North Carolina Industrial Commission

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.

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

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 ☐ M ☐ F Sex / / Date of Birth	Carrier's Telephone Number Carrier's Fax Number

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: _____ (Time of Injury) on _____ (Date (required)) at _____ (City and County). 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 typewritten, 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) ☐ Employee, ☐ Attorney, ☐ Representative, or ☐ Dependent — Telephone Number

Address City State Zip Date Completed

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: _____

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FORM 18

MAIL TO:
NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4334
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.COMP.STATE.NC.US/