

## **DHHS POLICES AND PROCEDURES**

<b>Section V:</b>	<b>Human Resources</b>
<b>Title:</b>	<b>Policies and Standard Operating Procedures for Workers' Compensation Program</b>
<b>Current Effective Date:</b>	<b>July 1, 2026</b>
<b>Revision History:</b>	<b>7/1/03, 4/1/04, 7/1/18</b>
<b>Original Effective Date:</b>	<b>6/27/91</b>

### **PURPOSE**

The purpose of the Workers' Compensation Policies and Standard Operating Procedures (SOPs) is to ensure appropriate and uniform operation and administration of the Department of Health and Human Services (DHHS) Workers' Compensation Program, consistent with the North Carolina Workers' Compensation Act (the "Act"), the Rules of the North Carolina Industrial Commission ("NCIC" or "Commission"), promulgated pursuant to the Act, and guidelines and policy published by the Office of State Human Resources (OSHR).

### **POLICY**

- A. It is the policy of the Department of Health and Human Services to provide lawful coverage for DHHS employees who suffer an injury by accident or who contract an occupational disease arising out of and in the course and scope of their employment with DHHS, within the meaning of the North Carolina Workers' Compensation Act.
- B. It is the policy of DHHS to administer benefits defined under N.C.G.S. Chapter 97 (Workers' Compensation Act); N.C.G.S. Chapter 143, Article 12B (Salary Continuation Plan for Certain State Law Enforcement Officials); and N.C.G.S. §115C-338 (Salaries for Employees Injured During an Episode of Violence) in a timely manner as established under law.
- C. It is the policy of DHHS to ensure that employee claims for accidental injury or occupational disease will be processed according to Standard Operating Procedures contained herein.
- D. DHHS recognizes the value of our employees. It is policy of DHHS that whenever possible, DHHS will provide injured employees the opportunity to return to work when they reach maximum medical improvement and are released to return to work by the authorized treating physician. The DHHS Workers' Compensation Return to Work Program outlines the policy that all divisions are to follow to ensure DHHS maintains its talented employees.

## **ROLES AND RESPONSIBILITIES**

**A. WORKERS' COMPENSATION ATTORNEY.** Oversight and overall management of the DHHS Workers' Compensation Program shall be vested with the Workers' Compensation Attorney (WC Attorney) in the Office of General Counsel. The DHHS Workers' Compensation Attorney shall have the following Responsibilities:

- a. Overall management of the workers' compensation program for DHHS.
- b. Monitoring the program for compliance with the Workers' Compensation Act and Rules of the Industrial Commission.
- c. Developing policy and procedure for the workers' compensation program.
- d. Providing consultation and advice to the WCAs, HR, and management throughout DHHS.
- e. Monitoring and assessing pending workers' compensation claims, with the following objectives:
  - i. Ensure proper handling of the claims by the facility, division, and school WCAs, including site visits as deemed appropriate.
  - ii. Participation in claims review meetings with the facilities and divisions, for assessment of claims handling and claims targeted for potential for settlement.
  - iii. Potential reduction of cost through identifying claims for settlement, and assessing the value of claims for settlement, making recommendations to DHHS.
  - iv. Ensure proper management of claims by the claims adjusters of the Third-Party Administrator (TPA) contracted through OSHR to administer workers' compensation claims for the State of North Carolina.
  - v. Scheduling and conducting training for WCAs and other personnel.
- f. Coordinating with the Safety Program Director to identify and eliminate safety hazards, to reduce potential for accidental injury to employees throughout DHHS.

**B. SAFETY PROGRAM DIRECTOR.** The DHHS Safety Program Director is responsible for overall management of the safety program throughout the agency, and shall oversee all Safety Officers and Workers' Compensation Administrators within the facilities and divisions. The Safety Program Director shall coordinate with the Workers Compensation Attorney, providing updated safety data and reports generated for the Safety Program, to identify ways to improve the safety of working environments and reduce risks for accidental injury to employees throughout DHHS. Safety Officers assigned to the facilities and divisions shall be responsible for ongoing inspections to identify any safety hazards and to recommend corrective actions, reporting to the Safety Program Director. The Safety Officers shall also investigate work-related injuries, illnesses, and safety incidents throughout DHHS.

## C. PROGRAM MANAGEMENT THROUGHOUT DHHS

### a. Within the Facilities and Divisions:

i. **Director Responsibility.** The facility and division directors shall have responsibility to ensure that the Workers' Compensation Program is being properly managed at the facility/division level, through the Safety Department.

ii. **Employee Responsibility.** It is the employee's responsibility to timely notify management of any accident and/or occupational illness. Pursuant to the Act, notice shall be given to the employer "immediately" or "as soon thereafter as practicable." Employees shall provide such notice to their supervisor or the next person in the chain of command if the supervisor is not available. The employee shall also notify their supervisor of any unsafe or hazardous working conditions. The employee is responsible for keeping the employer informed of their work status, and medical treatment, by providing their supervisor or the WCA a copy of all work notes from the authorized treating physician, as soon as possible.

iii. **Supervisor's Responsibility.** Upon receiving notice of an employee's report of alleged accident, the supervisor shall immediately report the matter to the Workers' Compensation Administrator and/or Safety Officer. The supervisor shall assist the Workers' Compensation Administrator and Safety Officer as necessary in any investigation. Supervisors shall report any unsafe or hazardous working conditions to the Safety Officer for the facility or division.

iv. **Workers' Compensation Administrator Responsibility.** The WCAs assigned to the facilities and divisions shall have responsibility for administration of the workers' compensation program at the facility or division level. Such administration includes investigation of injuries or illness reported by employees, the timely reporting of claims to the TPA, monitoring the injured employee's work status, maintaining communication with the injured employee and the employee's supervisor, and maintaining a record of the workers' compensation claim on behalf of DHHS. The WCA is responsible for keeping in communication with the TPA, the WC Attorney as needed, and any attorney from the Attorney General's office assigned to a claim.

### b. Agency Leadership

i. Agency management, working with the WC Attorney, shall schedule and conduct necessary training for WCAs and any other staff as appropriate pertaining to the workers' compensation program and policies herein.

ii. Agency financial and budget officers shall manage the workers'

compensation fund, including any funds allocated from OSHR, for the payment and settlement of workers' compensation claims. This includes making timely payment for billings from the TPA, including payment for settlements.

## **IMPLEMENTATION: CLAIMS REPORTING, INVESTIGATION AND MANAGEMENT**

### **I. Management Roles**

A. Employee Responsibility. It is the employee's responsibility to provide timely notice of any accident or occupational illness to DHHS management immediately after the accident occurs or illness is diagnosed, or as soon as possible if immediate report is not possible. The employee shall complete an employee incident report form, provided by their supervisor or the WCA, which describes the incident in the employee's own words. See Addendum Page 1 for the Employee Accident Report.

