State of South Carolina

1333 Main Street, 5th Floor
P.O. Box 1715
Columbia, S.C. 29202-1715

TEL: (803) 737-5700
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Workers' Compensation Commission

February 21, 2019

ADVISORY NOTICE

Changes to Commission Forms

The Commission edited the language on the Form 50, Form 30, Form 32 and Form 18 for the purposes of clarity and judicial expediency. In addition to these changes the Commission discontinued the use of the Form 22. Any Form 22 submitted after the below effective date will be returned.

Changes to the Form 50

- The "Date of Injury or Illness" has been removed since the information is captured in item number one (1).
- 9a has been changed in order to determine if claimant is at MMI for purposes of determining if the claim is subject to mandatory mediation. This section must be completed or the Form will be returned.
- 13a and 13b are eliminated. Use check box number 13 for filing of a claim, and use check box number 14 to request a hearing.
- A check box has been included for electronic service as an option for service. The email address used for service must match what is listed in eCase or with the S.C. Bar Association.

Changes to the Form 30

- Language has been added regarding mediation.
- A check box has been included for electronic service as an option for service. The email address used for service must match what is listed in eCase or with the S.C. Bar Association.

Changes to the Form 18

- Requesting an informal conference and sending a memo to the Commission is no longer available via this form. To request an informal conference send a letter to the Judicial Department or an email to conferences@wcc.sc.gov.

Changes to the Form 32

- The word "appeal" was removed from the titling of the form since it may be used by a *pro se* claimant on any filing fee.

Effective March 1, 2019 all pleadings submitted on outdated forms will be returned.

For additional information, please contact:

Amy Bracy
Judicial Director
Judicial@wcc.sc.gov
803.737.5672

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 #: ( ) -

A claim for workers' compensation benefits is made based on the following grounds:
☐Injury ☐ Illness ☐ Repetitive Trauma ☐Occupational Disease ☐Physical Brain Injury ☐Concurrent Jurisdiction

1. The claimant sustained an injury to _____ (Part(s) of Body Injured) on _____ (Month/Day/Year) in _____ county, state of _____.
2. Body part(s) affected are: _____
   Briefly describe how the accident occurred. _____
3. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
4. The relationship of employer and employee existed at the time of injury.
5. At the time of the injury the claimant was performing services arising out of and in the course of employment.
6. Notice of the accidental injury was given to the Employer on _____ (Month/Day/Year) in the following manner:

☐7. Due to injury, the claimant is in need of (check one):
   ☐(a) medical examination and treatment for: _____
   ☐(b) additional medical examination and treatment for: _____

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

☐9. Due to the injury, the Claimant has permanent disability of the following nature and extent (check one):
   ☐(1) General Disability: ☐Total ☐ Partial ☐(2) Specific Disability: ☐Total ☐ Partial ☐ (3) Wage Loss
   9a. Claimant at MMI: ☐ Yes ☐ No

☐10. 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:

11. Further grounds or unusual aspects of claim:

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

11b. 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.

☐13. **I am filing a claim. I am not requesting a hearing at this time.** Estimated time needed for hearing: ___________

☐14. **I am requesting a hearing. A $50 fee is required.**

☐ **Mediation**
   ☐a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
   ☐b. Mediation is required pursuant to Reg. 67-1802.
   ☐c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
   ☐d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to **mediation@wcc.sc.gov.**

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to____
address____________________________ on the ___day of _____20__,by ☐ first class postage ☐certified mail ☐personal service ☐electronic service

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

Preparer's Signature ______ Title ______ Email ______ Date ______

Questions about the use of this form should be directed to the Claims Department at 803.737.5723. Refer to Regulations 67-204 through 67-211 and Regulations 67-601 through 67-615 as well as Reg. 67-1801.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5675 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 #: (   ) - ______

REQUEST FOR COMMISSION REVIEW

Request for Commission Review by ☐ Claimant ☐ Employer (check one) Date of Injury or Illness: (m/d/yyyy)

The undersigned makes application for review of the findings of the Commissioner in the above-captioned case. The request for review is based on the following grounds: (State the grounds of your appeal in the form of questions presented. Each question presented must contain a concise statement of one proposition of law or fact. Refer to evidence by title and exhibit number. Use additional pages if necessary).

