North Carolina Industrial Commission

IC File #_____

EMPLOYER'S ADMISSION OF EMPLOYEE'S RIGHT TO COMPENSATION (G.S. §97-18(b))

Emp. Code #_____

Carrier Code #_____

Carrier File #_____

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

Employer FEIN _____

Employee's Name			Employer's Name		( ) - Telephone Number
Address			Employer's Address	City	State Zip
City	State	Zip	Insurance Carrier	Policy Number	
( ) - Home Telephone	( ) - Work Telephone		Carrier's Address	City	State Zip
- - Social Security Number	☐ M ☐ F Sex	/ / Date of Birth	( ) - Carrier's Telephone Number	( ) - Fax Number	

TO DEFENDANTS: Describe with particularity the body part(s) or condition(s) for which you are admitting liability and compensability.
TO EMPLOYEE: Your employer admits your right to compensation for an

☐ injury by accident on __/__/____ (date) (Specify body part(s) involved):

☐ occupational disease on __/__/____ (date) (Specify condition(s) and body part(s) involved):

THE FOLLOWING ITEMS 1 THROUGH 4 ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY AND DO NOT CONSTITUTE AN AGREEMENT:

1. The description of the injury or occupational disease, including body parts involved is:

2. The employee was paid for the entire day of injury. ☐ Yes ☐ No
3. The employee's average weekly wage, subject to verification, including overtime and all allowances, was $_____, which results in a weekly compensation rate of $_____.
   - ☐ a. Temporary total compensation is being paid at the compensation rate above.
   - ☐ b. Temporary partial compensation is being paid in the amount of $_____.
   - ☐ c. Other: _____
4. The disability resulting from the injury began on __/__/____ (date), and compensation commenced on __/__/____ (date).

SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR	TITLE	/ / DATE

EMPLOYER: Failure to file Form 28B, Report of Compensation and Medical Compensation Paid, within 16 days after last payment pursuant to an agreement or award subjects employer or carrier/administrator to a penalty pursuant to N.C. Gen. Stat. §97-18(h). Form 30 must be used for compensable injuries resulting in death. A copy of this Form 60 shall be provided to the employee and the employee's attorney of record, if any, and the original provided to the Industrial Commission at the address below.

FORM 60

SELF-INSURED EMPLOYER OR CARRIER 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.IC.NC.GOV/