B. Supervisor Responsibility. Upon receiving notice of an employee's accident, the supervisor shall promptly report the matter to the WCA by completion and submission of the supervisor investigation form. The supervisor shall direct the injured employee to a medical facility approved by the TPA, where the employee may be subject to a post-accident drug screen at the discretion of the facility or division, with or without cause. The supervisor shall provide the injured employee with a copy of the TPA's workers' compensation authorization form for initial medical treatment. Should the employee decline medical treatment, the supervisor will secure the employee's signature on the appropriate form. The supervisor shall assist both the WCA and the Safety Officer as reasonably necessary to conduct further investigation of the matter, including the gathering of any written witness statements. See Addendum Pages 2 -6 for the Supervisor Investigation form, TPA Initial Medical Treatment form, Refusal of Medical Treatment form.

C. Workers' Compensation Administrator Responsibility. Upon receiving notice of an accidental injury or illness to an employee, the WCA shall initiate an investigation, in coordination with the employee's supervisor and the Safety Officer for the facility or division. Information gathered, including written statements, shall be provided to the TPA. Upon receiving notice of an accidental injury or illness to an employee, as soon thereafter as possible, and preferably within 24 hours, the WCA shall upload all the required and relevant information to the TPA's portal and thereafter shall complete a Form 19. See Addendum Pages 7-8 for the Form 19.

D. Safety Officer Responsibility. The Safety Officer coordinates with the employee's supervisor and the WCA to conduct any necessary investigation into the circumstances of the employee's accident. The investigation should identify any potential safety hazard that may have been a factor in the employee's injury or illness and make recommendations for elimination of the hazard. The Safety Officer reports to the Safety

Program Director, who shall coordinate with the WC Attorney regarding appropriate remedial measures.

E. Third-Party Administrator Responsibility. The TPA is responsible for gathering all information related to the claim, including a recorded statement if necessary as well as preexisting and/or injury-related medical records directly from medical providers, and for consulting with the WCA and if necessary, the WC Attorney, to determine the compensability of the claim. No claims are to be denied without first consulting the WC Attorney. Final discretion to accept or deny a claim is vested in the WC Attorney. Once a compensability decision is made, the TPA will file all appropriate forms with the Industrial Commission and administer the claim pursuant to the Workers' Compensation Act to include making appropriate payments and calculations of payments owed to the employee.

## II. Medical Treatment

A. Supervisor. A supervisor shall direct an employee to an approved medical facility upon reporting a work-related injury requiring medical attention. A list of approved facilities is maintained by the WCA or TPA. If the situation involves critical or life-threatening injuries, it may be necessary to contact an ambulance or EMS.

B. Third-Party Administrator. Once the injury has been properly reported to the TPA by the WCA, the assigned TPA claims adjuster shall direct all further medical care and shall keep the WCA informed of the employee's ongoing medical treatment and progress.

C. Employee. It is the employee's responsibility to keep the employer advised of their medical status. The employee is responsible for providing their supervisor or the WCA with all work notes from the authorized treating physician.

D. Unauthorized Medical Treatment. Medical treatment for all workers' compensation claims, if deemed compensable, shall be provided by DHHS through the TPA. The employee is put on notice that payment for unauthorized medical treatment may be denied.

E. Employee Health Clinic's (EHS) Responsibility. All cases in which the injured employee receives initial medical treatment at an employee health clinic are subject to the following conditions:

- a. Treatment by In-House Staff at Facilities. Treatment for minor injuries and other urgent care may be rendered initially at the facility where the employee is employed, or adjacent DHHS facility, insofar as allowed under DSOHF Policy HR 523. Ongoing medical treatment and management for a workers' compensation injury shall not be provided at the employee health clinic or facility of employment. If follow-up treatment is needed after initial first aid, the employee shall be referred to a TPA-approved medical provider.

b. An Employee should not be written out of work by DHHS staff for more than one workday by a DHHS medical provider. Should EHS staff determine an employee requires more than one workday out of work, EHS shall refer the employee to an outside medical facility approved by the TPA to obtain the necessary work note. The TPA then directs all future medical care for the injury or illness subject to the workers' compensation claim.

c. In-house medical notes must be sent to the WCA within 24 hours of treatment. If an outside referral is made, the WCA should be notified as soon as possible to arrange for approval.

### III. Work-Related Employee Deaths

In the event of death, the deceased employee's supervisor shall work with the WCA to complete the claims reporting process to the Third-Party Administrator, and to initiate investigation. The TPA is responsible for administering benefits to the dependents of the decedent in the event of a compensable death claim.

### IV. Salary Continuation For Eligible Employees

A. All DHHS employees who are sworn state law enforcement officers with the power of arrest and are certified by the Criminal Justice Training and Standard Act are also subject to the provisions of Article 12B of Chapter 143 (§143-166.13 through §143-166.20). The division or facility director is responsible for initially determining the application of this Article to an employee's reported injury or incapacity. The initial decision shall be submitted to the agency WC Attorney and TPA. A final decision on the employee's eligibility for benefits under these statutes shall be made by the WC Attorney or other designee of the Secretary of DHHS.

B. All full-time (not part-time, temporary or substitute) employees who are assigned to be educators within DHHS facilities or schools are additionally subject to the provisions of N.C.G.S. §115C-338. The division or facility director is responsible for initially determining the application of this section to a reported injury or disability. The initial decision shall be submitted to the WC Attorney and TPA. A final decision on the employee's eligibility for benefits under these statutes will be made by the WC Attorney or other designee of the Secretary of DHHS, by the Secretary's capacity with the DHHS Board of Education.

C. For employees subject to and eligible for compensation payments under both N.C.G.S. §143, Article 12B and N.C.G.S. §115C-338, the provisions of the former shall take precedence. An employee receiving salary payments under N.C.G.S. §143, Article 12B or N.C.G.S. §115C-338 shall be additionally eligible for non-compensation benefits as provided by the Workers' Compensation Act and OSHR policy. Department policy

regarding return to work shall apply to employees who receive compensation benefits under Chapter 97, Article 12B of Chapter 143, and/or §115C-338.

D. Salary continuation is the total base pay on the employee's salary statement and does not include overtime pay, shift differential pay, holiday pay, or other additional earnings, to which the employee may have been entitled prior to the incapacity.

#### V. Return To Work

NCDHHS has adopted a Workers' Compensation Return to Work Program (RTWP) for employees who have pending workers' compensation claims. The RTWP is incorporated by reference as if fully set forth herein, and shall be the policy of the Agency. This policy shall be enforced by agency management.

