South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 ● Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723
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 #: ( ) -

Complete each information blank. To request a hearing, check Box 13b, indicate the kinds of benefits claimed by checking the box(es) at Lines 6, 7, 8, and 9, and file this form in duplicate.

A claim for workers' compensation benefits is made based on the following grounds: **Date of Injury or Illness:**__________________

☐ Injury ☐ Illness ☐ Repetitive Trauma

1a. The claimant sustained an injury to _____ (Part(s) of Body Injured) on _____ (Month/Day/Year) in _____ county, state of _____.

1b. Body part(s) affected are: _____

Briefly describe how the accident occurred. _____

2. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.

3. The relationship of employer and employee existed at the time of injury.

4. At the time of the injury the claimant was performing services arising out of and in the course of employment.

5. Notice of the accidental injury was given to the Employer on _____ (Month/Day/Year) in the following manner:

☐ 6. Due to injury, the claimant is in need of (check one):

☐ (a) medical examination and treatment for: _____

☐ (b) additional medical examination and treatment for: _____

☐ 7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:

_____

☐ 8. Due to the injury, the Claimant has permanent disability of the following nature and extent (check one):

☐ (1) General Disability: ☐ Total ☐ (2) Specific Disability: ☐ Total
☐ (3) Wage Loss ☐ Partial ☐ Partial

☐ 9. Due to the injury, the Claimant has a serious bodily disfigurement consisting of:

_____

10a. At the time of the injury, the Claimant was paid weekly wages of $_____, and demands accounting of days worked and wages earned as provided by law.

10b. Give names and addresses of all employers for whom the Claimant has worked since the date of the accident:

11a. Further grounds or unusual aspects of claim:

11b. List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident:

11c. To the best of your knowledge, did you have any prior permanent disability? _____
If yes, describe: _____

12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.

☐ 13a. **I am filing a claim. I am not requesting a hearing at this time.**

☐ 13b. **I am requesting a hearing. A $25 fee is required.**

14. Estimated time needed for hearing: ____________________

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

____________ ____________ ____________ ____________
Preparer's Signature Title Email Date

Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Claims Department.