTORNEYS: FILE VIA EDFP
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML
EMPLOYEES EMAIL TO: FORMS@IC.NC.GOV
OR MAIL TO: NCIC – CLAIMS SECTION
1235 MAIL SERVICE CENTER
RALEIGH, NC 27699-1235
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

North Carolina Industrial Commission

IC File #_____

NOTICE OF TERMINATION OF COMPENSATION BY REASON OF TRIAL RETURN TO WORK G.S. § 97-18.1(b) AND G.S. § 97-32.1

Emp. Code #_____

Carrier Code #_____

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

Carrier File #_____

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- ☐ M ☐ F / /	( ) ( )
Last 4 Digits of SSN Sex Date of Birth	Carrier's Telephone Number Fax Number

Important Notice to Employee: Your disability compensation has been stopped because you have returned to work. You are entitled to a trial return to work for a period not to exceed nine months, unless you have been released by an authorized treating physician to unrestricted work, in which case your trial return to work may be limited to 45 days. During your trial return to work, you may be entitled to partial disability compensation if, because of your on-the-job injury, you earn less wages now than before your injury. In order to request that your compensation be reinstated if your trial return to work is unsuccessful, you should complete Form 28U, which may be obtained by calling (800) 688-8349. In addition, you should notify an appropriate person at the company named below in order to request that your compensation be reinstated:

NAME OF EMPLOYER OR CARRIER/ADMINISTRATOR ADDRESS TELEPHONE NUMBER

When an employee returns to work other than on a trial return to work basis [see I.C. Rule 11 NCAC 23A .0404A(g)], Form 28 must be used.

EMPLOYER: COMPLETE THE FOLLOWING.

1. Date of injury: _____ 2. Date disability began: _____
3. Date temporary total compensation was/will be terminated: _____.
4. Date the employee returned/will return to work: _____
   at the ☐ **same or greater wages**, than received at the time of injury, or
   at ☐ **reduced wages** which were/are paid at the rate of $ _____ weekly.
   If employee has returned to work at reduced wages, is employee entitled to compensation for partial disability pursuant to N.C. Gen. Stat. § 97-30? ☐ **yes** ☐ **no**
   If "Yes", submit proper Form, such as Form 26 or Form 62
   If not, explain: _____
5. If different employment has been verified, name of employer: _____
   Address: _____
   Telephone: ( ) _____

SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR **TITLE** **DATE**

Employer: The original of this form shall be mailed to the address below, and a copy sent to the employee and the employee's attorney of record, if any. Form 28B must be filed to report the amount and last date compensation and/or medical compensation were paid.

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

FORM 28T
03/2020
PAGE 1 OF 1

FORM 28T

CONTACT INFORMATION:
NCIC-CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

North Carolina Industrial Commission

IC File #_____

EMPLOYEE'S REQUEST THAT COMPENSATION BE REINSTATED AFTER UNSUCCESSFUL TRIAL RETURN

Emp. Code #_____

Carrier Code #_____

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.

EMPLOYEE: COMPLETE AND MAIL TO EMPLOYER AND CARRIER/ADMINISTRATOR, AND TO THE INDUSTRIAL COMMISSION AT THE ADDRESS BELOW:

1. I request that my total disability compensation be resumed immediately. I had a trial return to work with _____ (name of employer) from _____ (date first worked) until _____ (date last worked). The date of my injury by accident or the date of disability from my occupational disease was _____
2. Explain in detail the reasons you are no longer working: _____
3. The employee **MUST** obtain the following from an authorized treating physician:

TREATING PHYSICIAN'S STATEMENT

This is to certify that the employee is unable to continue the trial return to work due to the employee's injury for which compensation has been paid. My medical specialty is: _____

SIGNATURE OF AUTHORIZED TREATING PHYSICIAN	PRINTED NAME	DATE
ADDRESS	CITY STATE	ZIP

IF RETURN TO WORK WAS WITH THE EMPLOYER FROM WHOM YOU HAVE RECEIVED WORKERS' COMPENSATION, SIGN HERE AND DO NOT COMPLETE THE REMAINDER OF THIS FORM. IF RETURN TO WORK WAS WITH A DIFFERENT EMPLOYER, COMPLETE SECTION B BELOW.

SIGNATURE OF EMPLOYEE _____ DATE

SECTION B.

EMPLOYEE'S RELEASE OF EMPLOYMENT INFORMATION

I hereby request and authorize my last employer, _____
(Name and address of last employer)

to release to my prior employer and carrier/administrator listed above, or their attorney of record, the following information relating to my trial return to work: first and last date worked, total wages earned, and the reasons this employee is no longer so employed.

READ BEFORE SIGNING _____
SIGNATURE OF EMPLOYEE DATE

SEND A COPY OF THIS FORM TO THE EMPLOYER AND CARRIER/ADMINISTRATOR FROM WHOM YOU WERE RECEIVING WORKERS' COMPENSATION. SEND THE ORIGINAL TO THE INDUSTRIAL COMMISSION AT THE ADDRESS BELOW.

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 28U

North Carolina Industrial Commission

IC File #_____

APPLICATION TO REINSTATE PAYMENT OF DISABILITY COMPENSATION (G.S. § 97-18(k))

Carrier File #_____

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

IMPORTANT NOTICE TO EMPLOYER: The employee in this claim has applied for reinstatement of compensation. If the employer or carrier believes that compensation should not be reinstated, the employer or carrier must respond to this Application by completing Section B of this Form and returning one copy to the Industrial Commission. If the Industrial Commission has not received the completed copy of this Form from the employer or carrier by _____, an Order may be issued reinstating compensation. If the employer or carrier timely objects to reinstatement, the matter will be scheduled for informal telephonic hearing. (The date to be inserted above by the employee shall be 17 days after this Application was sent to the employer or carrier and Industrial Commission, whether by mail, facsimile, or e-mail.)

SECTION A. TO BE COMPLETED BY THE EMPLOYEE:

1. Date of injury by accident or occupational disease: _____
2. Nature and extent of injury or occupational disease: _____
   _____
   _____
3. (a) Has your claim been accepted or determined to be compensable by the Industrial Commission: Yes: ☐ No: ☐
   (b) If so, how: Form 21 ☐ Form 60 ☐ Form 63 ☐ Opinion and Award ☐
   Other_____
4. Number of weeks compensation already paid: _____ From:_____/_____/_____ To:_____/_____/_____
5. Date from which seeking compensation:_____
6. Application is made to reinstate compensation on the grounds that:_____
   _____

YOU MUST ATTACH DOCUMENTATION TO SUPPORT THIS APPLICATION FOR REINSTATEMENT OF COMPENSATION.

NUMBER OF PAGES ATTACHED: _____

TELEPHONE NUMBER AT WHICH YOU CAN BE REACHED IF AN INFORMAL HEARING IS SCHEDULED, FROM MONDAY THROUGH FRIDAY BETWEEN 8:00 A.M. AND 5:00 P.M.: _____ THE INDUSTRIAL COMMISSION WILL NOTIFY YOU IF AN INFORMAL HEARING IS SCHEDULED.

