

*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 # _____				

1. Date of injury: \_\_\_\_\_  
month day year

2. Total Weeks of Compensation Paid: \_\_\_\_\_

3. Type of Compensation Paid (TP or TT)/Periods of Payment:

Type: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Type: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Type: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

4. Date of First Payment: \_\_\_\_\_  
month day year

5. Total Amount Paid (a) Compensation: \_\_\_\_\_

(b) Medical (Include Nursing, Hospital Drugs, Etc.): \_\_\_\_\_

6. Informal Conference is Requested:  yes  no  
(check one)

7. Use these lines to send a memo to the Commission:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Employer's Representative \_\_\_\_\_ Phone # \_\_\_\_\_ Date \_\_\_\_\_

Type or print all information. File this form 6 months after the alleged injury date and each 6 months until the Commission's File is closed. Form 18 must be filed whether or not compensation is ongoing. Check "yes" after number 6 to request an informal conference. Refer to R.67-413, R.67-507, and R.67-804 for further information.