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 #: ( ) -

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. The claimant sustained an injury to _____ (Part(s) of Body Injured) on _____ (Month/Day/Year) in _____ county, state of _____.
2. 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.

☐ 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.

_____ _____ _____ _____
Preparer's Signature Title Email Date

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