IN ADDITION TO FILING THE ORIGINAL OF THIS APPLICATION AND SUPPORTING DOCUMENTS WITH THE INDUSTRIAL COMMISSION, I HEREBY CERTIFY THAT A COPY OF THIS APPLICATION, TOGETHER WITH ALL SUPPORTING DOCUMENTS, WAS SENT TO THE EMPLOYER OR CARRIER/ADMINISTRATOR AT: (ADDRESS/FAX NO):_____
AND THE EMPLOYER/CARRIER'S ATTORNEY OF RECORD, IF ANY, AT: (EMAIL/FAX NO.) _____
(IF E-MAIL, USE THE DIRECT E-MAIL ADDRESS OF THE ATTORNEY OF RECORD)

SIGNATURE OF EMPLOYEE OR ATTORNEY: _____ DATE:_____

FORM 23

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

I.C. NO. _____

SECTION B. TO BE COMPLETED BY THE EMPLOYER OR CARRIER/ADMINISTRATOR

1. THE EMPLOYER/CARRIER MUST COMPLETE EITHER 1.(a) OR 1.(b)

(a) If reinstatement of compensation is not contested, complete the following:

Compensation in the amount of $_____ per week was or will be reinstated from _____/_____/_____

commencing on: _____/_____/_____

If compensation is reinstated on a date other than the date requested by the employee in Section A.5., please explain:_____
_____
_____
_____

(b) Compensation should not be reinstated because:_____
_____
_____
_____

2. (a) Specify whether this claim has been accepted, denied or determined compensable by the Industrial Commission:_____
_____

(b) How: Form 61 ☐ Form 21 ☐ Form 60 ☐ Form 63 ☐ Opinion and Award ☐

Other_____

3. If compensation has been paid, provide the number of weeks: _____From:_____/_____/_____To:_____/_____/_____

IF REINSTATEMENT OF COMPENSATION IS CONTESTED, GIVE A TELEPHONE NUMBER AT WHICH YOU CAN BE REACHED WHEN THE INFORMAL HEARING IS SCHEDULED, FROM MONDAY THROUGH FRIDAY BETWEEN 8:00 A.M. AND 5:00 P.M. _____ AND A FACSIMILE NUMBER OR E-MAIL ADDRESS FOR SERVICE OF THE HEARING NOTICE AND ANY OTHER CORRESPONDENCE:

IN ADDITION TO FILING THE ORIGINAL OF THIS RESPONSE WITH THE INDUSTRIAL COMMISSION, I HEREBY CERTIFY THAT A COPY OF THIS RESPONSE, TOGETHER WITH SUPPORTING DOCUMENTS, WAS SENT TO THE EMPLOYEE OR THE EMPLOYEE'S ATTORNEY OF RECORD, IF ANY, AT (ADDRESS/FAX NO:)_____

_____

ON _____

SIGNATURE OF EMPLOYER,
CARRIER/ADMINISTRATOR OR
ATTORNEY:_____DATE:_____

FORM 23

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

North Carolina Industrial Commission

IC File #_____

Emp. Code #_____

Carrier Code #_____

Carrier File #_____

APPLICATION TO TERMINATE OR SUSPEND PAYMENT OF COMPENSATION (G.S. § 97-18.1)

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- M ☐ F ☐ / /	
Last 4 Digits of SSN / Sex / Date of Birth	Carrier's Telephone Number / Fax Number

IMPORTANT NOTICE TO EMPLOYEE: **YOUR BENEFITS MAY BE STOPPED UNLESS YOU OBJECT IMMEDIATELY. IF YOU BELIEVE YOUR BENEFITS SHOULD NOT BE STOPPED, YOU MUST FILL OUT SECTION B. OF THIS FORM AND RETURN ONE COPY OF THIS FORM TO THE INDUSTRIAL COMMISSION. IF THE INDUSTRIAL COMMISSION HAS NOT RECEIVED THE COMPLETED COPY OF THIS FORM FROM YOU BY_____, YOUR BENEFITS MAY BE STOPPED WITHOUT FURTHER NOTICE TO YOU. IF YOU OBJECT, YOU MAY HAVE THE RIGHT TO AN INFORMAL HEARING BY THE INDUSTRIAL COMMISSION BEFORE YOUR BENEFITS CAN BE STOPPED. (THE DATE TO BE INSERTED ABOVE BY THE EMPLOYER OR CARRIER/ADMINISTRATOR SHALL BE AT LEAST 17 DAYS AFTER THIS APPLICATION WAS ELECTRONICALLY FILED WITH THE INDUSTRIAL COMMISSION.)**

SECTION A. TO BE COMPLETED BY THE EMPLOYER OR CARRIER/ADMINISTRATOR:

1. Date of injury by accident: _____ Date disability began: _____

2. Nature and extent of injury: _____

_____

3. Number of weeks compensation paid: _____ From: _____ To: _____

4. Total amount of indemnity compensation paid to date: $ _____

5. Check applicable box(s):
   - ☐ a. An agreement was approved by the Industrial Commission on _____
   - ☐ b. The employer admitted employee's right to compensation pursuant to N.C. Gen. Stat. § 97-18(b).
   - ☐ c. The employer paid compensation to employee without contesting claim within the statutory period provided under N.C. Gen. Stat. § 97-18(d).
   - ☐ d. Other: _____

6. Application is made to ☐ terminate or ☐ suspend compensation to the employee on the grounds that:

_____

_____

_____

7. Check box if employee is in managed care. ☐

ATTORNEYS FILE VIA EDFP
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

In addition to filing this application and supporting documents with the Industrial Commission, I hereby certify that a copy of this application, together with all supporting documents, was served on the employee via Standard U. S. Mail, at:

(address) _____

(city, state, zip) _____

OR on the employee's attorney of record, if any, by e-mail or facsimile to:

_____
(If e-mail, use the direct e-mail address for employee's attorney of record)

On the day of: _____. The attached documents consist of _____ pages.
(date) (number)

_____
SIGNATURE PRINTED NAME DATE

_____
TELEPHONE NUMBER DIRECT E-MAIL ADDRESS

TO BE COMPLETED BY THE EMPLOYEE

SECTION B. IF YOU THINK YOUR COMPENSATION SHOULD NOT BE STOPPED, YOU SHOULD COMPLETE THIS SECTION.

1. I do not think my compensation should be stopped because: _____

2. Enclose and specify the number of pages of documents the Industrial Commission should consider: _____

3. Provide a telephone number below at which you can be reached when the informal hearing is scheduled, from Monday through Friday between 8:00 a.m. and 5:00 p.m.. The Industrial Commission will notify you of the date and time of the hearing.

_____
SIGNATURE OF EMPLOYEE OR ATTORNEY, IF REPRESENTED PRINTED NAME DATE

_____
TELEPHONE NUMBER DIRECT E-MAIL ADDRESS

If you need assistance in completing this form, you may contact the Industrial Commission at (800) 688-8349. You must contact the Office of the Executive Secretary at (919) 807-2657 to obtain an extension of time in which to submit medical records, or to obtain documents you have not been able to obtain.

EMPLOYEE: SEND A COPY YOUR RESPONSE ON THIS FORM AND SUPPORTING DOCUMENTS TO THE ATTORNEY IN SECTION A WHO FILED THIS FORM 24 APPLICATION ON BEHALF OF THE EMPLOYER AND CARRIER/ADMINISTRATOR FROM WHOM YOU ARE RECEIVING COMPENSATION. FILE A COPY WITH THE INDUSTRIAL COMMISSION AS INSTRUCTED AT THE BOTTOM OF THE FORM.

