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|  **South Carolina Workers’ Compensation Commission** 1333 Main Street, Suite 500 P.O. BOX 1715 Columbia, SC 29202-1715 803-737-5675 [www.wcc.sc.gov](http://www.wcc.sc.gov)  | SCSealBWjpg |

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| WCC File #: |  |
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| Carrier File #: |  |
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| Carrier Code #: |  |
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| Employer FEIN #: |  |
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| Claimant's Name: |       | SSN: |     -    -      |
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| Address: |       |
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| City: |       | State: |    | Zip: |       |

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| Home Phone: | (     )     -      | Work Phone: | (     )     -      |

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| Employer's Name: |       |
|  |  |
| Address: |       |
|  |  |  |  |  |  |
| City: |       | State: |    | Zip: |       |

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| Insurance Carrier: |       |

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|  Preparer’s Name: |       |  Law Firm: |       |  Preparer’s Phone #:  | (     )     -      |
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**REQUEST FOR COMMISSION REVIEW**

|  |  |  |  |
| --- | --- | --- | --- |
| 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 by delivering a copy to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**address on the \_\_\_day of \_\_\_\_20\_\_,**

**by** [ ] **first class postage** [ ] **certified mail** [ ]  **personal service** [ ]  **electronic service**

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

Preparer’s Signature Title Email Date

Check this box if you are not represented by an attorney [ ]