____
____
____
____
____
____
____

(Check one) Oral argument ☐ is ☐ is not requested. Appellant's request for oral argument is waived if not indicated on this form.

☐ **Mediation**

- ☐a. Mediation is requested by consent of the Parties pursuant to Reg. 67-1801 B.
- ☐b. Mediation is required pursuant to Reg. 67-1802.
- ☐c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
- ☐d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to **mediation@wcc.sc.gov**.

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to____________________

address____________________ **on the ___day of _____20__,**

by ☐first class postage ☐certified mail ☐ personal service ☐ electronic service

____________ ____________ ____________ ____________
Preparer's Signature Title Email Date

Check this box if you are not represented by an attorney ☐

Questions about the use of this form should be directed to the Judicial Department at 803.737.5675 or appeals@wcc.sc.gov.

If the claimant appeals and is not represented by counsel, the Judicial Department will properly serve this form pursuant to Reg. 67-607 C. Pursuant to Reg. 67-205 and Reg. 701, the appeal must be postmarked no later than 14 days from the date of service of the Decision and Order of the Hearing Commissioner along with the filing fee. Attach a Form 32, if you are unable to pay the filing fee. Refer to Reg. 67-211 and Reg. 67-701 through 711.

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WCC File #: ____________________
Carrier File #: ____________________
Carrier Code #: ____________________
Employer FEIN #: ____________________

Claimant's Name: ____________________ 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 #: ( ) -

1. **Date of injury:** ____________________ (m/d/yyyy)

2. Total Weeks Compensation Paid: ____________________

3. Type of Compensation Paid (TP or TT)/Periods of Payment:

Type:	From: (m/d/yyyy)	To: (m/d/yyyy)
______	______	______
______	______	______
______	______	______
______	______	______

4. Date of First Payment: ____________________ (m/d/yyyy)

5. Total Amount Paid
   (a) Compensation: $ ____________________
   (b) Medical (Include Nursing, Hospital, Drugs, Etc.): $ ____________________

Employer's Representative ____________________ Phone ( ) - ____________ Date ____________

Type or print all information. File this form six months after the alleged injury date and each six months until the Commission's File is closed. Form 18 must be filed whether or not compensation is ongoing. Check "yes" after Number 6 to request an informal conference. Refer to R.67-413, and R.67-804 for further information.

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Carrier Code #: ____________
Employer FEIN #: ____________

Claimant's Name: ____________ SSN: ____________ Employer's Name: ____________
Address: ____________ Address: ____________
City: ____________ State: ______ Zip: ______ City: ____________ State: ______ Zip: ______
Home Phone: ( ) - Work Phone: ( ) - Carrier: ____________
Preparer's Name: ____________ Preparer's Phone #: ( ) -

REQUEST TO WAIVE FILING FEE

1. Are you presently employed? ☐ Yes ☐ No
   a. If yes, state the name and address of your employer and wages below.
   b. If no, where did you last work, when did you stop working, and what were your wages?
   c. Is your spouse employed? ☐ Yes ☐ No If yes, where? ____________
      What are your spouse's wages? $ ____________
   d. What is the total income of all working members of your household?
2. How many people are dependent on you for their support (include children and relatives)? ____________
   How much do you spend weekly for their support? $ ____________
3. List any money you have received in the past year other than that listed above and state from what source that money came (gift, inheritance, insurance, other).
4. Do you have a checking or savings account? ☐ Yes ☐ No
   If yes, what is the balance in each account? Checking: $ ____________ Savings: $ ____________
5. Do you rent or own your home? ☐ Rent ☐ Own Rent or mortgage payment: $ ____________
6. Do you own a car? ☐ Yes ☐ No Payments: $ ____________
7. List the names of your creditors and amount of debt.

To the best of my knowledge, the information above is true and accurate. I have made no attempt to misrepresent my financial condition. I request that the filing fee be waived.

Signature ____________ Date ____________

For official use only. ☐ Fee Waived ☐ Waiver Rejected ☐ Other Disposition

Chair, S.C. Workers' Compensation Commission

File this form with a Form 30, Application for Commission Review. Refer to R.67-701 through R.67-711 for additional information. File this form with a Form 50, 52, 54, Requests for Motions, Consents and Settlements. Refer to R.67-207, R.67-208, R.67-215, R.67-803 and R.67-805.