ATTORNEYS FILE VIA EDFP
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

North Carolina Industrial Commission

IC File # _____

AUTHORIZATION FOR REHABILITATION PROFESSIONAL TO OBTAIN MEDICAL RECORDS OF CURRENT TREATMENT

Emp. Code # _____

Carrier Code # _____

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

Carrier File # _____

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

I, _____, the employee-claimant, hereby authorize the
(Please Print)

release of all my medical records of treatment resulting from a work-related injury/occupational disease that occurred/was contracted on _____ to the Rehabilitation
(Please Print)

Professional assigned to me. That Rehabilitation Professional is:

Name: _____

Address: _____

_____

Telephone: ( ) - _____

_____ / /

Employee's Signature Date

NOTE: THE REFUSAL OF THE CLAIMANT TO SIGN THIS FORM UPON THE REQUEST OF THE REHABILITATION PROFESSIONAL MAY BE DEEMED BY THE INDUSTRIAL COMMISSION TO BE NONCOMPLIANCE WITH REHABILITATION AND MAY RESULT IN THE SUSPENSION OF BENEFITS.

PLEASE MAIL THIS COMPLETED FORM TO THE REHABILITATION PROFESSIONAL NAMED ABOVE.

FORM 25C

NORTH CAROLINA INDUSTRIAL COMMISSION
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

North Carolina Industrial Commission

IC File #_____

NOTICE TO THE COMMISSION OF ASSIGNMENT OF REHABILITATION PROFESSIONAL

Emp. Code #_____

Carrier Code #_____

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

Carrier File #_____

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

1. The case has been assigned to the following rehabilitation professional who meets the qualifications as outlined in Rule 11 NCAC 23C .0105 of the Industrial Commission Rules for Utilization of Rehabilitation Professionals in Workers' Compensation Claims.

Name of RP: _____ Telephone Number: ( ) -

_____ Fax Number: ( ) -

Name of Supervisor of Conditional Provider if Applicable

Company: _____ Type of Certification: _____

Address: _____ Certificate Number: _____

CHECK ONE: ☐ **FIELD/ON SITE CASE MANAGEMENT** ☐ **TELEPHONIC CASE MANAGEMENT**

2. The purpose of this rehabilitation assignment is:

Purpose (check all that apply): ☐ **Medical Case Management** ☐ **Vocational Rehabilitation**

Date of Injury: / /

Type of Injury:

3. This rehabilitation professional was assigned by the following carrier, self-insured employer, or third-party administrator:

Date Completed: _____ Company Name: _____

Signed By: _____ Official Title: _____

Print Name: _____ cc: Plaintiff's Attorney _____

4. The Commission should return this completed form to _____ (Name) at E-Mail: _____ (E-Mail Address)

By accepting this assignment, the above-named Rehabilitation Professional agrees that he/she meets the qualifications of a qualified/conditional rehabilitation provider as outlined in Rule 11 NCAC 23C .0105 of the Industrial Commission Rules for Utilization of Rehabilitation Professionals.

NORTH CAROLINA INDUSTRIAL COMMISSION
THE FOREGOING ASSIGNMENT IS HEREBY ACKNOWLEDGED:

FORM 25N

FILE WITH AN **IC FILE NUMBER** VIA **EDFP**
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML **OR**
IF NO IC FILE NUMBER, E-MAIL TO 25N@IC.NC.GOV
NCIC-NURSES SECTION
TELEPHONE: (919) 807-2616
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

North Carolina Industrial Commission

IC File #_____

ITEMIZED STATEMENT OF CHARGES FOR TRAVEL

Emp. Code #_____

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

Carrier Code #_____

Employee's Name

Address

City State Zip

( ) -
Home Telephone

( ) -
Work Telephone

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

For travel beginning January 1, 2023, employees are entitled to reimbursement of $0.655, provided they travel 20 miles or more roundtrip. Special consideration will be given to employees who are totally disabled. No reimbursement is allowed for trips to purchase medications or supplies unless medically necessary. These items must be purchased on visits to medical providers (G.S. § 97-25).

DATE	NAME OF MEDICAL PROVIDER	CITY	TOTAL MILES ROUNDTRIP
/ /			
/ /			
/ /			
/ /			
/ /			

OTHER EXPENSES	If overnight stay is necessary, the following items will be approved as submitted. (Receipts must be furnished for carrier's file.)	Total motel expense incurred through 6/30/21 (actual, up to $71.20 per day for in-state or $84.10 per day out-of-state). Total motel expense incurred on or after 7/1/21 (actual, up to $78.90 per day for in-state or $93.20 per day out-of-state).		Total Miles:	
		Total meal expense incurred through 6/30/21 ($8.40 Breakfast, $11.00 Lunch, and $18.90 Dinner in-state or $21.60 out-of-state). Total Meal expense incurred on or after 7/1/21 ($9.00 Breakfast, $11.80 Lunch, and $20.50 Dinner in-state or $23.30 out-of-state). :		**X [mileage rate]***	
		Total parking & cab expense (actual charge):		Other expenses:	
		Total for other expenses:		Total all expenses:	

*Prior mileage rates are as follows: (a) $0.625 for 7/1/22-12/31/22; (b) $0.585 for 1/1/22-6/30/22; (c) $0.56 for 2021; (d) $0.575 for 2020; (e) $0.58 for 2019.

I hereby certify that I have incurred all expenses listed above as a result of my workers' compensation injury.

Employee signature

Employee:
Mail your bill in duplicate promptly to employer and/or insurance carrier

Carrier's approval

Employer or Carrier/Administrator:
Travel may be reimbursed directly to the employee. It is not necessary to submit bills to the Commission for approval. Pay and retain copy in carrier's file.

NOTICE TO INJURED EMPLOYEE:
THIS FORM SHOULD BE RETURNED TO THE CARRIER AT THE ADDRESS ABOVE FOR PAYMENT.

FOR ASSISTANCE, CALL:
N.C. INDUSTRIAL COMMISSION
MAIN TELEPHONE: ***(919) 807-2500***
HELPLINE: ***(800) 688-8349***

FORM 25T

North Carolina Industrial Commission

IC File #_____

ITEMIZED STATEMENT OF CHARGES FOR DRUGS

Emp. Code #_____

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

Carrier Code #_____

Employee's Name

Address

City State Zip

( ) ( )
Home Telephone Work Telephone

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

( )
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

DATE	DRUG STORE	CITY	NAME OF DRUG & PRESCRIPTION NO.	PHYSICIAN	AMOUNT
				TOTAL	**$**

This is to certify that the drugs listed above were related to my workers' compensation injury. (Receipts must be furnished for carrier's file)

Employee signature

Carrier's approval

Reimburse employee
Yes ☐ no ☐

Reimburse drug store
Yes ☐ no ☐

EMPLOYER OR CARRIER/ADMINISTRATOR: DRUGS MAY BE REIMBURSED DIRECTLY TO THE EMPLOYEE OR DRUG STORE. IT IS NOT NECESSARY TO SUBMIT BILLS TO THE COMMISSION FOR APPROVAL. PAY AND RETAIN COPY IN CARRIER'S FILE.

