

Claimant's Name _____				SSN _____	Employer's Name _____			
Address _____	City _____	State _____	Zip _____	Address _____	City _____	State _____	Zip _____	
Home Phone # _____		Work Phone # _____		Insurance Carrier _____				
Preparer's Name _____				Phone # _____				

Date of injury: _____ Date of Notice to Employer of Injury: _____
month day year month day year

I. Payment of Temporary Compensation (choose A, B, or C) **Check one:** Initial period Additional period Corrected compensation rate

A. Temporary Total at the compensation rate of \$ _____ per week. For this period of disability, disability began on _____ and the date of first payment was _____

B. Temporary Partial at the compensation rate of _____ per week. Note: When Temporary Partial compensation rate will vary, report first payment here. Supplement throughout the period of Temporary Partial compensation by filing Form 15S with the Form 18, which shall be filed six months after the date of injury and each six months thereafter until the file is closed. For this period of disability, disability began on _____ and the date of first payment was _____

Calculation of Temporary Partial rate: Average weekly wage before injury _____
Current weekly wage _____
Difference in wages before injury and now _____
x .6667 x _____
Temporary Partial Compensation Rate _____

C. Salary in lieu of temporary total / temporary partial (circle one) compensation in the amount of _____ began on _____ and the date of first payment of salary in lieu of temporary compensation was _____

THIS SECTION MAY BE USED ONLY WITHIN 150 DAYS AFTER NOTICE TO EMPLOYER OF THE INJURY. ATTACH DOCUMENTATION AS TO THE REASON FOR THE TERMINATION.

II. Termination of Temporary Compensation Temporary compensation payments were stopped on _____ for the following reason:

- Claimant has returned to work at least 15 days and no temporary partial compensation is due.
- Claimant agrees he/she is able to return to work and has signed a Form 17.
- Based on a good faith investigation, the claim is denied. Reason for denial: _____
- Claimant has been released to return to work without restrictions and employment has been offered.
- Claimant has been released to return to work at limited duty and employer has provided limited duty work consistent with the terms upon which the Employee has been released.
- Claimant has refused medical treatment, examination, or evaluation. Note: Benefits must be resumed if claimant accepts the treatment, examination, or evaluation. Additional report must be filed if compensation is resumed.

I certify that this form has been served on the claimant per R.67-211.

Signature of Claims Administrator

Date

III. Notice to Injured Worker or Legal Representative when Temporary Compensation Has Been Stopped:

The employers representative may stop temporary compensation within 150 days of the date of notice of injury for the above reasons. However, if you believe that temporary compensation should not have been stopped, you may request a hearing by signing below and returning this form to the SCWCC Judicial Department at the address at the top of the form. A hearing will be held within 60 days of receipt of your request to determine if temporary compensation has been properly terminated.

MY SIGNATURE BELOW INDICATES THAT I DO NOT AGREE WITH THE TERMINATION OF TEMPORARY COMPENSATION. I REQUEST A HEARING TO DETERMINE WHETHER I AM ENTITLED TO FURTHER TEMPORARY COMPENSATION PAYMENTS.

Check one: Form 115(11) has has not been received.

Signature of claimant or legal representative

Date

Employers representative must complete and file Form 15 with Claims Department within ten days after compensation begins or is terminated. Employers representative must serve the Form 15 on the claimant when compensation begins per R.67-211. Employees representative must prepare and serve Form 20 within thirty days of beginning compensation per R.67-1603. Employees representative must serve per R.67-211 two copies of the Form 15 on claimant immediately on termination of compensation with documentation attached as to the reason for the termination. Injured worker may contest termination of compensation by completing section III of the Form 15 and filing it with Judicial Department.