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 #: _____

Compensation Paid:	Number of Weeks	From (m/d/yyyy)	To (m/d/yyyy)	Amount
1. Number of Weeks T.T.				$
2. Number of Weeks T.P.				$
3. Number of Weeks P.P.				$
4. Disfigurement				$
5. Agreement and Final Release				$
Total Compensation Paid				$ 0.00
6. Total Medical Benefits* Paid				$
7. Funeral Benefits				$

☐ Case Denied

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

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

By: _____ Claimant

By: _____ Employer's Representative

_____ Date (m/d/yyyy)

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

By: _____

Report of Additional Fees and Recoupment

A. Carrier Reimbursement by Third Party $ _____

B. Attorney's Fee Paid by Employer $ _____

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

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