

# NOTICE OF ACCIDENT TO EMPLOYER AND CLAIM OF EMPLOYEE, REPRESENTATIVE, OR DEPENDENT (G.S. §§97-22 THROUGH 24)

IC File # \_\_\_\_\_

Emp. Code # \_\_\_\_\_

Carrier Code # \_\_\_\_\_

Employer FEIN \_\_\_\_\_

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

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

Employee's Name _____			Employer's Name _____			Telephone Number ( ) - _____		
Address _____			Employer's Address _____			City State Zip _____		
City State Zip _____			Insurance Carrier _____			Policy Number _____		
Home Telephone ( ) - _____			Carrier's Address _____			City State Zip _____		
Social Security Number - - _____			Carrier's Telephone Number ( ) - _____			Carrier's Fax Number ( ) - _____		
Sex <input type="checkbox"/> M <input type="checkbox"/> F			Date of Birth / / _____					

**EMPLOYEE – This form must be filed with the Industrial Commission within two years of the date of injury or occupational disease or your claim may be barred. Notice shall be given to the employer immediately after the accident or as soon as practicable and within 30 days. (This form should also be used for occupational disease claims; however, for asbestosis, silicosis and byssinosis, Form 18B is to be used.)**

Notice is hereby given, as required by law, that the above-named employee sustained an injury or contracted an occupational disease, described as follows: \_\_\_\_\_ on \_\_\_\_\_ / / \_\_\_\_\_ at \_\_\_\_\_ . Describe the injury or occupational disease, including the specific body part involved (e.g., right hand, left hand) \_\_\_\_\_ Describe how the injury or occupational disease occurred: \_\_\_\_\_

Occupation when injured: \_\_\_\_\_ Nature of employer's business: \_\_\_\_\_  
Number of days out of work due to injury: \_\_\_\_\_  
Medical treatment received?  Yes  No  
Weekly wage: \$ \_\_\_\_\_ Number of hours worked per day: \_\_\_\_\_ Days worked per week: \_\_\_\_\_

**NOTE:** If employee is unable to sign this form, another may sign for him. This form should be typed or printed by hand in black ink, if possible. Employee should retain one signed copy of this notice, mail one signed copy to the Industrial Commission at the address below, and provide one signed copy to employer.

Signature of (Check One) <input type="checkbox"/> Employee, <input type="checkbox"/> Attorney, _____				Telephone Number ( ) - _____			
<input type="checkbox"/> Representative, or <input type="checkbox"/> Dependent							
Address _____				Date Completed / / _____			
City _____				State _____ Zip _____			

**EMPLOYER:** This notice is being sent to you in compliance with requirements of the North Carolina Workers' Compensation Act, in order that the medical services prescribed by the Act may be obtained; and, if disability extends beyond 7 days duration, or if death ensues, compensation may be paid according to law.

FOR IC USE ONLY
RESEARCHER: _____
CC: _____
EC: _____
DATA ENTRY: _____

**MAIL TO:**  
NCIC - CLAIMS ADMINISTRATION  
4335 MAIL SERVICE CENTER  
RALEIGH, NORTH CAROLINA 27699-4335  
MAIN TELEPHONE: (919) 807-2500  
HELPLINE: (800) 688-8349  
WEBSITE: HTTP://WWW.COMP.STATE.NC.US/