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| **South Carolina Workers’ Compensation Commission**  1333 Main Street, Suite 500  P.O. BOX 1715  Columbia, SC 29202-1715  803-737-5700 [www.wcc.sc.gov](http://www.wcc.sc.gov) | | | SCSealBWjpg | | | | |  |  | | --- | --- | | WCC File #: |  | |  |  | | Carrier File #: |  | |  |  | | Carrier Code #: |  | |  |  | | Employer FEIN #: |  | |  |  | | |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Claimant's Name: | | |  | | | SSN: | | -    - | | |  | |  | | | | | | | | | Address: | |  | | | | | | | | |  |  | | |  |  | |  | |  | | City: |  | | | State: |  | | Zip: | |  |  |  |  |  |  | | --- | --- | --- | --- | | Home Phone: | (     )     - | Work Phone: | (     )     - | | | | | | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Employer's Name: | | |  | | | | | |  | | |  | | | | | | Address: | |  | | | | | | |  |  | | |  |  |  |  | | City: |  | | | State: |  | Zip: |  |  |  |  | | --- | --- | | Insurance Carrier: |  | | | | |
| Preparer’s Name: |  | Law Firm: | |  | | Preparer’s Phone #: | | (     )     - |
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**REQUEST FOR COMMISSION REVIEW**

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| Request for Commission Review by | Claimant  Employer (check one) | Date of Injury or Illness: | (m/d/yyyy) |

The undersigned makes application for review of the findings of the Commissioner in the above-captioned case. The request for review is based on the following grounds: (State the grounds of your appeal in the form of questions presented. Each question presented must contain a concise statement of one proposition of law or fact. Refer to evidence by title and exhibit number. Use additional pages if necessary).

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**(Check one) Oral argument**  **is**  **is not requested. Appellant’s request for oral argument is waived if not indicated on this form.**

**I certify I have served this document pursuant to Reg. 67-211. See attached certificate of service.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preparer’s Signature Title Email Date

Check this box if you are not represented by an attorney