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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: |       |
|  |  |  |  |  |  |
| City: |       | State: |    | Zip: |       |

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| --- | --- | --- | --- |
| Home Phone: | (     )    -     | Work Phone: | (     )    -     |
|  |  |  |  |
| Preparer's Name: |       |

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

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| Carrier: |       |

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| Preparer’s Phone #: | (     )    -     |
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 |

**Check applicable claims and complete all blanks.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  1. | The employee sustained a compensable accidental injury to the  |       | (part of the body) on  |       | (date) |
|  | in  |       | (county), | State of  |       | (state) | . |
|  2. | That the Second Injury Fund was put on notice of the claim on |       | (date) . |
|  3. | That the carrier concluded the disability claim by [ ]  Award [ ]  Agreement on  |       | (date) . |
|  4. | That the subsequent injury combined with or was aggravated by the below-named permanent impairment under S.C. Code Section 42-9-400(d):  |
|  | a. Listed Impairment – (1) – (33) |       |
|  | b. (34) (a)  |       |
|  | c. (34) (b) |       |
|  5. | [ ]  a. That the impairment preexisted;  |
|  | [ ]  b. That the impairment was permanent; and |
|  | [ ]  c. That the impairment is a physical condition.  |
|  6. | [ ]  That the prior impairment combined with or was aggravated by the subsequent injury. |
|  7. | [ ]  That the combination/aggravation substantially increased the liability of the carrier for: [ ]  disability [ ]  medical or [ ]  both. |
|  8. | [ ]  That the impairment was a hindrance or obstacle to employment or re-employment. |
|  9. | [ ]  a. That the employer has knowledge of the prior impairment; |
|  | [ ]  b. That the impairment was unknown to the employee and the employer; or |
|  | [ ]  c. That the employee concealed the prior impairment from the employer. |
| 10. | [ ]  That the subsequent injury would not have occurred “but for” the prior impairment. |
| 11. | That the above claim qualifies for reimbursement under S.C. Code Section 42-9-410 because: |
|  |       |
| 12. | Other grounds for claim: |       |
|  |       |

[ ]  **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.**

 **A $50.00 filing fee is required.**

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Preparer’s Signature Title Email Date