North Carolina Industrial Commission

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

IC File #_____

Emp. FEIN_____

Carrier FEIN_____

Carrier File #_____

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.

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, 1235 Mail Service Center, Raleigh, NC 27699-1235 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.

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 | ☐ M ☐ F Sex | / / Date of Birth | ( ) - Carrier's Telephone Number | ( ) - Fax Number

Employer	1.	Give nature of employer's business
Time And Place	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 : ☐ A.M. ☐ P.M.
	5.	Was employee paid for entire day 6. Date disability began / / ☐ A.M. ☐ P.M.
	7.	Date you or the supervisor first knew of injury / / 8. Name of supervisor
Person Injured	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
Cause And Nature Of Injury	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
Fatal Cases	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: : ☐ A.M. ☐ P.M.	If off-site medical treatment provided, answer entire next line.	
Name of facility:		Address: Street/City/Zip/Telephone	ER visit? ☐ Yes ☐ No	Overnight stay? ☐ Yes ☐ 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:_____

FORM 19

SELF-INSURED EMPLOYER OR CARRIER, FILE AS **FROI** VIA **EDI:**
HTTP://WWW.IC.NC.GOV/EDIFORM19.HTML

UNINSURED EMPLOYERS OR LUNG DISEASE CLAIMS:
E-MAIL TO: FORMS@IC.NC.GOV OR MAIL TO: NCIC - CLAIMS SECTION, 1235 MAIL SERVICE CENTER, RALEIGH, NC 27699-1235
MAIN TELEPHONE: (919) 807-2500 HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

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 ceriorarse 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.

FORM 19

SELF-INSURED EMPLOYER OR CARRIER, FILE AS **FROI** VIA **EDI:** **HTTP://WWW.IC.NC.GOV/EDIFORM19.HTML**

UNINSURED EMPLOYERS OR LUNG DISEASE CLAIMS:
E-MAIL TO: **FORMS@IC.NC.GOV** OR MAIL TO: **NCIC - CLAIMS SECTION, 1235 MAIL SERVICE CENTER, RALEIGH, NC 27699-1235**
MAIN TELEPHONE: **(919) 807-2500** HELPLINE: **(800) 688-8349**
WEBSITE: **HTTP://WWW.IC.NC.GOV/**

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

City State Zip

( ) -
Home Telephone

- - ☐ M ☐ F / /
Social Security Number Sex Date of Birth

Employer's Name ( ) -
Telephone Number

Employer's Address City State Zip

Insurance Carrier Policy Number

Carrier's Address City State Zip

( ) - ( ) -
Carrier's Telephone Number Carrier's Fax 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: _____ (Time of Injury) on ____/ /____ (Date (required)) at _____ (City and County). 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.

FORM 18
8/1/08
PAGE 1 OF 1

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

FORM 18

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.IC.NC.GOV/

SUPERVISOR REPORT OF ACCIDENT INVESTIGATION

Employee Name: _____ Date of Report: _____

Occupation: _____ Age: _____ Date of Hire: _____

Date and Time of Accident/Injury: _____ Exact Location: _____

Description of Accident (What was Employee doing? What tools or equipment was he/she using?) _____

_____

_____

_____

Witness (Names/What they saw or heard and when?) _____

_____

_____

_____

Describe extent of Employee's injury _____

_____

When did Employee report the accident? Date: _____ Time: _____

Did Employee go to a doctor for treatment? _____ Which one? _____

Did Employee go to a hospital? _____ Which one? _____

Did the Employee return to work after the accident? _____ When? _____

After investigating this accident, was this caused by an unsafe act or unsafe condition?

_____

_____

What should be done, and by whom, to prevent this accident from recurring in the future?

_____

_____

What are you doing to see that this is done? _____

_____

Supervisor's Signature _____ Date: _____

EMPLOYEE'S STATEMENT

NAME _____ DATE OF INJURY _____

Please explain when, how and where accident occurred and injuries received _____

_____

_____

_____

_____

(If additional space is needed, attach a separate sheet.)

