



Claimant's Name: _____ Employer's Name: _____
Address: _____ Address: _____
City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____
Home Phone: () - _____ Work Phone: () - _____ Carrier: _____
Preparer's Name: _____ Preparer's Phone #: () - _____

A claim for workers' compensation benefits is made based on the following grounds:

Injury Illness Repetitive Trauma

1. Compensation Rate: _____ 2. AWW: \$ _____ Date of Injury: _____
3. Type of injury and body part(s): _____
4. Facts in controversy: _____

5. Legal issues involved: _____

6. Unusual aspects: _____
7. Witnesses (designate if expert):* _____
8. Exhibits: _____
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance):

10. Name, address, and specialty, if any, of the treating physician: _____
11. Impairment rating(s); body part(s); physician and date of opinion: _____
12. I am amending my Form 50/51 in the following manner: _____

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. See attached certificate of service.

I verify the contents of this form are accurate and true to the best of my knowledge.

Signature: _____ Email: _____
Date of hearing: _____ Time needed for hearing: _____

Questions about the use of this form should be directed to the Jurisdictional Commissioner. Refer to Regulations 67-204 through 67-211 and Regulations 67-601 through 67-615; as well as Regulation 67-1801. File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports. * Commissioners reserve the right to admit expert witnesses at hearings.