**South Carolina Workers' Compensation Commission**
1333 Main Street, Suite 500 ● Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723
www.wcc.sc.gov

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Carrier: _____

Preparer's Name: _____ Preparer's Phone #: _____

**This form is only applicable to injuries by accident occurring on or after July 1, 2007 pursuant to Title 42-15-60 (A) as amended. The execution of this document is an agreement between the parties relating to a Workers' Compensation claim under §§42-1-160, 42-1-172 or 42-11-10.**

**Date of Injury or Illness_____**

The above parties agree to pay and accept compensation based on the following facts:
A compensable ☐ Injury ☐ Illness ☐ Repetitive Trauma occurred on: _____ (month/day/year).

The injury was to _____ body part(s) injured and also the injury affected other body part(s).
_____

**The authorized treating physician has released the Claimant from his or her care and has found maximum medical improvement on _____** (month/day/year).
**with an impairment rating of_____.**

Average weekly wage $_____ Compensation rate $_____

**By agreement of the parties**, the following award has been referred to the Commission for approval:

| | | |
|---|---|---|
| ____ Percentage loss of use to: _____ | (body part(s) injured). | _____weeks |
| ____ Percentage loss of use to:_____ | (body part(s) affected). | _____weeks |
| ____ Percentage loss of use to: whole person | | _____weeks |
| Disfigurement to: _____ | | _____weeks |
| Wage Loss: $_____amount | | _____weeks |
| Total and Permanent Disability: _____ | | _____weeks |
| Other: _____ | | _____weeks |

Estimated award (number of weeks times compensation rate) $ _____
**The estimated award is subject to verification by the Commission**

Additionally, the Employer's Representative agrees to pay and the Claimant accepts the following medical care and treatment as recommended by the authorized treating physician pursuant to the attached physician's statement, **Form 14B**

**Additional medical ordered:** ☐ **Yes** ☐ **No**
**See attached 14B physician's statement dated:** _____

☐ **Claimant is entitled to lifetime replacement, repair and maintenance of causally related medical hardware pursuant to 42-15-60(C).**

This agreement is binding on approval by the Commission. A claim for additional compensation based on a worsening of the Claimant's condition **must be filed no later than one (1) year from the date of the last payment of compensation.** Only medical care specifically detailed herein will be paid under this agreement. If a dispute arises with regard to continued medical treatment, either party may request a hearing before the Commission pursuant to 42-15-60(B) 3 and (C).

| | | |
|---|---|---|
| _____ | _____ | _____ |
| Claimant's Signature | Date Agreement Signed | Attorney/Witness/Translator |
| _____ | _____ | _____ |
| Employer's Representative | Attorney for Carrier | Email |
| _____ | _____ | _____ |
| Claims Mediator | Date Agreement Approved | Jurisdictional Commissioner |