



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: _____ Date of Injury or Illness: _____

- 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 _____. Body part(s) affected are: _____
2. 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 \$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 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.

Preparer's Signature _____ Title _____ Email _____ Date _____

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.