#### VI. Benefits and Leave

Consistent with OSHR policy, the following SOPs apply to employees subject to the Workers' Compensation Act:

A. Supplemental Pay. An employee may choose to use accrued sick, vacation, bonus, or compensatory leave earned prior to the injury during the seven-day waiting period, or the employee may go on leave without pay. Once an option is selected, it may not be rescinded. After the seven-day waiting period, an employee may supplement receipt of temporary total disability benefits by using a portion of accrued and available leave earned prior to the injury. The workers' compensation leave in this scenario is referred to as WC Leave of Absences with Supplement. Supplemental leave may only be used in accordance with a schedule published by OSHR annually, and available on OSHR's website. Use of voluntary shared leave is permitted for supplemental leave. Supplemental leave is subject to state and federal withholding taxes and Social Security, but not subject to retirement withholding. The employee shall complete the appropriate form provided by the WCA to make this election.

B. Vacation and Sick Leave. An employee will continue to accumulate vacation and sick leave while on workers' compensation. This leave will be credited to the employee's account pursuant to 25 NCAC 01E .210.

a. If the employee does not return to work and is separated, the vacation and sick leave accumulated for up to twelve (12) months will be exhausted by a lump sum payment along with other unused vacation, or bonus leave incurred at the time of the injury, as well as any bonus leave granted subsequently.

b. If an employee returns to work and has accumulated more than the 240-hour maximum vacation leave, 240 hours will carry forward, and hours over the

240-hour maximum will be converted to sick leave at the end of the calendar year.

C. Health Insurance. While on Workers' Compensation Leave, an injured employee may elect to continue or not continue health insurance coverage under the State Health Plan or other employer-based health plan. Injured employees are responsible for paying the employee's share of monthly premiums for the employee coverage and premiums for any dependent coverage. Once an employee is separated from the State Agency the employee is no longer eligible to participate in the State Health Plan.

D. Longevity Pay. An employee who is eligible for longevity pay shall receive their annual longevity payments while out on workers' compensation leave.

E. Reinstatement Salary. Upon reinstatement, an employee's salary will be computed based on the last salary plus any legislative increase and any performance increase for which the employee is entitled.

F. Total State Service Credit. An employee remains in pay status and continues to receive total state service credit while on workers' compensation leave.

G. Retirement Service Credit. An employee does not receive retirement credit while on workers' compensation leave. The employee, as a member of the State Retirement System, may purchase credits for the time they were on workers' compensation leave after returning to work. Upon request by the employee, the State Retirement System will provide a statement of the cost and a date by which purchase must be made. If the employee does not purchase the credits back by that date, the cost must be recomputed.

H. Disability Income Plan of North Carolina. Eligible employees who become temporarily or permanently disabled and are unable to perform their regular work duties may receive partial replacement income through the Disability Income Plan of North Carolina (the Plan). Benefits paid under the Plan are offset by indemnity payments made for lost wages under the Workers' Compensation Act.

I. Leave Policy:

a. If on the date of injury, the employee leaves work for medical treatment and the authorized treating physician provides a work note that the employee cannot return to work, no leave shall be charged.

b. If the authorized treating physician issues a work note removing the employee from work for any time, the seven-day waiting period begins as of that date (excluding the date of injury). The seven-day waiting period may be either seven consecutive days or spread out over time. Only full days for which the

employee is excused from work by the authorized treating physician count against the seven-day waiting period.

c. Authorized medical visits during working hours should not be charged against the employee's leave. Time away from work for authorized medical visits due to a workers' compensation claim is limited to reasonable time and any excess time is to be charged as vacation, sick leave or leave without pay.

## VII. Calculation of Average Weekly Wage

The calculation of the employee's average weekly and preparation of the Industrial Commission Form 22 shall be done by the WCA based upon the employees timesheets and pay records (contained in the State's electronic personnel database). The WCA shall provide the completed Form 22 to the TPA. Questions regarding preparation of the Form 22 should be directed to the WC Attorney. The average weekly wage will include the following payments made to an employee:

- a. Regular hourly pay
- b. Shift differential pay
- c. Shift premium pay
- d. Holiday pay
- e. Longevity pay
- f. Sick pay
- g. Vacation pay
- h. Bonus leave: Designated leave hours granted by NC General Assembly that were used as leave time by the employee.
- i. In-range pay for temporary assignment: Temporary change in duties that may be altered by employer at any time.

Overtime pay that is regularly earned, i.e. more than 6 months of the year, may be determined to be included, but should be discussed with the WC Attorney. Do not include bonus pay granted by the General Assembly, as that is a one-time payment of additional funds and not reflective of earning power.

It is the responsibility of the TPA to calculate the average weekly wage and compensation rate of the employee based on the Form 22 completed by the WCA. See Addendum Page 9-10 for Form 22.

## VIII. Potential Fraud and Abuse

A. Responsibility of DHHS Personnel. When DHHS personnel has good grounds to suspect that an employee is engaged in fraud or abuse of the workers' compensation system, it shall be reported to the WCA and/or the WC Attorney.

B. The WC Attorney shall consult with the WCA and the TPA to address any fraudulent or abusive behavior by the injured employee. If there is an attorney from the Attorney General's office assigned to the case, that attorney shall also be consulted. Actions to be taken may include social media checks and surveillance by authorized licensed investigators.

C. Surveillance. The WC Attorney or TPA may recommend surveillance of an employee suspected of fraud or abuse. The decision on whether to proceed with surveillance shall be made by facility/division management. The TPA shall manage the contracts, billing and reporting, and communications with the vendor selected to conduct surveillance.

#### IX. Litigation of Workers' Compensation Claims

All litigation of DHHS workers' compensation cases is managed by the Attorney General's Office. The assigned Assistant Attorney General (AG) will work with the WC Attorney and WCA on all claims in litigation. The AG may need to interview DHHS personnel, call personnel as witnesses in a hearing, and compel the production of documents by DHHS personnel. It is the policy of DHHS that DHHS personnel shall fully cooperate with the AG by attending all court proceedings as necessary, and providing full access to documents and information required by the AG. DHHS personnel may consult with the WC Attorney in fulfilling requests by the AG.

Any Industrial Commission form, legal pleading or filing, discovery request, letter of representation or other legal document prepared by an attorney for an employee should be immediately sent to the WCA, who shall send the document to the TPA.

#### X. Closing Claims

A. Consideration for Medicare Set Aside. When the Agency decides to settle a claim, a determination must be made as to whether a Medicare Set Aside ("MSA") will be required to protect Medicare's financial interest in future potential medical expenses, under the Medicare Secondary Payer (MSP) laws. The WC Attorney is responsible for determining whether an MSA is required for settlement. If an MSA is required, the TPA will secure the MSA quote from a vendor approved by the WC attorney or if assigned, AG.

B. Compromise Settlement Agreements ("CSA" or "Clincher"). A claim may be settled via compromise settlement agreement entered by the parties, subject to the approval of the Industrial Commission. Entering into a clincher agreement fully concludes the claim for both parties.

