

*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 # _____			

Compensation Paid:	Number of Weeks	From	TO	Amount
1. Number of weeks T.T. ....	_____	_____	_____	_____
2. Number of weeks T.P. ....	_____	_____	_____	_____
3. Number of weeks P.P. ....	_____	_____	_____	_____
4. Disfigurement .....	_____	_____	_____	_____
5. Agreement and Final Release .....	_____	_____	_____	_____
Total Compensation Paid .....				_____
6. Total Medical Benefits* Paid .....	_____	_____	_____	_____
7. Funeral Benefits .....	_____	_____	_____	_____

Case Denied Date of Injury: \_\_\_\_\_  
month day year

By signing this receipt, I acknowledge that I have received the compensation shown above.

By: \_\_\_\_\_ By: \_\_\_\_\_ Date: \_\_\_\_\_  
Claimant Employer's Representative

\_\_\_\_\_  
Print or type the name of the person, other than the claimant, receiving benefits and sign below.

By: \_\_\_\_\_

Report of additional Fees and Recoupment

A. Carrier Reimbursement by Third Party .....	_____
B. Attorney's Fee Paid by Employer .....	_____
C. Attorney's Fee Paid by Claimant .....	_____
<small>(Non contingent fees, only)</small>	

File this form with the Claims Department according to R.67-414 and R.67-1204. A person, other than the claimant, receiving benefits should sign on the line provided. \*Do not include as medical costs fees paid for expert testimony, fees for determining carrier's liability, costs of autopsy, birth and death certificates and impartial examination. Form 1 9 must be filed within sixteen days of final payment of compensation. Form 19 must be filed when a claim is denied.