

**REPORT OF EMPLOYER OR CARRIER/ADMINISTRATOR OF
COMPENSATION AND MEDICAL COMPENSATION PAID
PURSUANT TO A COMPROMISE SETTLEMENT AGREEMENT**

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

THIS FORM IS ONLY TO BE USED IN SETTLED CASES

| | | | | | | | | | | | |
|------------------------------|-----------------------------------------------------------|---------------------|--------------------------|----------------------------------|-------------------------|-------------------------|------------------|---------------------|------------|-------------|-----------|
| 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 _____ | | | | |

1. Date of accident or disability from occupational disease _____
2. Salary was / was not continued. Total Dollar Amount
3. Number of weeks temporary total _____ from _____, through _____ \$ _____
 _____ from _____, through _____ \$ _____
4. Number of weeks temporary partial _____ from _____, through _____ \$ _____
 _____ from _____, through _____ \$ _____
5. Number of weeks permanent partial _____ from _____, through _____ \$ _____
6. Disfigurement amount paid \$ _____
7. Loss of organ or body part benefits paid \$ _____
8. TOTAL OF LINES 3 THROUGH 7 \$ _____
9. Compromise Settlement Agreement amount \$ _____
10. Total Medical Paid \$ _____

NAME OF EMPLOYER OR CARRIER/ADMINISTRATOR _____

SIGNATURE _____ TITLE _____ DATE _____

This form must be filed with the Industrial Commission at the address below.

| | |
|-------------------------------------------|----------|
| FOR INDUSTRIAL COMMISSION USE ONLY | |
| Days | _____ |
| Compensation Paid \$ | _____ |
| Medical | \$ _____ |
| IC Code: | _____ |

**MAIL TO: NCIC - STATISTICS SECTION
4334 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4334
MAIN TELEPHONE: (919) 807-2500
OMBUDSMAN: (800) 688-8349**