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| **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](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 #: | (     )     - |

**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**](mailto: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.   |  |  |  | | --- | --- | --- | | **WCC Form # 50**  Revised 9/2023 | 50 | Employee’s Notice of Claim and/orRequest for Hearing | |