

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

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

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

**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.

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

Carrier File # \_\_\_\_\_

**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, 4335 Mail Service Center, Raleigh, NC 27699-4335 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.

**\*Required Information.**

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 ( ) - _____		Work Telephone ( ) - _____		Carrier's Address _____	
- -		/ /		( ) - _____	
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 _____				
	2. Location of plant where injury occurred _____ County _____ Department _____ State if employer's premises _____				
<b>Time And Place</b>	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 / /		<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
	7. Date you or the supervisor first knew of injury / /		8. Name of supervisor _____		
<b>Person Injured</b>	9. Occupation when injured _____				
	10. (a) Time employed by you _____		(b) Wages per hour \$ _____		
	11. (a) No. hours worked per day _____		(b) Wages per day \$ _____		(c) No. of days worked per week _____
	11. (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 \_\_\_\_\_

**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

**Attention:** 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.

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

**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/**

## 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 período 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 período 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.