EMPLOYEE: Mail your bill in duplicate promptly to employer and/or insurance carrier

FORM 25P

NCIC - MEDICAL BILLING SECTION
1236 MAIL SERVICE CENTER
RALEIGH, NC 27699-1236
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688- 8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

North Carolina Industrial Commission

REQUEST THAT CLAIM BE ASSIGNED FOR HEARING

IC File #_____

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

Social Security Number Disclosure Statement

The North Carolina Public Records Act (N.C. Gen. Stat. § 132-1.10) permits the North Carolina Industrial Commission to request a social security number from an individual when doing so is imperative to the performance of its duties and responsibilities. The purpose of requesting your social security number on this form is for the Industrial Commission to verify the correct employer with the North Carolina Department of Commerce, Division of Employment Security and to identify workers' compensation insurance coverage. The disclosure of a social security number by an individual to the Industrial Commission is voluntary. Social security numbers are confidential and exempt from public disclosure by the Industrial Commission. The Industrial Commission may not share your social security number unless otherwise permitted to do so pursuant to N.C. Gen. Stat. § 132-1.10.

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

Date of injury: _____ Part of body: _____

City and county where the injury occurred: _____

Estimated length of hearing: _____

This case will be set in the county where the injury occurred unless otherwise authorized by the Commission. If the requesting party wants the hearing to be set in a different county, name the county below and the reason for that location.

(County) (Reason for setting in requested county)

I,_____, ☐ Plaintiff/Attorney ☐ Defendant/Attorney, respectfully notify you that the above named parties have failed to reach an agreement regarding compensation, and I request a hearing.

We have been unable to agree because (State reason with specificity. If appealing an Administrative Order, provide the file date of the Order and the name of the hearing officer who issued the order.):

☐ Payment of compensation for days missed (give dates): _____

☐ Payment of medical expenses/treatment: _____

☐ Payment for permanent partial disability: _____

☐ Payment for permanent and total disability: _____

☐ Payment for scars: _____

☐ Other: _____

Has claimant participated in mediation? ☐ Yes ☐ No

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

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

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

FORM 33

Below is a list of names of all witnesses, including doctors, whose testimony is to be taken by the requesting party. Addresses must be provided for the doctors listed below.

NAME	ADDRESS

I hereby certify that this case is ready for hearing. When a date of hearing is set, I respectfully request the Commission to send me signed subpoenas for my witnesses. When I receive these subpoenas, I will serve them pursuant to the instructions on Page 2 of the Industrial Commission Form 36.

Signature of Party Requesting Hearing
Check one: ☐ Employee, ☐ Employer; ☐ Attorney

Printed Name of Party Requesting Hearing

Mailing Address: Street and number, city, state and ZIP Code

Telephone Number: **Date of Notice:**

E-mail Address:

Notice to Employees: The original of this form must be sent to the Industrial Commission at the address below or by e-mail to dockets@ic.nc.gov. A copy of the form must be sent to opposing parties.

CERTIFICATE OF SERVICE

I hereby certify that on_____, I served a copy of this Form 33 Request for Hearing, together with all supporting documents, on the following party(ies) by way of

_____.
(U.S. Mail, special delivery mail, e-mail, fax, hand delivery, etc.)

[Note: List name and address of each attorney or party served. Attach a separate sheet if necessary.]

Signature Printed Name Date

FORM 33

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

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

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

North Carolina Industrial Commission IC File #_____

RESPONSE TO REQUEST THAT CLAIM BE ASSIGNED FOR HEARING

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- ☐ M ☐ F / / Last 4 Digits of SSN Sex Date of Birth	( ) Carrier's Telephone Number ( ) Fax Number

In response to the Request for Hearing filed we have been unable to agree because (state reason with specificity):

_____

_____

_____

PLAINTIFF/DEFENDANT AGREES TO THE FOLLOWING:

Compensability Denied

Subject to Act: _____
Employment relationship: _____
Insurance coverage: _____
Date of injury: _____
Injury by accident _____
Arising out of and in the course of employment: _____
Occupational disease _____
Average weekly wage $ _____
Part of body: _____
Other: _____

Compensability Admitted

Form 21 approved on: _____
Form 60 approved on: _____
Temp. total paid from: _____
to _____
Temp. partial paid from: _____
to _____
Perm. partial paid from: _____
to _____
for _____% ppd of _____

Form 26 approved on: _____
Form 24 approved on: _____
Form 28B filed on: _____
Other: _____
Part of body: _____

City and county wherein injury occurred: _____

Estimated length of hearing: _____

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

EMPLOYEE FILING OPTIONS:
E-MAIL TO ***DOCKETS@IC.NC.GOV***
OR FAX TO ***(919) 715-0282***
OR MAIL TO
NCIC-DOCKET SECTION
1236 MAIL SERVICE CENTER
RALEIGH, NC 27699-1236

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

FORM 33R

Below is a list of names and addresses of all witnesses, including doctors, whose testimony is to be taken by the undersigned.

NAME	ADDRESS

When a date of hearing is set, I respectfully request the Commission to send me signed subpoenas for my witnesses. When I receive these subpoenas, I will serve them pursuant to the instructions on Page 2 of the Industrial Commission Form 36.

Signature **Date** **Printed Name** of Party Responding **Title**

Mailing Address: Street and number, city, state and ZIP Code

Telephone Number:

E-mail Address:

Notice to Employees: The original of this form must be sent to the Industrial Commission at the address below or by e-mail to dockets@ic.nc.gov. A copy of the form must be sent to opposing parties.

CERTIFICATE OF SERVICE

I hereby certify that on _____, I served a copy of this Form 33R Response to Request That Claim Be Assigned for Hearing, together with all supporting documents, on the following party(ies) by way of

_____.
(U.S. Mail, special delivery mail, e-mail, fax, hand delivery, etc.)

[Note: List name and address of each attorney or party served. Attach a separate sheet if necessary.]

Signature Printed Name Date

FORM 33R

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

EMPLOYEE FILING OPTIONS:
E-MAIL TO ***DOCKETS@IC.NC.GOV***
OR FAX TO ***(919) 715-0282***
OR MAIL TO
NCIC-DOCKET SECTION
1236 MAIL SERVICE CENTER
RALEIGH, NC 27699-1236

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

North Carolina Industrial Commission IC File #_____

EVALUATION FOR PERMANENT IMPAIRMENT

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 Social Security Number ☐ M ☐ F Sex / / Date of Birth | ( ) ( ) Carrier's Telephone Number Fax Number

Date of Injury: _____

EMPLOYEE'S WORK-RELATED INJURY WILL RESULT IN:

MEMBER	% OF IMPAIRMENT (IF AMPUTATION, DESCRIBE ON REVERSE.)
1) Thumb	
2) Index Finger	
3) Middle Finger	
4) Ring Finger	
5) Little Finger	
6) Great Toe	
7) Toes (other than great toe)	
8) Hand	
9) Arm	
10) Foot	
11) Leg	
12) Back	

Physician Signature

Printed Name

Fed. Tax ID Number

Date

Address

In regard to this rated body part:

1) Is employee at maximum medical improvement? _____
2) Was employee released with restrictions? _____

TEETH: Age of employee: _____
List all crowns by number : _____
List all extractions by number : _____
Has dental work been completed? ☐ Yes ☐ No

VISION: List vision reading without the use of a corrective lens.
Distance: _____ Near: _____

HEARING: Scale used: _____ Percentage of loss: Right ear _____
PLEASE ATTACH AUDIOGRAMS AND CALCULATIONS OF HEARING LOSS Left ear _____

