South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723

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

Claimant's Name: _____ SSN: ___-___-___ Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Insurance Carrier: _____

Preparer's Name: _____ Law Firm: _____ Preparer's Phone #: _____

1. Date of injury: _____ (m/d/yyyy) 2. Total Weeks Compensation Paid: _____

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

		(m/d/yyyy) From:	(m/d/yyyy) To:
Type:	_____	_____	_____
Type:	_____	_____	_____
Type:	_____	_____	_____

4. Date of First Payment: _____ (m/d/yyyy)

5. Total Amount Paid
   (a) Compensation: $ _____
   (b) Medical (Include Nursing, Hospital, Drugs, Etc.): $ _____

6. Informal Conference is Requested: ☐ Yes ☐ No (check one)

Use these lines to send a memo to the Commission: _____

_____

_____

_____

_____ _____ _____
Employer's Representative Phone Date

Type or print all information. File this form six months after the alleged injury date and each six 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.