South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737.5700 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 #: (___) ___-_____

The date of injury reported on Form 12A is: _____ (m/d/yyyy)

Check appropriate section(s). The Employer's Representative requests a hearing to:

I. ☐ **Stop payment of compensation.** Claimant has reached maximum medical improvement and Claimant continues to receive temporary compensation payments. The employer's representative requests a hearing pursuant to § 42-9-260(D) to stop payment of temporary compensation. A hearing requested pursuant to this section must be held within sixty days of the date of the request.

Claimant reached maximum medical improvement on_____ (m/d/yyyy) (copy of medical report must be attached).
Compensation payments are current as of _____ (m/d/yyyy) and shall continue until otherwise ordered or until Form 17 is signed by the claimant.
A Form 17 was offered and refused on _____ (m/d/yyyy).

II. ☐ **Address suspension, termination, or reduction of temporary disability payments for any cause.**

☐ a. At any time pursuant to § 42-9-260(E).

☐ b. After the one-hundred-fifty day period has expired pursuant to § 42-9-260(F), R.67-505 and R.67-506.

The basis for the termination/ suspension is _____.

III. ☐ **Determine if compensation is due** pursuant to § 42-9-10, § 42-9-20 or § 42-9-30 and, if so, in what amount, based on the following grounds:

_____

Claimant reached maximum medical improvement on_____ (m/d/yyyy) (copy of medical report must be attached).

IV. ☐ **Request Credit for Overpayment of temporary compensation pursuant to § 42-9-210.**

V. ☐ **Determine amount of compensation for claims involving a fatality.**

☐ a. Payment of unpaid balance of compensation when employee dies pursuant to § 42-9-280.

☐ b. Amount of compensation for death of employee due to accident pursuant to § 42-9-290.

☐ **Amendment to Prior Hearing Request**

☐ a. I am adding a party pursuant to Reg. 67-610(C). Party Name/Address: _____.

☐ b. I am removing a party pursuant to Reg. 67-610(C). Party Name/Address: _____.

☐ c. Other amendment: _____.

☐ **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.

Failure to respond pursuant to Reg. 67-208 B in writing may result in ordered mediation pursuant to Reg. 67-1801 B.
Questions regarding mediation may be submitted to **mediation@wcc.sc.gov**.

I certify I have served this document pursuant to Reg. 67-211. See attached certificate of service. I verify the contents of this form are accurate and true to the best of my knowledge.

Preparer's Signature	Title	Email	Date (m/d/yyy)
_____	_____	_____	_____

Refer to Regulations 67-211, 67-504, 67-505, 67-506; and 67-510.