**South Carolina Workers' Compensation Commission**
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723

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

Claimant's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Preparer's Name: _____ Law Firm: _____

Employer's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Insurance Carrier: _____
Preparer's Phone #: _____

1. Date of injury: _____ (m/d/yyyy)
2. Total Weeks Compensation Paid: _____
3. Type of Compensation Paid (TP or TT)/Periods of Payment:

| | | (m/d/yyyy) From: | (m/d/yyyy) To: |
|---|---|---|---|
| Type: | _____ | _____ | _____ |
| Type: | _____ | _____ | _____ |
| Type: | _____ | _____ | _____ |

4. Date of First Payment: _____ (m/d/yyyy)
5. Total Amount Paid
   (a) Compensation: $ _____
   (b) Medical (Include Nursing, Hospital, Drugs, Etc.): $ _____
6. Informal Conference is Requested: ☐ Yes ☐ No (check one)

Use these lines to send a memo to the Commission: _____

_____

_____

_____

_____ _____ _____
Employer's Representative Phone Date

Type or print all information. File this form six months after the alleged injury date and each six months until the Commission's File is closed. Form 18 must be filed whether or not compensation is ongoing. Check "yes" after Number 6 to request an informal conference. Refer to R.67-413 and R.67-804 for further information.