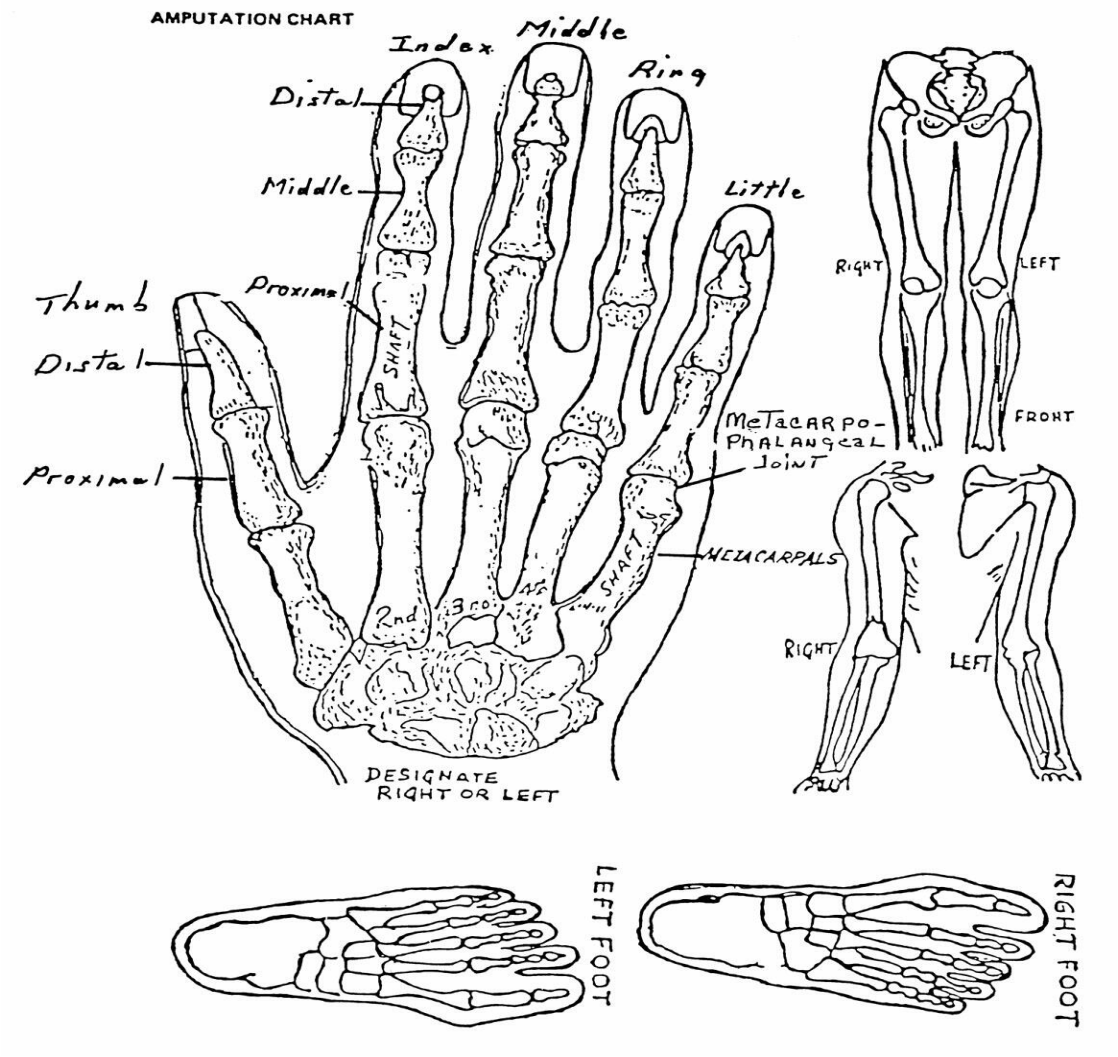
OTHER: Permanent injury to or impairment of any other organ or part of body (identify) : _____
Disfigurement: ☐ Yes ☐ No Location: ☐ face ☐ head ☐ body

FORM 25R
05/2017
PAGE 1 OF 2

FORM 25R

CARRIERS – FILE VIA ELECTRONIC DOCUMENT FILING PORTAL

CONTACT INFORMATION:
NCIC-CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV



Comments:

A copy of this form must be provided to the employee or the employee's attorney of record if any.
Medical Providers – Please return the completed form to the carrier.

FORM 25R

CARRIERS – FILE VIA ELECTRONIC DOCUMENT FILING PORTAL

CONTACT INFORMATION:
NCIC-CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

North Carolina Industrial Commission

EMPLOYER'S ADMISSION OF EMPLOYEE'S RIGHT TO PERMANENT PARTIAL DISABILITY (G.S. § 97-31)

IC File # _____

Emp. Code# _____

Carrier Code# _____

Carrier File #_____

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- ☐ M ☐ F / /	( ) ( )
Last 4 Digits of SSN Sex Date of Birth	Carrier's Telephone Number Carrier's Fax Number

WE, THE UNDERSIGNED, DO HEREBY AGREE AND STIPULATE AS FOLLOWS:

1. All the parties hereto are subject to and bound by the provisions of the Workers' Compensation Act and _____ is the Carrier/Administrator for the Employer.

2. The employee sustained an injury by accident or the employee contracted an occupational disease arising out of and in the course of employment on _____.

3. The injury by accident or occupational disease resulted in the following injuries:
_____.

4. The employee □ was □ was not paid for the 7 day waiting period.
If not, was salary continued? □ yes □ no. Was employee paid for the date of injury? □ yes □ no

5. The average weekly wage of the employee at the time of the injury, including overtime and all allowances, was $_____.
This results in a weekly compensation rate of $_____.

6. The employee □ has □ has not returned full time to work for _____
on _____, at an average weekly wage of $_____.

7. Claimant was released □ with permanent restrictions □ without permanent restrictions. If claimant was released with permanent restrictions and has returned to work for the employer of injury, attach a job description if known to exist.

8. Permanent partial disability compensation will be paid to the injured worker as follows:

____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)
____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)
____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)

Total amount of permanent partial disability compensation is $_____. Date of first payment:_____.

9. State any further matters agreed upon, including disfigurement, loss of teeth, election of temporary partial disability, waiting period or other: _____.

Form 26A

ATTORNEYS/CARRIERS/SELF-INSURED EMPLOYERS:
FILE VIA ELECTRONIC DOCUMENT FILING PORTAL
HTTPS://WWW.IC.NC.GOV/DOCFILING.HTML
CONTACT INFORMATION:
NCIC- CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTPS://WWW.IC.NC.GOV/

10. An overpayment is claimed in the amount of $_____. Overpayment was calculated as follows:_____.
If overpayment claimed, a Form 28B, *Report of Compensation and Medical Compensation Paid*, is attached. □ yes □ no

11. If applicable, the Second Injury Fund Assessment is $ _____. A check □ is □ is not included.

The undersigned hereby certify that the material medical and vocational records related to the injury, including any job description known to exist if the employee has permanent restrictions and has returned to work for the employer of injury, have been provided to the employee or the employee's attorney and have been filed with the Industrial Commission for consideration pursuant to G.S. § 97-82(a) and Rule 11 NCAC 23A .0501.

Name of Employer	Signature	Title	Date

Name of Carrier/ Administrator	Signature	Direct phone number	Email Address	Title	Date

By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on page 3 of this form.

Signature of Employee	Address	Email Address	Date

Signature of Employee's Attorney	Address	Email Address	Date

□ Check box if no attorney retained.

