

**South Carolina Workers' Compensation Commission**

1333 Main Street, Suite 500  
Post Office Box 1715  
Columbia, South Carolina 29202-1715  
(803) 737.5675 [www.wcc.sc.gov](http://www.wcc.sc.gov)



WCC File #: \_\_\_\_\_  
Carrier File #: \_\_\_\_\_  
Carrier Code #: \_\_\_\_\_  
Employer FEIN #: \_\_\_\_\_

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 #: ( ) - \_\_\_\_\_

The date of injury reported on Form 12A is: \_\_\_\_\_ (m/d/yyyy)

**Check appropriate section(s). The Employer's Representative requests a hearing to:**

I.  **Stop payment of compensation.** Claimant has reached maximum medical improvement and Claimant continues to receive temporary compensation payments. The employer's representative requests a hearing pursuant to § 42-9-260(D) to stop payment of temporary compensation. A hearing requested pursuant to this section must be held within sixty days of the date of the request.

Claimant reached maximum medical improvement on \_\_\_\_\_ (m/d/yyyy) (copy of medical report must be attached).  
Compensation payments are current as of \_\_\_\_\_ (m/d/yyyy) and shall continue until otherwise ordered or until Form 17 is signed by the claimant.  
A Form 17 was offered and refused on \_\_\_\_\_ (m/d/yyyy).

II.  **Address suspension, termination, or reduction of temporary disability payments for any cause.**

- a. At any time pursuant to § 42-9-260(E).
- b. After the one-hundred-fifty day period has expired pursuant to § 42-9-260(F), R.67-505 and R.67-506.

The basis for the termination/ suspension is \_\_\_\_\_

III.  **Determine if compensation is due** pursuant to § 42-9-10, § 42-9-20 or § 42-9-30 and, if so, in what amount, based on the following grounds:

\_\_\_\_\_ Claimant reached maximum medical improvement on \_\_\_\_\_ (m/d/yyyy) (copy of medical report must be attached).

IV.  **Request Credit for Overpayment of temporary compensation pursuant to § 42-9-210.**

V.  **Determine amount of compensation for claims involving a fatality.**

- a. Payment of unpaid balance of compensation when employee dies pursuant to § 42-9-280.
- b. Amount of compensation for death of employee due to accident pursuant to § 42-9-290.

VI.  **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.

Failure to respond pursuant to Reg. 67-208 B in writing may result in ordered mediation pursuant to Reg. 67-1801 B.

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  electronic service. **A \$50.00 filing fee and updated Form 18 is required.**

Preparer's Signature \_\_\_\_\_ Title \_\_\_\_\_ Email \_\_\_\_\_ Date \_\_\_\_\_

Questions about the use of this form should be directed to the Judicial Department at 803-737-5675, or [judicial@wcc.sc.gov](mailto:judicial@wcc.sc.gov) or [mediation@wcc.sc.gov](mailto:mediation@wcc.sc.gov)  
Refer to Regulations 67-211, 67-504, 67-505, 67-506; and 67-510.