C. Settlement Assessment Process. When settlement is being considered, the TPA shall prepare a settlement evaluation for submission to the WC Attorney. The WC Attorney will review the settlement evaluation and make a recommendation on fund

approval to the facility/division. If the facility/division decides to move forward with fund approval, the appropriate settlement fund approval form shall be completed by the WCA and circulated to all necessary signatories. Settlement negotiations are then conducted by the claims adjuster, or AG if assigned. See Addendum Page 11-12, Settlement Fund Approval form.

D. Approval of Settlement Funds. Consideration must be given to the budgets of the DHHS facility, division or school when assessing claims for potential settlement funding. Upon recommendation of the WC Attorney, the facility, division, or school shall review and make a decision whether to approve funds to settle the claim. Such decisions should be made whenever possible within 5 business days of communication of the recommendation, and the entire process for approval of funds should be completed within a maximum of 12 business days as set forth below. Some recommendations may require more urgent decisions. Approval for settlement funds should follow the following procedure:

E. Facilities and Schools Approval of Settlement Funds. For all DHHS facilities, settlement funds must be approved by the facility WCA or HR Director, facility Budget Officer or Business Manager and the Facility Director, before being sent to the WC Attorney for approval. Certain state-operated healthcare facilities, receive financial support through the Division of State Operated Healthcare Facilities (DSOHF), and may need approval of settlement funds by DSOHF.

a. Recommendations for settlement will come from the WC Attorney after review of a settlement evaluation by the assigned claims adjuster. Within two (2) business days of the recommendation, if the facility has interest in pursuing settlement given budgetary considerations of settlement versus leaving the claim open, the WCA shall make written request for settlement funds (*which may be done electronically via email*) to the in-house budget officer or business manager of the facility, and provide any necessary information or supporting documents.

b. Within 3 business days of receipt of the WCA's written request for settlement funds, the facility budget officer/business manager shall review the request, and either approve or deny the request for settlement funds. If the budget officer/business manager approves and DSOHF approval is required, the budget officer/business manager shall submit a written request to DSOHF, to the Business Manager or Budget Officer for approval.

i. If DSOHF approval is required, the budget officer/business manager will submit an approval request. Within 5 business days of receipt of the facility's request for approval of settlement funds, DSOHF shall notify the facility of its decision. DSOHF shall designate at least two separate individuals with authority to approve settlement funds and shall arrange for coverage when those individuals are out of the office and unavailable for 5 or more business days.

- c. Following approval of the budget officer or business managers, the WCA shall secure the remaining signatures for fund approval. The WCA shall forward the signed Settlement Approval Request Form to the WC Attorney, for signature by the WC Attorney.
- d. Upon receipt of the Settlement Approval Request Form, in compliance with the WC Attorney's recommendation, the WC Attorney shall sign the form and return to the facility. Settlement negotiations will be conducted by the claims adjuster or AG.
- F. Divisions Approval of Settlement Funds. For all Divisions, DHHS management requires approval for settlement funds by the WCA or HR Director, the Division Director and the Division budget or financial officer. The above procedure will then be followed by the division WCA.
- G. Attorney General's Office Approval of Settlement Value. Any case in which settlement funds will be approved at \$75,000 or more requires approval of the Attorney General's office. Such approval may be granted after DHHS in-house approval of funds.
- H. Alternative Sources of Funding. In the event a facility or division declines to pursue settlement of a claim, the WC Attorney may present the matter for consideration by DHHS leadership. Upon consideration of the matter, including DHHS financial considerations, DHHS management may authorize settlement, and designate a source of settlement funding.
- I. Settlement Agreements. Counsel with the Attorney General's Office shall draft the compromise settlement agreement (CSA) for signature by the parties and submit the CSA for approval by the Industrial Commission. The CSA will be signed by the WC Attorney on behalf of DHHS. Upon approval of the CSA by the Industrial Commission, the AG will notify all parties, and payment will be issued promptly by the claims adjuster, no later than two business days from notice of approval.
- J. Mediation. In addition to informal ongoing negotiations, the parties may participate in mediated settlement conferences, either voluntarily or by Order of the Industrial Commission. The TPA will appear at the mediation on behalf of DHHS, along with the assigned AG. The WCA's attendance is optional unless required by the AG.
- K. Subrogation. In some cases, DHHS may have a lien for reimbursement of expenses due to Third-Party Liability. The lien will be noticed by the TPA, and informal lien settlement negotiations may be conducted by the claims adjuster or AG. Formal

third-party lien litigation will be handled by the AG's office. A lien may also be waived as consideration or partial consideration for settlement of a claim.

XI. Records Retention

Records Retention Policy must comply with the NC Functional Schedule for State Agencies maintained by the State Archives of North Carolina.

**DHHS POLICES AND PROCEDURES - ADDENDUM**

**Section V:** Human Resources  
**Title:** Safety and Benefits  
**Chapter:** Policies and Standard Operating Procedures  
for Workers' Compensation Program  
**Current Effective Date:** 7/1/26  
**Revision History:** 7/1/03, 4/1/04, 7/1/18  
**Original Effective Date:** 6/27/91

**FORMS**

- 1. Employee Incident Report (Electronic copy [here](#)).....Pg. 1
- 2. Supervisor Incident Investigation Form (Electronic copy [here](#)).....Pg 2
- 3. TPA Initial Treatment Form (Current for 2026).....Pg 4
- 4. Refusal of Medical Treatment Form.....Pg 6
- 5. Form 19.....Pg 7
- 6. Form 22.....Pg 9
- 7. Settlement Fund Approval Form.....Pg 11



# NORTH CAROLINA EMPLOYEE INCIDENT REPORT

**Instructions: Employee must complete report. If more room is needed, continue in a Word document and attach it to this submission.**

Employees are required to complete this form for all incidents and near hits. This form should be completed in its entirety and should be an accurate and truthful account of the accident/incident. Providing false and/or misleading information may result in disciplinary action up to or including dismissal and/or additional criminal and/or civil liability. This form should be completed by the employee only.

**Supervisor Review:** If an employee is unable to complete this form, the Supervisor must list reason(s) for assisting or completing this report.

My signature below certifies that the information I have provided is true and accurate. I further understand that this information may be used to determine whether the claim will be paid or denied and that I should not complete this form unless there are exceptional circumstances present preventing the employee from completing this form. Check  Not applicable (employee completed form) or sign below if you assisted with the completion of this form.

**Supervisor Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

<b>Employee Information</b>		<b>Date/Location Information</b>	
<b>Name (Full):</b>		<b>Date of Incident:</b> /    /	<b>Time of Day:</b>
<b>Employee ID #:</b>		<b>Date Reported to Supervisor:</b> /    /	<b>Time of Day:</b>
<b>Job Title:</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Work Address:</b>	
<b>Telephone #:</b>			
<b>Department:</b>		<b>Incident Location (address, Building name, office, cross streets, fire name, woods, facility, room #, etc.):</b>	
<b>Agency/University:</b>			
<b>Supervisor:</b>	<b>Phone #:</b>		
<b>Date Hired:</b>	<b>Time in Current Job:</b>	<b>County:</b>	

**Witness Information**

Were there any witnesses to the incident?  Yes  No      **Number of Witnesses (if applicable):** \_\_\_\_\_

If yes, list all known witnesses/phone #'s below, please include additional names on attachment if needed.