North Carolina Industrial Commission

The FOREGOING AGREEMENT IS HEREBY APPROVED:

_____
NCIC Claims Examiner/ Special Deputy/ Other

$_____
ATTORNEY FEE APPROVED

Form 26A

ATTORNEYS/CARRIERS/SELF-INSURED EMPLOYERS:
FILE VIA ELECTRONIC DOCUMENT FILING PORTAL
HTTPS://WWW.IC.NC.GOV/DOCFILING.HTML
CONTACT INFORMATION:
NCIC- CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTPS://WWW.IC.NC.GOV/

IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM PAYMENTS

Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial Commission in writing within two years from the date of receipt of your last compensation check or your rights to these benefits may be lost.

IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5,1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several factors. Your right to payment of future medical compensation will terminate two years after your employer or carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think you will need future medical compensation, you must file an application for additional medical compensation pursuant to G.S. 97-25.1 within two years, or your right to these benefits may be lost. An application for additional medical compensation may be made on a Form 18M Employee's Application for Additional Medical Compensation or by written request. In the alternative, an employee may file an application for additional medical compensation by filing a Form 33 Request that Claim be Assigned for Hearing pursuant to 11 NCAAC 23A .0602. All Industrial Commission forms are available at https://www.ic.nc.gov/forms.html.

IMPORTANT NOTICE TO EMPLOYER

The employee must be provided a copy when the agreement is signed by the employee. Pursuant to Rule 11 NCAC 23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or carrier/administrator must submit the agreement to the Industrial Commission. The employer or carrier/administrator shall file a Form 28B, Report of Compensation and Medical Compensation Paid, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.

NEED ASSISTANCE?

If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at (800) 688-8349.

Form 26A

ATTORNEYS/CARRIERS/SELF-INSURED EMPLOYERS:
FILE VIA ELECTRONIC DOCUMENT FILING PORTAL
HTTPS://WWW.IC.NC.GOV/DOCFILING.HTML
CONTACT INFORMATION:
NCIC- CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTPS://WWW.IC.NC.GOV/

North Carolina Industrial Commission

IC File # _____

APPLICATION FOR LUMP SUM AWARD

Emp. Code # _____

Carrier Code # _____

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

Carrier File # _____

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

APPLICATION MUST BE COMPLETED IN FULL BEFORE REQUEST WILL BE CONSIDERED.

The applicant represents that he or she has been granted an award of compensation by the North Carolina Industrial Commission, and that the award has been paid in periodical payments for not less than six weeks. The applicant hereby requests that he or she be allowed a lump-sum payment in an amount as requested below. (If the applicant desires to buy property of any kind with this lump sum settlement, three estimates of the value of the property must be submitted with the application to the Industrial Commission.)

Name: _____ Present Employer: _____

How Long: _____

Address: _____ Job Title: _____

_____ Average Wage/Wk : _____

_____ Are you unemployed: _____

Birth Date: _____ Other Income (Including Spouse's): _____

Phone Number: _____

Marital Status: _____

Dependents (Names & Ages): _____

_____

_____

Outstanding Bills (Creditor and Amount Owed): _____

_____

_____

Purpose of Lump Sum Request: _____

_____ Amount Requested $ _____

Applicant's Signature: _____ Date: _____

Applicant must send a copy of this form to the carrier and a copy to the Industrial Commission at the address below.

TO BE COMPLETED BY CARRIER/ADMINISTRATOR

The _____ (Name Insurance Company), ☐ agrees to pay the requested amount of $ _____ in a lump sum without commutation, or ☐ agrees to pay the following recommended amount of **$** _____ in a lump sum without commutation or ☐ refuses to pay the compensation in a lump sum without commutation.

Balance due applicant (pre-lump sum): _____

For Commission's Use Only

Approved By:	
Amount:	
Denied By:	
Date:	

_____

Signature Title

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

CONTACT INFORMATION:
NCIC-CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

FORM 31

North Carolina Industrial Commission

IC File #_____

AGREEMENT FOR PAYMENT OF UNPAID COMPENSATION IN UNRELATED DEATH CASES (G.S. § 97-37)

Emp. Code #_____

Carrier Code #_____

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

Carrier File #_____

Deceased 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- ☐ M ☐ F / /	( ) ( )
Last 4 Digits of SSN Sex Date of Birth	Carrier's Telephone Number Fax Number

WE, THE UNDERSIGNED, DO HEREBY AGREE AND STIPULATE AS FOLLOWS:

1. All parties hereto are subject to and bound by the provisions of the North Carolina Workers' Compensation Act.
2. Deceased employee contracted an occupational disease or sustained an injury by accident arising out of and in the course of employment on _____(date of accident or occupational disease).
3. The accident or occupational disease resulted in the following injury and disability: _____

   _____
   Description of injury and permanent disability
4. The employee earned an average weekly wage of $ _____, which resulted in payment of compensation at the rate of $ _____ per week for temporary total disability for _____weeks covering the period from _____ to _____ and for permanent partial disability for _____weeks, and is entitled to the unpaid balance of _____weeks of permanent partial disability compensation for _____.
   Rating of body part pursuant to G.S. 97-31
5. Employee died on _____, 20 ___, from causes unrelated to the occupational disease or injury by accident referenced in No. 2 above.
6. The following is/are the ☐ whole dependent(s), ☐ partial dependent(s), ☐ next of kin, ☐ or personal representative of the estate of deceased employee: _____
7. The parties agree to pay and receive the balance of the compensation at the rate of $ _____per week for a period of _____weeks beginning _____ , 20 ___.

Signature of dependent, next of kin or personal representative	Signature of Employer Title
Signature of dependent, next of kin or personal representative	Signature of Carrier/Administrator Title

Signature of claimant's attorney

Attorney's address

NORTH CAROLINA INDUSTRIAL COMMISSION
THE FOREGOING AGREEMENT IS HEREBY APPROVED:

CLAIMS EXAMINER DATE

ATTORNEY'S FEE APPROVED

ATTORNEYS: FILE VIA EDFP
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML
EMPLOYEES EMAIL TO: FORMS@IC.NC.GOV
OR MAIL TO: NCIC – CLAIMS SECTION
1235 MAIL SERVICE CENTER
RALEIGH, NC 27699-1235
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

FORM 26D

North Carolina Industrial Commission

IC File # _____

Emp. Code # _____

Carrier Code # _____

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

(APPLICABLE TO INJURIES BY ACCIDENT OR OCCUPATIONAL DISEASES 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- ☐ M ☐ F / / Last 4 Digits of SSN 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

REPORT OF EMPLOYER OR CARRIER/ADMINISTRATOR OF COMPENSATION AND MEDICAL COMPENSATION PAID AND NOTICE OF RIGHT TO ADDITIONAL MEDICAL COMPENSATION

IC File #_____
Emp. Code #_____
Carrier Code #_____
Carrier File #_____

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

1. Date of accident or disability from occupational disease_____.
2. Salary ☐ was / ☐ was not continued. Total Dollar Amount
3. Number of weeks temporary total _____ from _____, through _____ $_____
   _____ from _____, through _____ $_____
4. Number of weeks temporary partial _____ from _____, through _____ $_____
   _____ from _____, through _____ $_____
5. Number of weeks permanent partial _____ from _____, through _____ $_____
6. Disfigurement amount paid $_____
7. Death benefits paid $_____
8. Loss of organ or body part benefits paid $_____
9. Total of lines 3 through 8, including any attorney fee paid to employee's attorney $_____
10. Compromise Settlement Agreement amount $_____
11. a. Total medical paid $_____ Does this include final medical? ☐ Yes / ☐ No
    (Include bills for nursing, doctor, hospital, drugs, etc., but exclude rehabilitation and "medical only" paid)
    b. Total rehabilitation paid $_____
    c. Total "medical only" paid $_____
12. Total of lines 9, 10, 11a, and 11b. $_____
13. Miscellaneous payments:
    Funeral benefits $_____
    Second injury fund $_____
    Hearing Costs $_____
    Expert witness fees $_____
    Other $_____
    Total Miscellaneous Payments
    $_____
14. Has employee returned to work? ☐ Yes / ☐ No If so, on what date? _____ At what wage? _____
15. Date last compensation check forwarded _____ Was this the final payment? ☐ Yes / ☐ No
16. Date last medical compensation paid _____ Was this the final payment? ☐ Yes / ☐ No

NAME OF EMPLOYER OR CARRIER/ADMINISTRATOR

SIGNATURE | TITLE | DATE

This form must be filed with the Industrial Commission at the address below, and a copy provided the employee with his last compensation check within 16 days following final payment of compensation and final medical payment.

