

EMPLOYER'S ADMISSION OF EMPLOYEE'S RIGHT TO PERMANENT PARTIAL DISABILITY (G.S. §97-31)

IC File # _____
Emp. Code# _____
Carrier Code# _____
Carrier File # _____
Employer FEIN _____

The Use of This Form Is Required Under the Provisions of The Workers' Compensation Act

Employee's Name _____
Address _____
City _____ State _____ Zip _____
() _____ () _____
Home Phone _____ Work Phone _____
Social Security Number _____ M F / / _____
Date of Birth _____

Employer's Name _____ Phone _____
Employer's Address _____ City _____ State _____ Zip _____
Insurance Carrier _____
Carrier's Address _____ City _____ State _____ Zip _____
() _____ Ext. _____ () _____
Carrier's Telephone Number _____ Carrier's Fax Number _____

WE, THE UNDERSIGNED, DO HEREBY AGREE AND STIPULATE AS FOLLOWS:

- All the parties hereto are subject to and bound by the provisions of the Workers' Compensation Act and _____ is the Carrier/Administrator for the Employer.
 - The employee sustained an injury by accident or the employee contracted an occupational disease arising out of and in the course of employment on _____.
 - The injury by accident or occupational disease resulted in the following injuries: _____.
 - The employee was was not paid for the 7 day waiting period.
If not, was salary continued? yes no. Was employee paid for the date of injury? yes no
 - The average weekly wage of the employee at the time of the injury, including overtime and all allowances, was \$ _____.
This results in a weekly compensation rate of \$ _____.
 - The employee has has not returned full time to work for _____
on _____, at an average weekly wage of \$ _____.
 - Claimant was released with permanent restrictions without permanent restrictions.
 - Permanent partial disability compensation will be paid to the injured worker as follows:
____ weeks of compensation at rate of \$ _____ per week for _____% rating to _____ (body part)
____ weeks of compensation at rate of \$ _____ per week for _____% rating to _____ (body part)
____ weeks of compensation at rate of \$ _____ per week for _____% rating to _____ (body part)
- Total amount of permanent partial disability compensation is \$ _____. Date of first payment: _____.
- State any further matters agreed upon, including disfigurement, loss of teeth, election of temporary partial disability, waiting period or other: _____.

**IMPORTANT NOTICE TO EMPLOYEE CLAIMING
ADDITIONAL WEEKLY CHECKS
OR LUMP SUM PAYMENTS**

Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial Commission in writing within two years from the date of receipt of your last compensation check or your rights to these benefits may be lost.

**IMPORTANT NOTICE TO EMPLOYEE
INJURED BEFORE JULY 5, 1994
CLAIMING ADDITIONAL MEDICAL BENEFITS**

If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

**IMPORTANT NOTICE TO EMPLOYEE
INJURED ON OR AFTER JULY 5, 1994
CLAIMING ADDITIONAL MEDICAL BENEFITS**

If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several factors. Your right to payment of future medical compensation will terminate two years after your employer or carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think you will need future medical compensation, you must apply to the Industrial Commission in writing within two years, or your right to these benefits may be lost. To apply you may also use Industrial Commission Form 18M.

IMPORTANT NOTICE TO EMPLOYER

The employee must be provided a copy when the agreement is signed by the employee. Failure to file Form 28B, Report Of Compensation And Medical Compensation Paid, within 16 days after last payment pursuant to this agreement may subject the employer or carrier/administrator to a penalty. Pursuant to Rule 501, within 20 days after receipt of the agreement executed by the employee, the employer or carrier/administrator must submit the agreement to the Industrial Commission, or show good cause for not submitting the agreement.

NEED ASSISTANCE?

If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at (800) 688-8349.

SELF-INSURED EMPLOYER OR CARRIER 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.COMP.STATE.NC.US/](http://www.comp.state.nc.us/)