

# EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

\*Emp. Code # \_\_\_\_\_

\*Carrier Code # \_\_\_\_\_

**To the Employer:**

A copy of this Form 19 accompanied by a blank Form 18 must be given to the employee. It does not satisfy the employee's obligation to file a claim. The filing of this report is required by law.

This form MUST be transmitted to the Industrial Commission through your Insurance Carrier.

Employer FEIN \_\_\_\_\_

Carrier File # \_\_\_\_\_

**To the Employee:**

This Form 19 is not your claim for workers' compensation benefits. To make a claim, you must complete and sign the enclosed Form 18 and mail it to Claims Administration, N.C. Industrial Commission, 4335 Mail Service Center, Raleigh, NC 27699-4334 within two years of the date of your injury or last payment of medical compensation. For occupational diseases, the claim must be filed within two years of the date of disability or the date your doctor told you that you have a work-related disease, whichever is later.

**\*Required Information.**

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

<b>Employer</b>	1. Give nature of employer's business _____
<b>Time And Place</b>	2. Location of plant where injury occurred County _____ Department _____ State if employer's premises _____
	3. Date of injury / / 4. Day of week _____ Hour of day : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
	5. Was employee paid for entire day 6. Date disability began / / <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
	7. Date you or the supervisor first knew of injury / / 8. Name of supervisor _____
<b>Person Injured</b>	9. Occupation when injured _____
	10. (a) Time employed by you _____ (b) Wages per hour \$ _____
	11. (a) No. hours worked per day _____ (b) Wages per day \$ _____ (c) No. of days worked per week _____
	(d) Avg. weekly wages w/ overtime \$ _____ (e) If board, lodging, fuel or other advantages were furnished in addition to wages, estimated value per day, week or month. \$ _____ per _____
<b>Cause And Nature Of Injury</b>	12. Describe fully how injury occurred and what employee was doing when injured _____  (Statement made without prejudice and without vouching for correctness of information)
	13. List all injuries and specify body part involved (e.g. right hand or left hand) _____
	14. Date & hour returned to work / / at : .M. 15. If so, at what wages \$ _____ per _____
	16. At what occupation _____ 17. Employee's salary continued in full? _____
	18. Was employee treated by a physician _____
<b>Fatal Cases</b>	19. Has injured employee died 20. If so, give date of death (Submit Form 29) / / _____

Employer name \_\_\_\_\_ Date Completed / /  
 Signed by \_\_\_\_\_ Official Title \_\_\_\_\_

**OSHA 301 Information:**

Case Number from Log: _____	Date Hired: / / _____	Time Employee began work on date of incident: : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	If off-site medical treatment provided, answer entire next line.
Name of facility: _____	Address: Street/City/Zip/Telephone _____		ER visit? <input type="checkbox"/> Yes <input type="checkbox"/> No Overnight stay? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Attention:** This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

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

## IMPORTANT INFORMATION FOR EMPLOYER

Employer must furnish a copy of this form, as completed, to the employee or the employee's representative when submitted to the Insurance Carrier or Claims Administrator for transmission to the Commission. Every question must be answered. This Form 19 must be transmitted to the Commission through your insurance carrier/claims administrator, and is required by law to be filed within 5 days after knowledge of accident. Employer must also give employee a blank Form 18.

## IMPORTANT INFORMATION FOR EMPLOYEE

### Reporting an Injury

If you do not agree with the description or time of the accident given on this form, you should make a written report of injury to the employer within thirty (30) days of the injury.

### Making A Claim

To be sure you have filed a claim, complete a Form 18, Notice of Accident, within two years of the date of the injury and send a copy to the Industrial Commission and to your employer. The employer is required by law to file this Form 19, but the filing of the Form 19 does not satisfy the employee's obligation to file a claim. The employee must file a Form 18 even though the employer may be paying compensation without an agreement, or the Commission may have opened a file on this claim. A claim may also be made by a letter describing the date and nature of the injury or occupational disease. This letter must be signed and sent to the Industrial Commission and to your employer.

**FOR ASSISTANCE OR TO OBTAIN A FORM 18 FROM THE INDUSTRIAL COMMISSION, YOU MAY CALL (800) 688-8349**

USE YOUR I.C. FILE NUMBER (IF KNOWN) OR SOCIAL SECURITY NUMBER ON  
ALL FUTURE CORRESPONDENCE WITH THE COMMISSION

[SPANISH TRANSLATION]

## INFORMACIÓN IMPORTANTE PARA LOS EMPLEADOS

### Reporte de una Lesión (Reporting an Injury)

Si usted no está de acuerdo con la descripción o la hora del accidente que aparece en el formulario, debe hacer un reporte de la lesión por escrito y dárselo a su empleador dentro de un período de treinta (30) días a partir de la fecha de la lesión.

### Cómo Presentar una Reclamación (Making a Claim)

Para cerciorarse de que ha presentado una reclamación, complete el Formulario 18 Notificación de Accidente dentro de un período de dos años a partir de la fecha de la lesión y envíe una copia a la Comisión Industrial y una copia a su empleador. Por ley, el empleador debe presentar el Formulario 19, sin embargo, el presentar el Formulario 19 no cumple con la obligación que tiene el empleado de presentar una reclamación. El empleado debe presentar el Formulario 18 aunque el empleador esté pagando compensación sin tener un acuerdo o si la Comisión ha creado un expediente con respecto a esta reclamación. También se puede presentar una reclamación por medio de una carta explicando la fecha y la naturaleza de la lesión o la enfermedad ocupacional. Esta carta se debe firmar y enviar a la Comisión Industrial así como al empleador.

**PARA RECIBIR ASISTENCIA O PARA OBTENER EL FORMULARIO 18 DE LA COMISIÓN INDUSTRIAL, USTED  
PUEDE HABLAR AL (800) 688-8349**

EN TODA LA CORRESPONDENCIA QUE ENVÍE A LA COMISIÓN INDUSTRIAL POR FAVOR ESCRIBA  
EL NÚMERO DE CASO DESIGNADO POR LA COMISIÓN [I.C. FILE NUMBER] (SI LO SABE)  
O SU NÚMERO DE SEGURO SOCIAL.

# 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 _____		
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) \_\_\_\_\_ 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 typed or printed by hand in black ink, 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) <input type="checkbox"/> Employee, <input type="checkbox"/> Attorney, _____				Telephone Number ( ) - _____			
<input type="checkbox"/> Representative, or <input type="checkbox"/> Dependent							
Address _____				Date Completed / / _____			
City _____				State _____ Zip _____			

**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: \_\_\_\_\_

**MAIL TO:**  
NCIC - CLAIMS ADMINISTRATION  
4335 MAIL SERVICE CENTER  
RALEIGH, NORTH CAROLINA 27699-4335  
MAIN TELEPHONE: (919) 807-2500  
HELPLINE: (800) 688-8349  
WEBSITE: HTTP://WWW.COMP.STATE.NC.US/

## GENERAL INFORMATION ON THE FORM 18

### **1. What does a Form 18 do?**

A Form 18 establishes a legal claim of injury on your behalf if filed within two years of the date of injury or occupational disease, and gives the required written notice to the employer if a copy is submitted to the employer within 30 days of the injury. The employer is required by law to file a Form 19 if the employee misses more than one day of work due to the injury or if the medical bills exceed \$2,000.00. However, the employer's filing of a Form 19 does not satisfy the employee's obligation to file a claim. In order to ensure the employee's rights are protected, the employee must file a Form 18 even though the employer may be paying compensation or the Industrial Commission may have opened a file for the injury.

### **2. To whom should the Form 18 be sent?**

The original Form 18 should be submitted to the Industrial Commission. The injured worker should keep one copy for his or her records and one copy should be submitted to the employer at the time of the injury.

### **3. What numbers do I write in the upper right corner?**

You do not need to fill in the spaces on the upper right corner of the Form 18. If you know that your employer has already filed a report of injury, (Form 19) and you know what your I.C. (Industrial Commission), File Number is, you may write the number in the "I.C. File No." space. If you do not already have an I.C. File Number, the Industrial Commission will assign one upon receipt of the Form 18. The other three spaces, "Emp. Code No.," "Carrier Code No.," and "Employer FEIN" are for internal use only.

### **4. What if I do not know who my employer's insurance carrier is?**

If you do not know who the employer's insurance carrier is you may either ask your employer for the information, call the Industrial Commission's Claims Administration Section at (800) 688-8349 then press "1" after the prompt, or simply leave the line blank.

### **5. When listing the number of days out of work, do I count partial days?**

Yes, you include partial as well as whole calendar days not worked. However, the days do not need to be consecutive.

### **6. What happens after I file the Form 18?**

The Industrial Commission will mail an acknowledgement letter to you after your Form 18 is processed. Processing time varies according to current workload. The Industrial Commission will mail a copy of the acknowledgement letter to the employer or its workers' compensation insurance carrier asking them to contact you and inform you if compensation will be paid to you voluntarily.