1. Use of Leave – if you lose time from work, you may choose one of the following:
   a. Elect to take earned sick leave during the required waiting period and then go on workers' compensation leave and begin drawing workers' compensation weekly benefits.
   b. Elect to go on workers' compensation leave with no pay for the required waiting period and then begin drawing workers' compensation weekly benefits.
   c. Elect to supplement the workers' compensation weekly benefit with the use of partial earned sick leave in accordance with the State Board of Education Workers' Compensation Policy.

   Note: All elections involving the use of earned sick leave are subject to their availability.

2. Waiting Period – No compensation shall be paid for the first seven days of disability unless the disability continues for more than 21 days. (Sick leave may be used for the first 7 days.)

3. Workers' Compensation Rate – Two/thirds of your average weekly wage during the 52 weeks preceding the date of the injury not to exceed the maximum established by the N.C. Industrial Commission.

4. Medical Services and Referrals – You may choose you own doctor. You may not change doctors unless you are referred to another doctor by the last treating physician or obtain approval from the State Board of Education and/or the N.C. Industrial Commission.

5. Nursing Services – Nursing services are provided only at the request of the treating physician. NOTE: Housekeeping services in your home and/or childcare are not considered nursing care.

6. Prescription Drugs – All prescription drugs must be on Form 25P giving the name of the doctor, name of drug and receipts attached before reimbursement can be made.

7. Travel – Employees are entitled to mileage for medical treatment at the rate of 20 cents per mile beyond a 10-mile radius from point of origin. (Form 25T must be completed for reimbursement.)

I have read the above information and understand the rules set out to be followed in the handling of my claim.

Witness _____ Employee's Signature _____

Date _____ Date _____

Witness Statement

Witness:

Date:

Statement:

_____

_____

_____

_____

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_____

_____

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_____

_____

_____

_____

Signature

sedgwick®

MEDICAL AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the use or disclosure of my individually identifiable health information, as described below, for purposes of administering my claim or request for reasonable accommodation. I understand that the information I authorize to be used or disclosed possibly may be re-disclosed in accordance with the terms of this Authorization by the recipient and may no longer be protected by federal privacy regulations.

I specifically authorize physicians, nurses and hospitals to communicate information by any reasonable means, including written or telephonic communications or by direct interview, whether or not I am present during or notified of such communications, and I hereby authorize Sedgwick to initiate and conduct such communications whether or not I am present or have received notice.

1. **What Information is covered by this Authorization.** This authorization applies to all medical, psychological, and/or psychiatric information, records and reports, including information regarding pre-existing conditions (a) that are in existence while this authorization is valid (see Item 3) and (b) that are related to any of the following: my request for reasonable accommodation; my workers' compensation claim; my claim for disability benefits; my claim for bodily injury; my claim for personal injury; my claim for FMLA or my claim for dental benefits.

My claim or request for reasonable accommodation involves the following condition:

_____

Information to be disclosed may include, but is not limited to, medical history, chart notes, prescriptions, diagnostic test results, x-ray reports, and records received from other health providers. If directly related to my claimed condition, I am authorizing the release of the following information **(Please check "yes" to release the information or "no" to not release it and initial your choice. NOTE: checking "yes" or "no" does NOT mean that you have any of the following conditions or that any of the following types exists)**:

HIV test results, HIV or AIDS information.	YES	☐	NO	☐	Initial here_____
Psychiatric information.	YES	☐	NO	☐	Initial here_____
Information related to drug or alcohol abuse.	YES	☐	NO	☐	Initial here_____

2. **Who is covered by this Authorization.**

A. Any person or facility that attends, treats or examines me, including but not limited to

_____

(specific name, if needed) is to make this information available to Sedgwick Claims Management Services, Inc. ("Sedgwick ") or its representative; and

B. When relevant to my claim, Sedgwick may re-disclose (without further authorization) this information to any of the following, (a) Any person or facility that attends, treats or examines me; (b) Any person or facility that impacts determination of my claim or that coordinates my benefits, including without limitation the employer to the extent permitted by state or federal law; or (c) The Social Security Administration or a social security or vocational rehabilitation vendor. Sedgwick may use information obtained pursuant to this authorization in any other claim matter they handle related to me.

