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| **South Carolina Workers’ Compensation Commission**1333 Main Street, Suite 500 ● Post Office Box 1715Columbia, South Carolina 29202-1715(803) 737-5723 [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: |       |

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| --- | --- | --- | --- |
| 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: Date of Injury or Illness:\_\_\_\_\_\_\_\_\_\_\_**

[ ] 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. | 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 |
|  9a. | [ ] A determination of permanent disability is premature at this time. |
| [ ] 10. | Due to the injury, the Claimant has a serious bodily disfigurement consisting of:       |
|  10a. | 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. |
|  10b. | Give names and addresses of all employers for whom the Claimant has worked since the date of the accident:      |
|  11. | Further grounds or unusual aspects of claim:       |
|  11a. | List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident:      |
|  11b. | To the best of your knowledge, did you have any prior permanent disability?      If yes, describe:       |
|  12. | 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. |
| [ ] 13a. | **I am filing a claim. I am not requesting a hearing at this time.**  |  |  14. | Estimated time needed for hearing:      \_\_\_\_\_\_ |
| [ ] 13b. | **I am requesting a hearing. A $25 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 by delivering a copy to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_**

**address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on the \_\_\_day of \_\_\_\_20\_\_,by** [ ]  **first class postage** [ ] **certified mail** [ ] **personal 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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| Questions about the use of this form should be directed to the Claims Department at 803.737.5723. Refer to Regulations 67-204 through 67-211 and Regulations 67-601 through 67-615 as well as Reg. 67-1801.

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| **WCC Form # 50**Revised 7/13 | 50 | Employee’s Notice of Claim and/or Request for Hearing |

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