

**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 _____			Policy Number _____		
Home Telephone _____			Work Telephone _____			Carrier's Address _____		
Sex <input type="checkbox"/> M <input type="checkbox"/> F			Date of Birth _____			City _____	State _____	Zip _____
Social Security Number _____			Carrier's Telephone Number _____			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 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) _____ 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: _____ Return to work date or period of estimated disability: _____
Date 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 proscribed 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) 807-2500
OMBUDSMAN: (800) 688-8349