

IC File # _____

EMPLOYEE'S APPLICATION FOR ADDITIONAL MEDICAL COMPENSATION (G. S. 97-25. -1)

Emp. Code # _____

(APPLICABLE TO INJURIES BY ACCIDENT OR OCCUPATIONAL DISEASES CONTRACTED ON OR AFTER 5 JULY, 1994)

Carrier Code # _____

Employer FEIN _____

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 _____			Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth _____			Carrier's Telephone Number _____		
						Fax Number _____			

SECTION A. TO BE COMPLETED BY EMPLOYEE:

- The above-named employee claims additional medical compensation as a result of an injury by accident or an occupational disease which occurred on or by _____ (Date) because _____

 (Reason for Additional Medical Compensation)
- Additional medical and/or other supporting documentation is / is not attached (optional).
 (Place your I.C. File # on each attachment.)

 SIGNATURE OF EMPLOYEE DATE COMPLETED

Name and address Of employee's attorney, if any: _____

EMPLOYEE: SEND THE ORIGINAL OF THIS FORM TO THE INDUSTRIAL COMMISSION AT THE ADDRESS BELOW, AND A SIGNED COPY TO THE EMPLOYER OR CARRIER/ADMINISTRATOR.

SECTION B. TREATING PHYSICIAN'S STATEMENT (OPTIONAL)

This is to certify that:

- I am the above-named employee's treating physician. My area Of medical practice is _____, and my treatment Of the employee began on _____ (mo/day/yr)
- In my opinion, there is a substantial risk that the employee will need the following additional medical care or monitoring (including medical, surgical, hospital, nursing, rehabilitation services, medicines, sick travel, replacement of artificial members, medical and surgical supplies, and other treatment): _____
 The need for this medical treatment results from the injury by accident or occupational disease as set forth in Section A. above.

 SIGNATURE OF TREATING PHYSICIAN PRINTED NAME DATE

 ADDRESS CITY STATE Zip

MAIL TO:

*NCIC - EXECUTIVE SECRETARY
 4333 MAIL SERVICE CENTER
 RALEIGH, NC 27699-4333
 MAIN TELEPHONE: (919) 807-2500
 OMBUDSMAN: (800) 688-8349*