

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803)737-5700

WCC File # _____
Carrier File # _____
Carrier Code # _____
Employer FEIN _____

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: _____
month day year

The above named parties agree to pay and accept compensation based on the following facts.

On _____, the treating physician, _____ assigned a _____ percent
month day year Name of Treating Physician
permanent impairment to the _____ The parties agree that the Claimant reached maximum medical
Body Part
improvement on _____ and has sustained _____ percent permanent disability
month day year
to the _____ and/or _____ weeks disfigurement as a result of his/her injury The
Body Part
Employer's Representative agrees to pay and the Claimant accepts _____ weeks of compensation at the rate of
_____, which is based on the Claimant's average weekly wage of _____. The estimated award is
_____, which is subject to verification by the Commission.

This agreement is binding on approval by the Commission. A claim for additional compensation based on a worsening of claimant's condition must be filed no later than one (1) year from the date of the last payment of compensation. Only medical care authorized by the employer's representative, or specific medical care detailed herein, will be paid under the terms of this agreement.

Claimant's Signature

Employers Representative

Witness Claimant's Attorney
(Choose one)

Commissioner

Date Agreement Signed

Date Approved

Refer to R.67-801 through R.67-804 for instructions regarding the Form 16.