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| **South Carolina Workers’ Compensation Commission**1333 Main Street, Suite 500 ● Post Office Box 1715Columbia, South Carolina 29202-1715(803) 737-5700 [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: |    -  -     |
|  |  |
| Address: |       |
|  |  |  |  |  |  |
| City: |       | State: |    | Zip: |       |

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

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

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| 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. 2.  | The claimant sustained an injury to       (Part(s) of Body Injured) on       (Month/Day/Year) in       county, state of      .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. | Claimant at MMI: [ ] Yes [ ] No. 9a. If yes, 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 |
| [ ] 10. | Due to the injury, the Claimant has a serious bodily disfigurement consisting of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. |
| [ ]  11. | 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. |
| [ ]  12. | Give names and addresses of all employers for whom the Claimant has worked since the date of the accident:      |
| [ ]  13. | Further grounds or unusual aspects of claim:       |
| [ ]  13a. | 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. | 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. |
| [ ] 13b. | List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident:      |
| [ ]  13c. | To the best of your knowledge, did you have any prior permanent disability?      If yes, describe:       |
| [ ]  14. | [ ]  I am adding a party. ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name/address). [ ]  I am removing a party. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name/address).[ ]  Other amendment: ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. |
| [ ] 15. | **I am filing a claim. I am not requesting a hearing at this time.**  |  |   | Estimated time needed for hearing:      \_\_\_\_\_\_ |
| [ ] 16. | **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. See attached certificate of service.**  **I verify the contents of this form are accurate and true to the best of my knowledge.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| Preparer’s Signature | Title | Email |  | Date |

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|  Refer to Regulations 67-204 - 67-211, Regulations 67-601 -67-615, and Regulation 67-1801.

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| **WCC Form # 50**Revised 9/2023 | 50 | Employee’s Notice of Claim and/or Request for Hearing |

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