

NOTICE OF ACCIDENT TO EMPLOYER AND CLAIM OF EMPLOYEE, REPRESENTATIVE, OR DEPENDENT (G.S. §§97-22 THROUGH 24)

IC File # _____

Emp. Code # _____

Carrier Code # _____

Employer FEIN _____

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employee's Name _____			Employer's Name _____ Telephone Number _____		
Address _____			Employer's Address _____ City _____ State _____ Zip _____		
City _____ State _____ Zip _____		Insurance Carrier _____ Policy Number _____			
Home Telephone _____ () _____		Carrier's Address _____ City _____ State _____ Zip _____		Work Telephone _____ () _____	
Social Security Number _____		Carrier's Telephone Number _____		Carrier's Fax Number _____	
Sex <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth _____ / _____ / _____			

EMPLOYEE – This form must be filed with the Industrial Commission within two years of the date of injury or occupational disease or your claim may be barred. Notice shall be given to the employer immediately after the accident or as soon as practicable and within 30 days. (This form should also be used for occupational disease claims; however, for asbestosis, silicosis and byssinosis, Form 18B is to be used.)

Notice is hereby given, as required by law, that the above-named employee sustained an injury or contracted an occupational disease, described as follows: _____ on _____ at _____. Describe the injury or occupational disease, including the specific body part involved (e.g., right hand, left hand) _____
Time of Injury Date (required) City and County
Describe how the injury or occupational disease occurred: _____

Occupation when injured: _____ Nature of employer's business: _____
Number of days out of work due to injury: _____
Medical treatment received? Yes _____ No _____
Weekly wage: _____ Number of hours worked per day: _____ Days worked per week: _____

NOTE: If employee is unable to sign this form, another may sign for him. This form should be typewritten, if possible. Employee should retain one signed copy of this notice, mail one signed copy to the Industrial Commission at the address below, and provide one signed copy to employer.

Signature of (Check One) Employee, Attorney,
 Representative, or Dependent Telephone Number _____

Address _____ City _____ State _____ Zip _____ Date Completed _____

EMPLOYER: This notice is being sent to you in compliance with requirements of the North Carolina Workers' Compensation Act, in order that the medical services prescribed by the Act may be obtained; and, if disability extends beyond 7 days duration, or if death ensues, compensation may be paid according to law.

FOR IC USE ONLY
RESEARCHER: _____
CC: _____
EC: _____
DATA ENTRY: _____