

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

Emp. Code # **0004210**

Carrier Code # **999000**

Employer FEIN _____

Carrier File # _____

To the Employer:

The filing of this report is required by law. It does not satisfy the employee's obligation to file a claim. **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, 4334 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 and 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 _____			NC Department of Transportation			Self-Insured		
Home Telephone _____			Insurance Carrier _____			Policy Number _____		
() - () - () -			1594 Mail Service Center			Raleigh NC 27699		
Work Telephone _____			Carrier's Address _____			City _____ State _____ Zip _____		
- - □ M □ F / /			(919) 250-4200			(919) 212-3121		
Social Security Number _____ 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 _____			
Person Injured	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 _____				
Cause And Nature Of Injury	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 _____				
	11. (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								
Fatal Cases	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 _____									
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
Nature _____
Body _____
Cause _____
SIC _____
Coder _____

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 report 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.

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 certiorarse 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.