<b>Name:</b>	<b>Phone #:</b>
<b>Name:</b>	<b>Phone #:</b>

**Medical Information**

**Part(s) of the body injured:**

Prior to this accident/incident, have you ever been hurt, suffered injury, or received treatment for the body part(s) listed above?  Yes  No

If yes, please provide the date of prior injury, type of injury, names of treating physician or practice group.

**Description of Accident/Incident**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What was the root cause of the incident? Ask why, and then ask why again. (e.g. Why? I slipped on scrap metal. Why? The work area was not cleaned up. Why? I was rushing to get project done and did not take time to clean up the work area.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Suggested Corrective Actions**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I hereby certify that the information I have provided is true and accurate. Any inaccurate or false statements may result in a delay in process of this claim. I further understand that this information may be used to determine whether the claim will be paid or denied.

**Employee Name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date**    /    /



# NORTH CAROLINA SUPERVISOR INCIDENT INVESTIGATION REPORT

Instructions: Begin Investigation within 24 hours and attach the Employee Incident Report and Witness Reports to this report. Forward all reports within 72 hours to the Program Administrator. If more room is needed, continue in a Word document and attach it to this submission.

Agency/University:	Date of Incident:
Employee Name:	Employee Phone #:
Incident Supervisor:	Supervisor Phone #:

Incident Classifications (check all that apply)

Near Hit     Injury     Fatality     Property Damage     Spill     Possible Blood Borne Pathogen exposure

Employee required:

First-Aid Only     Medical treatment and released     Hospitalized     Other:

Employee:

Returned to work no restrictions     Returned to work with restrictions     Did not return to work (Lost Days)

Hazard Types (select one based on origination of injury in this preference order)

Violence or Injuries caused by people or animals     Transportation     Fires or Explosions  
 Slips, Trips, Falls Surface Level     Fall from Elevation     Exposure to harmful substances or environment  
 Contact with objects or equipment (Struck By, Struck Against, Caught-on, Caught between, Puncture, Cut)     Over-Exertion (Lifting)  
 Bodily Motion (reaching, twisting, running)     Other (List Here):

Names of Witnesses Interviewed:

### Incident Information

Describe the specific activity the employee was engaged in and the sequence of events. Include objects or substances that directly injured or made the employee ill. Describe tools, equipment, and PPE in use. Describe property damage. Attach pictures or police reports. Describe the estimated damage to any vehicles or equipment (make, model, ID number, etc.)

Is the activity part of the employee's normal job?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prior to beginning activity, did the employee review potential hazards/dangers?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date employee last received training for the activity.	/ /
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What was the root cause of the incident? Ask why then ask why again (e.g. Why? The employee slipped on scrap metal. Why? The work area was not cleaned up. Why? The employee was rushing to get a project done and did not take time to clean up the work area.)

Action taken or will be taken to prevent recurrence (If corrective action will occur in the future, provide estimated completion date.)

I hereby certify that the information I have provided is true and accurate. Any inaccurate or false statements may result in a delay in process of this claim. I further understand that this information may be used to determine whether the claim will be paid or denied. I also acknowledge that I understand that in addition to being disciplined for providing false and/or misleading information up to and including dismissal, I may also be subjected to additional criminal and/or civil liability.

Supervisor's Name: \_\_\_\_\_ Signature \_\_\_\_\_ Date of Report: / /

Manager's Name: \_\_\_\_\_ Signature \_\_\_\_\_ Date Reviewed: / /

The Supervisor will obtain the Managers' signature and forward signed copies of the Employee Report, Witness Statements, and the Supervisor's report to the Program Administrator. The Program Administrator will send the Employee's and Supervisor's reports to the Manager's supervisor, Local Safety Contact, Safety Committee Chairperson, and Agency Safety Director within two business days. The WCA will receive all reports and all supporting documentation.

Program Administrator Name: \_\_\_\_\_ Signature \_\_\_\_\_ Date / /

Date Corrective-Actions Completed:

January 2015



**ACCIDENT BREAKDOWN BY CHARACTERISTIC**  
(check all that apply)

Nature of Injury	Part of Body Affected
<input type="checkbox"/> Amputation or Enucleation <input type="checkbox"/> Assault <input type="checkbox"/> Burn or Scald <input type="checkbox"/> Contusion, Bruise <input type="checkbox"/> Electric Shock <input type="checkbox"/> Eye, Foreign body In <input type="checkbox"/> Fracture, Broken Bone <input type="checkbox"/> Freezing, Frostbite <input type="checkbox"/> Hearing Loss or Impairment <input type="checkbox"/> Heat Exhaustion, Sunstroke <input type="checkbox"/> Hernia or Rupture <input type="checkbox"/> Infection <input type="checkbox"/> Inhalation Injury-Toxic Substance <input type="checkbox"/> Insect Bites <input type="checkbox"/> Laceration (Cut ) <input type="checkbox"/> Multiple Injuries <input type="checkbox"/> Needle Puncture <input type="checkbox"/> Rash, From Plants <input type="checkbox"/> Rash, Not From Plants (Dermatitis) <input type="checkbox"/> Scratches, Abrasions <input type="checkbox"/> Sprain, Strains <input type="checkbox"/> Other	<input type="checkbox"/> No Physical Injury <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Eyes (Including Vision) <input type="checkbox"/> Arm(s) (Above Wrist) <input type="checkbox"/> Hand(s) (Including Wrist) <input type="checkbox"/> Finger(s) and Thumb(s) <input type="checkbox"/> Upper Extremity, Multiple Parts (shoulder, arm, forearm, wrist, or hand) <input type="checkbox"/> Abdomen (Including Internal Organs) <input type="checkbox"/> Back (Including Muscles, Spine) <input type="checkbox"/> Chest (Including Internal Organs) <input type="checkbox"/> Hips (Including Pelvic Organs) <input type="checkbox"/> Shoulder(s) <input type="checkbox"/> Trunk, Multiple Parts <input type="checkbox"/> Leg(s) (Above Ankle) <input type="checkbox"/> Foot (Including Ankle) <input type="checkbox"/> Toes <input type="checkbox"/> Lower Extremity, Multiple Parts (from the hip to the toes) <input type="checkbox"/> Multiple Parts of Body, Severe <input type="checkbox"/> Digestive System <input type="checkbox"/> Respiratory System <input type="checkbox"/> Circulatory System <input type="checkbox"/> Skin <input type="checkbox"/> Other
Type of Accidents	Safety Equipment in Use
<input type="checkbox"/> Bodily Reactions (Sprains, Strains, Rupture, Etc.) <input type="checkbox"/> Caught In, Under, Or Between <input type="checkbox"/> Contact With Temperature Extremes (Fire, Cold) <input type="checkbox"/> Disease Exposure <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Falls (All Types) <input type="checkbox"/> Noise Exposure <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Rubbed Or Abraded By Object <input type="checkbox"/> Struck Against Object <input type="checkbox"/> Struck by Flying Object <input type="checkbox"/> Struck by Other Object/Person <input type="checkbox"/> Toxic Materials Exposure <input type="checkbox"/> Vehicle or Equipment Accident <input type="checkbox"/> Other	<input type="checkbox"/> Hard Hat <input type="checkbox"/> Safety Glasses <input type="checkbox"/> Goggles <input type="checkbox"/> Face shield or welder helmet <input type="checkbox"/> Gloves <input type="checkbox"/> Fire Shirt <input type="checkbox"/> Fire Pants <input type="checkbox"/> Safety Shoes <input type="checkbox"/> Fireline Boots <input type="checkbox"/> Ear Protection <input type="checkbox"/> Respirator <input type="checkbox"/> Lanyards & Lifelines <input type="checkbox"/> Fluorescent Vests <input type="checkbox"/> Buoyant Work Vest <input type="checkbox"/> Warning & Control <input type="checkbox"/> Seat Belts <input type="checkbox"/> Shoulder Harness <input type="checkbox"/> Safety Equipment, National Electrical Code (NEC) <input type="checkbox"/> Lab Coat <input type="checkbox"/> Other