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

FORM 28B

CONTACT INFORMATION:
NCIC-CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

FOR INDUSTRIAL COMMISSION USE ONLY	
Days	_____
Compensation Paid	$_____
Medical	$_____
IC Code:	_____

IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY COMPENSATION CHECKS OR LUMP SUM PAYMENT

If you claim further compensation, you must notify the Industrial Commission in writing within two years from the date of receipt of your last compensation check or your rights to these benefits may be lost.

IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL MEDICAL BENEFITS INJURED BEFORE JULY 5, 1994

If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL MEDICAL BENEFITS INJURED ON OR AFTER JULY 5, 1994

If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several factors. Your right to payment of future medical compensation will terminate two years after your employer or carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think you will need future medical compensation, you must apply to the Industrial Commission in writing within two years, or your right to these benefits may be lost. To apply you may also use Industrial Commission Form 18M.

DEFINITION OF MEDICAL COMPENSATION

The term "medical compensation" means medical, surgical, hospital, nursing and rehabilitative services, and medicines, sick travel, and other treatment, including medical and surgical supplies, as may reasonably be required to effect a cure or give relief, and for such additional time, as in the judgment of the Industrial Commission, will tend to lessen the period of disability; and any original artificial members as may reasonably be necessary at the end of the healing period, and the replacement of such artificial members when reasonably necessitated by ordinary use or medical circumstances. **N.C. Gen. Stat. § 97-2(19)**.

NEED ASSISTANCE?

If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission's Information Specialists at **(800) 688-8349**

FORM 28B

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

CONTACT INFORMATION:
NCIC-CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

North Carolina Industrial Commission

IC File #_____

REPORT OF EMPLOYER OR CARRIER/ADMINISTRATOR OF COMPENSATION AND MEDICAL COMPENSATION PAID PURSUANT TO A COMPROMISE SETTLEMENT AGREEMENT

Emp. Code #_____

Carrier Code #_____

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

Carrier File #_____

THIS FORM IS ONLY TO BE USED IN SETTLED CASES

Employee's Name

Address

City State Zip

( ) Home Telephone

XXX-XX- Last 4 Digits of SSN

☐ M ☐ F Sex

/ / Date of Birth

( ) 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

1. Date of accident or disability from occupational disease _____.
2. Salary ☐ was / ☐ was not continued.

Total Dollar Amount

3. Number of weeks temporary total _____ from _____ , through _____ $_____
   _____ from _____ , through _____ $_____
4. Number of weeks temporary partial _____ from _____ , through _____ $_____
   _____ from _____ , through _____ $_____
5. Number of weeks permanent partial _____ from _____ , through _____ $_____
6. Disfigurement amount paid $_____
7. Loss of organ or body part benefits paid $_____
8. TOTAL OF LINES 3 THROUGH 7 $_____
9. Compromise Settlement Agreement amount $_____
10. Total Medical Paid $_____

NAME OF EMPLOYER OR CARRIER/ADMINISTRATOR

SIGNATURE TITLE DATE

This form must be filed with the Industrial Commission at the address below.

FOR INDUSTRIAL COMMISSION USE ONLY

Days _____

Compensation Paid $_____

Medical $_____

IC Code: _____

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

FORM 28C
03/2020
PAGE 1 OF 1

FORM 28C

CONTACT INFORMATION:
NCIC-CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

North Carolina Industrial Commission

IC File # _____

Emp. Code # _____

SUPPLEMENTAL REPORT FOR FATAL ACCIDENTS

(FORM 19, EMPLOYER'S REPORT OF EMPLOYEE'S INJURY TO THE INDUSTRIAL COMMISSION, MUST ALSO BE SUBMITTED IN EVERY CASE)

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. Code numbers assigned to each employer and carrier should be inserted before mailing.

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

Deceased 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

1. Date of accident: _____ 2. Date of death: _____, 20 ____

3. Dependents, or if employee left no dependents, next of kin: (Indicate which are non-resident aliens)

	Name	Date of Birth	Relationship	Present Address
a.				
b.				
c.				
d.				
e.				
f.				

4. Immediate cause of death: _____

5. Amount of burial expenses authorized $ _____

_____
Signature of Employer or Carrier/Administrator Title Date

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

FORM 29
03/2020
PAGE 1 OF 1

FORM 29

CONTACT INFORMATION:
NCIC-CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

North Carolina Industrial Commission

IC File #_____

AGREEMENT FOR COMPENSATION FOR DEATH

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

Emp. Code #_____
Carrier Code#_____

Deceased 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

We, the dependent(s) or next of kin listed below and the employer and carrier/administrator hereby stipulate to the following facts as to the death of the deceased employee:

1. The employer and the deceased employee were bound by the provisions of the N.C. Workers' Compensation Act;

2. The deceased employee sustained a compensable injury by accident (or occupational disease) on _____, _____, that arose out of and in the course of his employment and resulted in his death on _____, _____.

3. The average weekly wage of deceased employee was $ _____, and the weekly compensation rate is $ _____.

4. The parties hereto have provided the Industrial Commission with the names and addresses of all known persons wholly or partially dependent for support upon the earnings of the deceased employee at the time of the accident, or the next of kin who might be entitled to compensation if there are no whole or partial dependents.

5. The following are the only persons entitled to receive compensation as a result of the death of employee:

Name	Address	Date of Birth	Age	Relationship	Indicate whole or partial dependent or next of kin

(IF ADDITIONAL SPACE NEEDED USE REVERSE SIDE)

6. Based upon the above stipulated facts, the employer and its carrier or third party administrator, agree to pay and the dependents, or next of kin agree to accept compensation based upon a weekly rate of $ _____ payable as follows:
(Check all that apply)
   - ☐ if widow/widower only, for 500 weeks
   - ☐ if widow/widower and minor child(ren), in equal shares for 500 weeks; however, minor child(ren) shall continue to receive compensation if they have not yet reached age 18 within the 500 week period
   - ☐ if minor child(ren) only, in equal shares for 500 weeks or until they reach age 18, whichever is longer
   - ☐ If whole dependent(s) other than widow/widower and/or child(ren), for 500 weeks
   - ☐ if partial dependent(s) only, in the weekly amount of $ _____ (compensation rate multiplied by the percentage of support provided by deceased) for 500 weeks
   - ☐ if next of kin, for 500 weeks payable in a lump sum commuted to present value in equal shares

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

FORM 30

CONTACT INFORMATION:
NCIC-CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

7. The parties agree that the employee's surviving widow/widower □ was able or □ was unable to support herself/himself because of physical or mental disability as of the date of death of the employee, and □ will or □ will not continue to receive additional weekly benefits during his/her lifetime or until remarriage.

