

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, Address, Telephone Number, Employer's Name, Address, City, State, Zip, Insurance Carrier, Policy Number, Carrier's Address, City, State, Zip, Carrier's Telephone Number, Carrier's Fax Number, Home Telephone, Sex, Date of Birth, Social Security Number

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) [] 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: _____