



Claimant's Name: _____ 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 #: () - _____

1. Date of injury: _____ 2. Total Weeks Compensation Paid: _____
(m/d/yyyy)

3. Type of Compensation Paid (TP or TT)/Periods of Payment:

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

4. Date of First Payment: _____
(m/d/yyyy)

5. Total Amount Paid (a) Compensation: \$ _____
(b) Medical (Include Nursing, Hospital, Drugs, Etc.): \$ _____

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. Refer to R.67-413, and R.67-804 for further information.