

South Carolina Workers' Compensation Commission

1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723



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

Claimant's Name: _____ SSN: _____ - - _____ Employer's Name: _____
Address: _____ Address: _____
City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Insurance Carrier: _____
Preparer's Name: _____ Law Firm: _____ Preparer's Phone #: _____

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

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

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

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

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

6. Informal Conference is Requested: Yes No (check one)

Use these lines to send a memo to the Commission: _____

Employer's Representative Phone Date

Type or print all information. File this form six months after the alleged injury date and each six months until the Commission's File is closed. Form 18 must be filed whether or not compensation is ongoing. Check "yes" after Number 6 to request an informal conference. Refer to R.67-413, R.67-507, and R.67-804 for further information.