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| **South Carolina Workers’ Compensation Commission**1333 Main Street, Suite 500Post Office Box 1715Columbia, South Carolina 29202-1715(803) 737.5700 [www.wcc.sc.gov](http://www.wcc.sc.gov)  | SCSealBWjpg |

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| WCC File #: |  |
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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: |       |

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|  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:**

1. [ ]  **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).

1. [ ]  **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       .

1. [ ]  **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).

1. [ ]  **Request Credit for Overpayment of temporary compensation pursuant to § 42-9-210.**
2. [ ]  **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.

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[ ]  **Amendment to Prior Hearing Request**

[ ] a. I am adding a party pursuant to Reg. 67-610(C). Party Name/Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

[x] b. I am removing a party pursuant to Reg. 67-610(C). Party Name/Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

[ ] c. Other amendment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

[ ]  **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**.

**I certify I have served this document pursuant to Reg. 67-211. See attached certificate of 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 |