When submitting this report, include pictures of incident location, equipment in use, the vehicle used (if applicable), and any third party reports (i.e. Police Report, OSHA Report, etc.).



## Initial Treatment Guide | Physician and Pharmacy Information

**EMPLOYER:** Give both pages of this document to the injured employee to provide to the authorized treating physician.

Employer/Company:

**EMPLOYEE:** The following provider/facility was an available provider selected from CorVel's provider network. It is your responsibility to contact a provider to schedule an appointment and to confirm the location.

**Employee name:**

**Record ID:**

Date of injury:

Treating physician/facility:

**INITIAL TREATMENT PROVIDER/FACILITY:**

Provider/ Facility Name

**Provider Location**

Address

Call to schedule an appointment

### Appointment Details

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Disclaimer: The provider/facility listed above is provided for informational purposes only and is not intended to require the employee to seek medical treatment with the provider/facility listed. The rights of the employee in choosing a provider/facility vary state by state and each state law and/or statute supersedes any information implicitly or explicitly stated on this guide.

**Medical Billing Address:**


PO Box 6966  
Portland, OR 97228  
Fax: 888-851-9190

**PHARMACY:** Process all injury-related prescriptions through CorVel's pharmacy program. Use of this program will waive any co-pay or cost to the claimant. Call CorVel at (800) 563-8438 for additional assistance. The Member ID is 9 digit social security number plus 8-digit date of injury.

**PARTICIPATING PHARMACIES\***

- |                        |                               |                             |
|------------------------|-------------------------------|-----------------------------|
| CostCo Pharmacy        | Hy-Vee Inc                    | Shoprite Supermarkets Inc.  |
| CVS Pharmacy           | Kroger Pharmacy               | Smith's Food & Drug Centers |
| Duane Reade Pharmacy   | Medicine Shoppe International | Stop & Shop Supermarket Co  |
| Fred's Pharmacy        | Meijer Pharmacies             | Target Pharmacy             |
| Giant Eagle Pharmacy   | Publix Pharmacies             | Walgreens Pharmacy          |
| Giant Food Stores LLC  | Rite Aid Pharmacy             | Wal-Mart Pharmacy           |
| Harris Teeter Pharmacy | Safeway Pharmacy              | Winn-Dixie Pharmacies       |

\*This is only a partial list of the over 65,000 participating pharmacies in the CorVel Network. Please call (800) 563-8438 for additional location.



**First Fill Only**

Bin: 004336  
PCN: ADV  
RX Group: RXFF  
Member ID: SSN + Date of Injury  
(ex: 12345678901012011)

**EMPLOYEE:** Take this form with you and have the treating physician complete the Physician section below.

**Employee name:** \_\_\_\_\_

**Record ID:** \_\_\_\_\_

Date of injury: \_\_\_\_\_

Physician/facility: \_\_\_\_\_

**PHYSICIAN: For compliance, please complete this section and email to [RTW@onlinecapturecenter.com](mailto:RTW@onlinecapturecenter.com) or fax to (800) 391-4320.** This document authorizes initial evaluation and treatment only, and payment for these services will be rendered without prejudice.

**DIAGNOSIS:** \_\_\_\_\_

A post-accident drug test (check one):       **has been completed**       **has not been completed**

**RESTRICTIONS:**

In accordance with this patient's physical capability, check all that apply:

- May resume work immediately, no restrictions.
- May resume work immediately, with the following restrictions:
  - Sedentary work (sitting, occasional walking, standing, lifting less than 10 pounds)
  - Light work (lifting less than 20 pounds)       Medium work (lifting less than 50 pounds)
  - Limited hours: \_\_\_\_\_ hours per day       Limited days: \_\_\_\_\_ days per week
  - Other: \_\_\_\_\_
  - Repetitive motion restrictions (specific to hand/arm injuries):

<u>FREQUENCY:</u>	No Use	Occasional	Frequent	Constant
LEFT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RIGHT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Patient is unable to return to work in any capacity.

**RETURN TO WORK/MMI/NEXT APPOINTMENT:**

Date patient may return to work at full duty: \_\_\_\_\_

Projected date of attainment of Maximum Medical Improvement: \_\_\_\_\_

Patient has a return appointment on (date): \_\_\_\_\_ at (time): \_\_\_\_\_

Physician Name: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

**WORKERS' COMPENSATION REFUSAL OF TREATMENT**

DATE: \_\_\_\_\_

EMPLOYEE: \_\_\_\_\_

As of the above noted date, I am notifying \_\_\_\_\_(agency) of an injury that occurred on(date)\_\_\_\_\_. This injury  was;  was not initially reported by me to my supervisor on (date)\_\_\_\_\_.

This injury (briefly describe condition/body part) \_\_\_\_\_, did occur while I was employed with the \_\_\_\_\_(agency), and while performing my assigned duties.

At this time I have been requested by a representative of \_\_\_\_\_(agency) to be *medically evaluated* by a \_\_\_\_\_(agency) preferred healthcare provider. However, I decline to be medically evaluated for the above noted condition. I understand that by signing this document any future claims regarding this injury will require a medical evaluation by the \_\_\_\_\_(agency) healthcare provider listed below. I also understand that should I decide to seek medical treatment for this injury that I must immediately notify my supervisor and go to the below listed provider:

PROVIDER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: (\_\_\_\_) \_\_\_\_\_

*(NOTE: SHOULD THE CONDITION BECOME LIFE THREATENING YOU SHOULD SEEK APPROPRIATE EMERGENCY MEDICAL CARE)*

I  have  have not sought medical treatment for this injury from:

TREATING PHYSICIAN'S Phone Number: \_\_\_\_\_  
NAME/ADDRESS (including city & state) \_\_\_\_\_

**STATEMENT:** I have read the above information and it is a factual and true statement. I authorize any physician, hospital or healthcare provider to release and furnish any, and all, medical records or other information pertaining to the above listed condition.

