South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723 www.wcc.sc.gov

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 #: ( ) -

A claim for workers' compensation benefits is made based on the following grounds:
☐Injury ☐ Illness ☐ Repetitive Trauma ☐Occupational Disease ☐Physical Brain Injury ☐Concurrent Jurisdiction

1. The claimant sustained an injury to _____ (Part(s) of Body Injured) on _____ (Month/Day/Year) in _____ county, state of _____.
2. Body part(s) affected are: _____
   Briefly describe how the accident occurred. _____
3. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
4. The relationship of employer and employee existed at the time of injury.
5. At the time of the injury the claimant was performing services arising out of and in the course of employment.
6. Notice of the accidental injury was given to the Employer on _____ (Month/Day/Year) in the following manner:

☐7. Due to injury, the claimant is in need of (check one):
   ☐(a) medical examination and treatment for: _____
   ☐(b) additional medical examination and treatment for: _____

☐8. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:

☐9. Due to the injury, the Claimant has permanent disability of the following nature and extent (check one):
   ☐(1) General Disability: ☐Total ☐ Partial ☐(2) Specific Disability: ☐Total ☐ Partial ☐ (3) Wage Loss
   9a. Claimant at MMI: ☐ Yes ☐ No

☐10. Due to the injury, the Claimant has a serious bodily disfigurement consisting of:

10a. At the time of the injury, the Claimant was paid weekly wages of $_____, and demands accounting of days worked and wages earned as provided by law.

10b. Give names and addresses of all employers for whom the Claimant has worked since the date of the accident:

11. Further grounds or unusual aspects of claim:

11a. List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident:

11b. To the best of your knowledge, did you have any prior permanent disability? _____
   If yes, describe: _____

12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.

☐13. **I am filing a claim. I am not requesting a hearing at this time.** Estimated time needed for hearing: ___________

☐14. **I am requesting a hearing. A $50 fee is required.**

☐ **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 certify I have served this document pursuant to Reg. 67-211 by delivering a copy to______________________________
address____________________________ on the ___day of _____20__,by ☐ first class postage ☐certified mail ☐personal service ☐electronic service

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

Preparer's Signature Title Email Date

Questions about the use of this form should be directed to the Claims Department at 803.737.5723. Refer to Regulations 67-204 through 67-211 and Regulations 67-601 through 67-615 as well as Reg. 67-1801.

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50

Employee's Notice of Claim and/or Request for Hearing