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

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

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

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

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

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

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

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

_____

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

_____

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

_____

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

_____

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

_____

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

_____

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

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

_____

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

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

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

_____

☐ **Mediation**

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

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

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

_____ _____ _____ _____
Preparer's Signature Title Email Date

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