''''03259342 848-6341''''

3. **How Long this Authorization is Valid.** This authorization is valid during the duration of my claim(s) and any future related claims, unless a different period is required under state law--release in connection with a claim for benefits for health insurance may not remain valid longer than the term of coverage of the policy; or for the duration of the claim for all other insurance claims.

4. **Revocation of this Authorization.** Unless otherwise provided by state law, I understand that I may revoke this authorization at any time by notifying, in writing, Sedgwick Claims Management Services, Inc. at P. O. Box 14433, Lexington, KY 40512-4433. I also understand that the revocation will not have any effect on any actions taken before they received the revocation.

5. **Refusal To Sign**. This Authorization is necessary for the processing of my claim or request for reasonable accommodation. Failure to sign this Authorization may impair or impede the processing of my claim or request for reasonable accommodation. I understand my treatment provider will not condition treatment, payment, enrollment or eligibility on the refusal to sign this authorization.

I understand that I have the right to request and receive a copy of this authorization. I understand that I have the right to inspect the disclosed information at any time. A photocopy of this authorization shall be valid and is to be accepted with the same effect as the original.

Signature of Patient or Patient's Representative	Patient's Address
Printed Name of Patient or Patient's Representative	Patient's Social Security Number
Representative's Relationship to Patient, if applicable	First Day Absent
Date Signed	

"03259342 848 6341"

Employee: _____
Claim #: _____

Please list the names and address of any doctors you have seen in the last 10 years, including any employers during that period.

1._____
_____
_____

2._____
_____
_____

3._____
_____
_____

4._____
_____
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5._____
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6._____
_____
_____

7._____
_____
_____

8._____
_____
_____

SIGNED: _____ DATE: _____

⑈0325934⑆ 848⑈6341⑈

EMC Insurance Companies

P.O. Box 621210
Charlotte, NC 28262-0120
Phone 704.916.8600
FAX 704.549.9263
Claims FAX 704.548.2836

I, _____, do hereby authorize the release of records unto Employers Mutual Casualty Company all medical records, dental records, ophthalmology records, optometry records, orthodontic records, chiropractic records or psychiatric records of every nature pertinent in any way to any medical treatment rendered on my behalf, including, but not limited to, the following:

1. All office notes, progress reports and summaries;
2. Clinical records;
3. Consultation Notes;
4. Admission Summaries;
5. Discharge Summaries
6. Radiographs;
7. Emergency Room Reports;
8. Results of all laboratory tests, including x-rays;
9. Records of prescribed medications and treatments;
10. Telephone logs;
11. Correspondence; and
12. Invoices.

The purpose of this requested disclosure is at the request of the undersigned individual, and this Authorization shall be deemed to comply with all notice requirements of HIPAA, specifically 45 CFR § 164.508.

This Authorization shall expire upon final resolution of the Workers Compensation Claim No. _____. I understand that I may revoke this Authorization at any time by sending notification to Employers Mutual Casualty Company.

_____
Name:

Social Security No.:_____

DOB: _____

Date Signed:_____

MEDICAL PROVIDER FORM

Please provide the name, address, phone number and fax number for each provider who rendered treatment for your injury(ies) pertaining to this loss. Please be advised that providing complete and accurate information will speed up the process of handling your claim. If additional space is needed, please continue on back of form.

Provider #1:

NAME: _____

ADDRESS: _____

_____

PHONE #: _____ FAX #: _____

ACCT #: _____

Provider #2:

NAME: _____

ADDRESS: _____

_____

PHONE #: _____ FAX #: _____

ACCT #: _____

Provider #3:

NAME: _____

ADDRESS: _____

_____

PHONE #: _____ FAX #: _____

ACCT #: _____

Provider #4:

NAME: _____

ADDRESS: _____

_____

PHONE #: _____ FAX #: _____

ACCT #: _____