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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **South Carolina Workers’ Compensation Commission**  1333 Main Street, Suite 500  P.O. BOX 1715  Columbia, SC 29202-1715  (803) 737-5675 [www.wcc.sc.gov](http://www.wcc.sc.gov) | SCSealBWjpg | | |  |  | | --- | --- | | WCC File #: |  | |  |  | | Carrier File #: |  | |  |  | | Carrier Code #: |  | |  |  | | Employer FEIN #: |  | |  |  | |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Claimant's Name: | | |  | | | SSN: | | -  - | | |  | |  | | | | | | | | | Address: | |  | | | | | | | | |  |  | | |  |  | |  | |  | | City: |  | | | State: |  | | Zip: | |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Home Phone: | (     )    - | | Work Phone: | (     )    - | | | |  |  | |  | |  | | | Preparer's Name: | |  | | | | | | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Employer's Name: | | |  | | | | | |  | | |  | | | | | | Address: | |  | | | | | | |  |  | | |  |  |  |  | | City: |  | | | State: |  | Zip: |  |  |  |  | | --- | --- | | Carrier: |  |      |  |  | | --- | --- | | Preparer’s Phone #: | (     )    - | |  |  | | |

**Check applicable claims and complete all blanks.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. | The employee sustained a compensable accidental injury to the | | | | | | |  | | (part of the body) on |  | | | (date) | |
|  | in |  | | | (county), | State of |  | | | | | | (state) | | . |
| 2. | That the Second Injury Fund was put on notice of the claim on | | | | | | |  | | | | (date) . | | | |
| 3. | That the carrier concluded the disability claim by  Award  Agreement on | | | | | | | |  | | | (date) . | | | |
| 4. | That the subsequent injury combined with or was aggravated by the below-named permanent impairment under S.C. Code Section 42-9-400(d): | | | | | | | | | | | | | | |
|  | a. Listed Impairment – (1) – (33) | | | |  | | | | | | | | | | |
|  | b. (34) (a) | |  | | | | | | | | | | | | |
|  | c. (34) (b) | |  | | | | | | | | | | | | |
| 5. | a. That the impairment preexisted; | | | | | | | | | | | | | | |
|  | b. That the impairment was permanent; and | | | | | | | | | | | | | | |
|  | c. That the impairment is a physical condition. | | | | | | | | | | | | | | |
| 6. | That the prior impairment combined with or was aggravated by the subsequent injury. | | | | | | | | | | | | | | |
| 7. | That the combination/aggravation substantially increased the liability of the carrier for:  disability  medical or  both. | | | | | | | | | | | | | | |
| 8. | That the impairment was a hindrance or obstacle to employment or re-employment. | | | | | | | | | | | | | | |
| 9. | a. That the employer has knowledge of the prior impairment; | | | | | | | | | | | | | | |
|  | b. That the impairment was unknown to the employee and the employer; or | | | | | | | | | | | | | | |
|  | c. That the employee concealed the prior impairment from the employer. | | | | | | | | | | | | | | |
| 10. | That the subsequent injury would not have occurred “but for” the prior impairment. | | | | | | | | | | | | | | |
| 11. | That the above claim qualifies for reimbursement under S.C. Code Section 42-9-410 because: | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | |
| 12. | Other grounds for claim: | | |  | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | |

**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**](mailto: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.**

**A $50.00 filing fee is required.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preparer’s Signature Title Email Date