\_\_\_\_\_  
Employee signature

\_\_\_\_\_  
Supervisor/witness signature

Date \_\_\_\_\_

Date \_\_\_\_\_

# EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

IC File # \_\_\_\_\_  
 Emp. FEIN \_\_\_\_\_  
 Carrier FEIN \_\_\_\_\_  
 Carrier File # \_\_\_\_\_

**To the Employer:**

A copy of this Form 19 accompanied by a blank Form 18 must be given to the employee. It does not satisfy the employee's obligation to file a claim. The filing of this report is required by law. This form MUST be transmitted to the Industrial Commission through your Insurance Carrier.

**To the Employee:**

This Form 19 is not your claim for workers' compensation benefits. To make a claim, you must complete and sign the enclosed Form 18 and mail it to Claims Administration, N.C. Industrial Commission, 1235 Mail Service Center, Raleigh, NC 27699-1235 within two years of the date of your injury or last payment of medical compensation. For occupational diseases, the claim must be filed within two years of the date of disability or the date your doctor told you that you have a work-related disease, whichever is later.

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.

**Social Security Number Disclosure Statement**

The North Carolina Public Records Act (N.C. Gen. Stat. § 132-1.10) permits the North Carolina Industrial Commission to request a social security number when doing so is imperative to the performance of its duties and responsibilities. The purpose of requesting a social security number on this form is for the Industrial Commission to verify the correct employer with the North Carolina Department of Commerce, Division of Employment Security and to identify workers' compensation insurance coverage. The disclosure of a social security number to the Industrial Commission is voluntary. Social security numbers are confidential and exempt from public disclosure by the Industrial Commission. The Industrial Commission may not share a social security number unless otherwise permitted to do so pursuant to N.C. Gen. Stat. § 132-1.10.

**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 _____	Work Telephone _____	Carrier's Address _____		City _____	State _____ Zip _____
Social Security Number _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth _____	Carrier's Telephone Number _____	Fax Number _____	

<b>Employer</b>	1. Give nature of employer's business _____
<b>Time And Place</b>	2. Location of plant where injury occurred County _____ Department _____ State if employer's premises _____
	3. Date of injury / / 4. Day of week _____ Hour of day _____ : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
	5. Was employee paid for entire day _____ 6. Date disability began / /
	7. Date you or the supervisor first knew of injury / / 8. Name of supervisor _____
<b>Person Injured</b>	9. Occupation when injured _____
	10. (a) Date employment began _____ (b) Wages per hour \$ _____
	11. (a) No. hours worked per day _____ (b) Wages per day \$ _____ (c) No. of days worked per week _____
	(d) Avg. weekly wages w/ overtime \$ _____ (e) If board, lodging, fuel or other advantages were furnished in addition to wages, estimated value per day, week or month. \$ _____ per
<b>Cause And Nature Of Injury</b>	12. Describe fully how injury occurred and what employee was doing when injured:  (Statement made without prejudice and without vouching for correctness of information)
	13. List all injuries and specify body part involved (e.g. right hand or left hand): _____
	14. Date & hour returned to work / / at : _____ M. 15. If so, at what wages \$ _____ per
	16. At what occupation _____ 17. Employee's salary continued in full? _____
	18. Was employee treated by a physician _____
<b>Fatal Cases</b>	19. Has injured employee died _____ 20. If so, give date of death (Submit Form 29) / /

Employer name \_\_\_\_\_ Date Completed / /  
 Signed by \_\_\_\_\_ Official Title \_\_\_\_\_

FOR IC USE ONLY

RESEARCHER: \_\_\_\_\_

CC: \_\_\_\_\_

EC: \_\_\_\_\_

DATA ENTRY: \_\_\_\_\_

## FORM 19

SELF-INSURED EMPLOYER OR CARRIER, FILE AS FROI VIA EDI:  
[HTTP://WWW.IC.NC.GOV/EDIFORM19.HTML](http://www.ic.nc.gov/EDIFORM19.HTML)

UNINSURED EMPLOYERS OR LUNG DISEASE CLAIMS:  
 E-MAIL TO: FORMS@IC.NC.GOV OR MAIL TO: NCIC - CLAIMS SECTION,  
 1235 MAIL SERVICE CENTER, RALEIGH, NC 27699-1235  
 MAIN TELEPHONE: (919) 807-2500 HELPLINE: (800) 688-8349  
 7 WEBSITE: [HTTP://WWW.IC.NC.GOV/](http://www.ic.nc.gov/)

**OSHA 301 Information:**

Case Number from Log:	Date Hired: / /	Time Employee began work on date of incident: : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	If off-site medical treatment provided, answer entire next line.	
Name of facility:	Address: Street/City/Zip/Telephone		ER visit? <input type="checkbox"/> Yes <input type="checkbox"/> No	Overnight stay? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Attention:</b> This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.				

**IMPORTANT INFORMATION FOR EMPLOYER**

Employer must furnish a copy of this form, as completed, to the employee or the employee's representative when submitted to the Insurance Carrier or Claims Administrator for transmission to the Commission. Every question must be answered. This Form 19 must be transmitted to the Commission through your insurance carrier/claims administrator, and is required by law to be filed within 5 days after knowledge of accident. Employer must also give employee a blank Form 18.

**IMPORTANT INFORMATION FOR EMPLOYEE****Reporting an Injury**

If you do not agree with the description or time of the accident given on this form, you should make a written report of injury to the employer within thirty (30) days of the injury.

**Making A Claim**

To be sure you have filed a claim, complete a Form 18, Notice of Accident, within two years of the date of the injury and send a copy to the Industrial Commission and to your employer. The employer is required by law to file this Form 19, but the filing of the Form 19 does not satisfy the employee's obligation to file a claim. The employee must file a Form 18 even though the employer may be paying compensation without an agreement, or the Commission may have opened a file on this claim. A claim may also be made by a letter describing the date and nature of the injury or occupational disease. This letter must be signed and sent to the Industrial Commission and to your employer.

**FOR ASSISTANCE OR TO OBTAIN A FORM 18 FROM THE INDUSTRIAL COMMISSION, YOU MAY CALL (800) 688-8349**

USE YOUR I.C. FILE NUMBER (IF KNOWN) OR SOCIAL SECURITY NUMBER ON ALL FUTURE CORRESPONDENCE WITH THE COMMISSION

[SPANISH TRANSLATION]

**INFORMACIÓN IMPORTANTE PARA LOS EMPLEADOS****Reporte de una Lesión (Reporting an Injury)**

Si usted no está de acuerdo con la descripción o la hora del accidente que aparece en el formulario, debe hacer un reporte de la lesión por escrito y dárselo a su empleador dentro de un periodo de treinta (30) días a partir de la fecha de la lesión.