8. The employer and its carrier agree to pay burial expenses not exceeding $10,000.00 for deaths on or after June 24, 2011 and medical expenses in accordance with Commission procedure.

9. Compensation for death to be paid under this agreement . . . . . $ _____
   Amount due for expense of burial . . . . . $ _____
   Total amount to be paid . . . . . $ _____

10. The date of this agreement is _____, 20 ___.

_____ _____
Signature of Dependent or Next of Kin Signature of Employer Title

_____
Signature of Dependent or Next of Kin

_____
Signature of Carrier/Administrator Title

_____
Signature of Dependent or Next of Kin

_____
Signature of Dependent or Next of Kin

_____
Signature of Plaintiff's Attorney

NOTICE TO EMPLOYER OR CARRIER: 11 NCAC 23A .0409(e) requires:

If the parties submit a Form 30 Agreement for Compensation for Death, the agreement shall be filed in accordance with Rule .0108 of this Subchapter with the following:

(1) a stipulation as to average weekly wage;
(2) any affidavits regarding dependents;
(3) the employee's death certificate;
(4) a Form 29 Supplemental Report for Fatal Accidents;
(5) a Form 42 Application for Appointment of Guardian ad Litem, if any beneficiary is a minor or incompetent;
(6) proof of beneficiary status, such as marriage license, birth certificate, or divorce decree;
(7) a funeral bill or stipulation as to payment of the funeral benefit;
(8) a Form 30D Award Approving Agreement for Compensation for Death; and
(9) an affidavit or itemized statement in support of an award of attorney's fees if an attorney is seeking fees for representation of one or more beneficiaries.

FORM 30

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

CONTACT INFORMATION:
NCIC-CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

North Carolina Industrial Commission

IC File # _____

Emp. Code # _____

Carrier Code # _____

AWARD APPROVING AGREEMENT FOR COMPENSATION FOR DEATH

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE WORKERS' COMPENSATION ACT

Deceased 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- ☐ M ☐ F / /	( ) - ( ) -
Last 4 Digits of SSN Sex Date of Birth	Carrier's Telephone Number Fax Number

Employer or carrier shall complete and submit to the Industrial Commission for approval this form or a document containing all pertinent information

The parties now have executed and submitted for approval a Form 30 Agreement for Compensation for Death, which is incorporated herein by reference. The Commission hereby approves said Agreement and directs payment of compensation to the person(s) and at the rate(s) as follows:

Person(s) Receiving Compensation	Compensation Rate	Time Period or Lump Sum

In addition, the employer and its insurance carrier, if any, shall pay burial expenses not exceeding $10,000.00 to the person or persons entitled for deaths occurring on or after June 24, 2011.

The employer and its insurance carrier, if any, shall pay all medical, hospital, nursing and other treatment expenses incurred by or on behalf of deceased employee as a result of the injury causing death when bills have been submitted to and approved through the procedure adopted by the Industrial Commission.

An attorney's fee of $_____.__ is approved for counsel for claimant(s). This amount shall be deducted from the amount claimant(s) is/are to receive, and paid directly to counsel.

This is an award of the Industrial Commission and any interested party may give notice of appeal within the time and in the manner provided by law.

NORTH CAROLINA INDUSTRIAL COMMISSION
THE FOREGOING AGREEMENT IS HEREBY APPROVED:

_____
CLAIMS EXAMINER

/ /
_____
DATE

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

FORM 30D

CONTACT INFORMATION:
NCIC-CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

North Carolina Industrial Commission

IC File # _____

Emp. Code # _____

Carrier Code # _____

APPLICATION FOR APPOINTMENT OF GUARDIAN AD LITEM

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE WORKERS' COMPENSATION ACT

_____ _____

_____ _____

_____ v. _____

Plaintiff (s) Defendant (s)

TO THE NORTH CAROLINA INDUSTRIAL COMMISSION:

The undersigned _____ respectfully shows unto the North Carolina Industrial Commission that _____ Is an ☐ infant or ☐ incompetent without general or testamentary guardian in this State, and that by reason thereof can bring an action only by a guardian ad litem; that the person has a cause of action against the defendants on account of the following matter and things:

_____

The undersigned is a reputable person closely connected with the infant or incompetent having the relationship with the infant or incompetent as follows: _____

WHEREFORE, the undersigned prays the Commission that a fit and proper person be appointed Guardian Ad Litem for the infant or incompetent for the purpose of bringing in his behalf an action as above set out.

_____

Signature of Applicant Date

(Please complete page 2 of form)

ORDER APPOINTING
GUARDIAN AD LITEM

It appearing to the North Carolina Industrial Commission from the above application that _____ _____ is an ☐ infant or ☐ incompetent having no general or testamentary guardian within this State and that said infant (or incompetent) appears to have a good cause of action against the defendant(s) ; and it further appearing to the Commission after due inquiry that _____ is a fit and proper person to be appointed guardian ad litem for the infant or incompetent for the purpose of bringing this action in his or her behalf;

IT IS THEREFORE ORDERED that _____ be and is hereby appointed guardian ad litem of _____ to bring this action in his or her behalf.

This _____ day of _____.

_____

Commissioner/Deputy Commissioner/Executive Secretary

PLEASE TYPE OR PRINT:

FORM 42

ATTORNEYS: FILE VIA EDFP
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML
EMPLOYEE FILING OPTIONS:
EMAIL TO: DOCKETS@IC.NC.GOV
FAX TO: (919) 715-0282
MAIL TO: NCIC – DOCKET SECTION
1236 MAIL SERVICE CENTER
RALEIGH, NC 27699-1236
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

Full name and address of minor or incompetent:

Birth date of minor: _____

Full name and address of proposed guardian ad litem:

Rule 11 NCAC 23A .0604

(a) Minors or incompetent individuals may bring an action only through their guardian ad litem. Upon the written application on a Form 42 Application for Appointment of Guardian Ad Litem, the Commission shall appoint the person as guardian ad litem, if the Commission determines it to be in the best interest of the minor or incompetent individual. The Commission shall appoint the guardian ad litem only after due inquiry as to the fitness of the person to be appointed.

(b) No compensation due or owed to an incompetent individual shall be paid directly to the guardian ad litem, unless the guardian ad litem has authority to receive the money pursuant to a federal or state court order. No compensation due or owed to a minor shall be paid directly to the guardian ad litem, except that a parent, legal guardian, or legal custodian may receive compensation on behalf of a minor in his or her capacity as parent, legal guardian, or legal custodian.

(c) The Commission may assess a fee to be paid by the employer or the insurance carrier to an attorney who serves as a guardian ad litem for services rendered upon receipt of an affidavit of time spent in representation of the minor or incompetent individual as part of the costs.

FORM 42

ATTORNEYS: FILE VIA EDFP
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML
EMPLOYEE FILING OPTIONS:
EMAIL TO: DOCKETS@IC.NC.GOV
FAX TO: (919) 715-0282
MAIL TO: NCIC – DOCKET SECTION
1236 MAIL SERVICE CENTER
RALEIGH, NC 27699-1236
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV