

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 _____

Home Telephone _____ Work Telephone _____

Social Security Number _____ Sex M 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 as soon as the accident occurred or as soon thereafter 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: _____

Disability began: _____ Date Return to work date or period of estimated disability: _____ Date

Weekly wage: _____ Number of hours worked per day: _____ Days worked per week: _____

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.

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

Telephone Number _____

Address _____ City _____ State _____ Zip _____ Date Completed _____

NOTE –If injured is unable to sign this, 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 Industrial Commission at the address below, and furnish employer with one signed copy.

For IC use ONLY
Nature _____
Body _____
Cause _____
SIC _____
Coder _____

MAIL TO:

NCIC - STATISTICS SECTION
4334 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4334
MAIN TELEPHONE: (919) 733-4820
OMBUDSMAN: (800) 688-8349