South Carolina Workers' Compensation Commission
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Columbia, South Carolina 29202-1715
(803) 737-5723
www.wcc.sc.gov

WCC File #: ____________________
Carrier File #: ____________________
Carrier Code #: ____________________
Employer FEIN #: ____________________

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 #: ( ) -

This form is only applicable to injuries by accident occurring on or after July 1, 2007 pursuant to Title 42-15-60 (A) as amended. The execution of this document is an agreement between the parties relating to a Workers' Compensation claim under §§42-1-160, 42-1-172 or 42-11-10.

Date of Injury or Illness____________

The above parties agree to pay and accept compensation based on the following facts:
A compensable ☐ Injury ☐ Illness ☐ Repetitive Trauma occurred on: ________________ (month/day/year).

The injury was to ______________________________ body part(s) injured and also the injury affected ______________________________ other body part(s).

The authorized treating physician has released the Claimant from his or her care and has found maximum medical improvement on ______________________ (month/day/year).
with an impairment rating of____.

Average weekly wage ________________ Compensation rate ____________________

By agreement of the parties, the following award has been referred to the Commission for approval:

____ Percentage loss of use to: ____________________ (body part(s) injured). _________weeks
____ Percentage loss of use to:____________________(body part(s) affected). _________weeks
____ Percentage loss of use to: whole person _________weeks
Disfigurement to: ____ _________weeks
Wage Loss: $_____amount _________weeks
Total and Permanent Disability: ______________________________ _________weeks
Other: ____ _________weeks

Estimated award (number of weeks times compensation rate) $ ____________
The estimated award is subject to verification by the Commission

Additionally, the Employer's Representative agrees to pay and the Claimant accepts the following medical care and treatment as recommended by the authorized treating physician pursuant to the attached physician's statement, **Form 14B**

Additional medical ordered: ______ Yes ______ No
See attached 14B physician's statement dated: ______________________________

This agreement is binding on approval by the Commission. A claim for additional compensation based on a worsening of the Claimant's condition **must be filed no later than one (1) year from the date of the last payment of compensation**. Only medical care specifically detailed herein will be paid under this agreement. If a dispute arises with regard to continued medical treatment, either party may request a hearing before the Commission pursuant to 42-15-60(B) 3 and (C).

____________________	____________________	____________________
Claimant's Signature	Date Agreement Signed	Attorney/Witness/Translator
____________________	____________________	____________________
Employer's Representative	Attorney for Carrier	Email
____________________	____________________	____________________
Deputy Commissioner	Date agreement approved	Jurisdictional Commissioner