**Cómo Presentar una Reclamación (Making a Claim)**

Para cerciorarse de que ha presentado una reclamación, complete el Formulario 18 Notificación de Accidente dentro de un periodo de dos años a partir de la fecha de la lesión y envíe una copia a la Comisión Industrial y una copia a su empleador. Por ley, el empleador debe presentar el Formulario 19, sin embargo, el presentar el Formulario 19 no cumple con la obligación que tiene el empleado de presentar una reclamación. El empleado debe presentar el Formulario 18 aunque el empleador esté pagando compensación sin tener un acuerdo o si la Comisión ha creado un expediente con respecto a esta reclamación. También se puede presentar una reclamación por medio de una carta explicando la fecha y la naturaleza de la lesión o la enfermedad ocupacional. Esta carta se debe firmar y enviar a la Comisión Industrial así como al empleador.

**PARA RECIBIR ASISTENCIA O PARA OBTENER EL FORMULARIO 18 DE LA COMISIÓN INDUSTRIAL, USTED PUEDE HABLAR AL (800) 688-8349**

EN TODA LA CORRESPONDENCIA QUE ENVÍE A LA COMISIÓN INDUSTRIAL POR FAVOR ESCRIBA EL NÚMERO DE CASO DESIGNADO POR LA COMISIÓN [I.C. FILE NUMBER] (SI LO SABE) O SU NÚMERO DE SEGURO SOCIAL.

SELF-INSURED EMPLOYER OR CARRIER, FILE AS FROI VIA EDI:  
HTTP://WWW.IC.NC.GOV/EDIFORM19.HTML

UNINSURED EMPLOYERS OR LUNG DISEASE CLAIMS:  
E-MAIL TO: FORMS@IC.NC.GOV OR MAIL TO: NCIC - CLAIMS SECTION,  
1235 MAIL SERVICE CENTER, RALEIGH, NC 27699-1235  
MAIN TELEPHONE: (919) 807-2500 HELPLINE: (800) 688-8349

8 WEBSITE: HTTP://WWW.IC.NC.GOV/

**STATEMENT OF DAYS WORKED AND EARNINGS OF INJURED EMPLOYEE**

IC File # \_\_\_\_\_  
 Emp. Code # \_\_\_\_\_  
 Carrier Code # \_\_\_\_\_  
 Carrier File # \_\_\_\_\_

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 _____
( ) - _____ ( ) - _____	Carrier's Address _____ City _____ State _____ Zip _____
Home Telephone _____ Work Telephone _____	( ) - _____ ( ) - _____
XXX-XX- _____ <input type="checkbox"/> M <input type="checkbox"/> F _____ / / _____	Carrier's Telephone Number _____ Fax Number _____
Last 4 Digits of SSN _____ Sex _____ Date of Birth _____	
Date of Injury: / / _____	

Year:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Amount Earned				
20																																				
Jan.																																				
Feb.																																				
Mar.																																				
Apr.																																				
May																																				
June																																				
July																																				
Aug.																																				
Sept.																																				
Oct.																																				
Nov.																																				
Dec.																																				
																																				Total

Was this employee given free rent, lodging, or board or other allowances made in lieu of wages? \_\_\_\_\_

If so, state weekly value thereof: \$ \_\_\_\_\_.

The undersigned employer of \_\_\_\_\_  
(Name of Employee)  
who alleges an injury on the \_\_\_\_\_ of \_\_\_\_\_, \_\_\_\_\_ 20\_\_\_\_  
(Day) (Month) (Year)

while in the employment of the undersigned, does hereby certify that the above is a true and correct statement of days worked and earnings of this employee during the 52 weeks immediately preceding the injury (or during the above weeks and parts thereof, if employed for less than 52 weeks) and while engaged in the occupation in which the employee was allegedly injured.

\_\_\_\_\_  
Employer  
By \_\_\_\_\_  
Authorized Signature  
/ / 20  
\_\_\_\_\_  
Date Signed

**To Employer: Making a false statement for the purpose of denying workers' compensation benefits may result in civil or criminal penalties.**

### INSTRUCTIONS

This form must be completed and filed with the Commission in all cases resulting in death unless maximum compensation rate is stipulated. It must also be filed in any other case if there is a disagreement about earnings or if the Commission requests it.

In preparing this form, place an X in the proper squares to indicate days paid in full. Days the employee is on paid vacation leave and/or paid sick leave should be marked with an X. Leave blank squares to indicate days not paid in full for any reason. Total earnings for each pay period should be placed in the proper column. If the employee's job or pay rate was changed during the reported period, this should be noted, with an indication as to the nature of the change.

The employer code number and the carrier code number, if any, must be inserted in the proper place at the upper right-hand corner of the form.



## Worker's Compensation Settlement Funds Approval Request Form

WCA Information:	
Requested by:	Date:
Division:	Facility/Department:
Contact Phone Number:	Email Address:
CCMSI Adjuster:	

Claimant Information:		
First Name:	Last Name:	
Job Title:	Years of Service:	Age:
Average Weekly Wage:	Compensation Rate:	
Date of Accident:	Current Medical Diagnosis:	
Description of Accident:	Medical Summary:	
Surgery?    Yes <input type="checkbox"/> No <input type="checkbox"/>	Permanent Restrictions?    Yes <input type="checkbox"/> No <input type="checkbox"/>	
List Restriction: N/A		
If PPD, Part of Body:	% PPD Rating:	Rating Dollar Value: \$
Has employee returned to previous job?    Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, explain:	
Has employee returned to previous salary?    Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, explain:	
Is employee still employed by DHHS?    Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, explain:	
Has employee applied for long-/short-term disability? LT: Yes <input type="checkbox"/> No <input type="checkbox"/> ST: Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, explain:	
Has employee been approved for long-/short-term disability? LT: Yes <input type="checkbox"/> No <input type="checkbox"/> ST: Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, explain:	
If applicable, what efforts have taken place to identify a job?		
Reason for Settlement:		
Was there an IC hearing?    Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, what was awarded? \$	
Mediation Ordered?    Yes <input type="checkbox"/> No <input type="checkbox"/>		
Top Negotiating Sum: \$	Are funds available?    Yes <input type="checkbox"/> No <input type="checkbox"/>	



## Worker's Compensation Settlement Funds Approval Request Form

<b>Signature of WC representative:</b>	<b>Date</b>
<b>Signature of Budget Officer/Business Manager:</b>	<b>Date</b>
<b>Signature of Division/Facility Director:</b>	<b>Date</b>
<b>Signature of DHHS Assistant General Counsel:</b>	<b>Date</b>