

**South Carolina Workers' Compensation Commission**

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Columbia, South Carolina 29202-1715

(803) 737-5723

www.wcc.sc.gov



WCC File #: \_\_\_\_\_

Carrier File #: \_\_\_\_\_

Carrier Code #: \_\_\_\_\_

Employer FEIN #: \_\_\_\_\_

Claimant's Name: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Carrier: \_\_\_\_\_

Preparer's Name: \_\_\_\_\_

Preparer's Phone #: \_\_\_\_\_

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

**Date of Injury or Illness** \_\_\_\_\_

The above parties agree to pay and accept compensation based on the following facts:

A compensable  Injury  Illness  Repetitive Trauma occurred on: \_\_\_\_\_ (month/day/year).

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

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

Average weekly wage \$ \_\_\_\_\_

Compensation rate \$ \_\_\_\_\_

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

- \_\_\_\_ Percentage loss of use to: \_\_\_\_\_ (body part(s) injured) \_\_\_\_\_ weeks
- \_\_\_\_ Percentage loss of use to: \_\_\_\_\_ (body part(s) affected) \_\_\_\_\_ weeks
- \_\_\_\_ Percentage loss of use to: whole person \_\_\_\_\_ weeks
- Disfigurement to: \_\_\_\_\_ weeks
- Wage Loss: \$ \_\_\_\_\_ amount \_\_\_\_\_ weeks
- Total and Permanent Disability: \_\_\_\_\_ weeks
- Other: \_\_\_\_\_ weeks

Estimated award (number of weeks times compensation rate) \$ \_\_\_\_\_

**The estimated award is subject to verification by the Commission**

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

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

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

\_\_\_\_\_  
Claimant's Signature

\_\_\_\_\_  
Date Agreement Signed

\_\_\_\_\_  
Attorney/Witness/Translator

\_\_\_\_\_  
Employer's Representative

\_\_\_\_\_  
Attorney for Carrier

\_\_\_\_\_  
Email

\_\_\_\_\_  
Deputy Commissioner

\_\_\_\_\_  
Date agreement approved

\_\_\_\_\_  
Jurisdictional Commissioner