EMPLOYEE OCCUPATIONAL INCIDENT REPORT

(Must be completed within 24 hours)

INJURED EMPLOYEE

Name: _____ **Sex:** ❒ Male ❒ Female

Address: _____

Home Phone: ( ) _____ **Date of Birth:** ____/____/____ **Date of Hire:** ____/____/____

Date of Injury/Illness: ____/____/____ **Time:** _____ **Department:** _____

Job Title: _____

INCIDENT FACTS

Describe Incident in Detail (use additional pages as necessary): _____

_____

_____

Were you doing your regular work assignment?: ❒ Yes ❒ No **If *No*, what job were you doing?** _____

_____

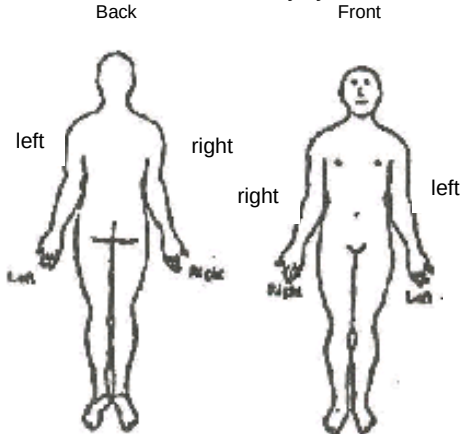
_____

_____

Type/Cause of Injury/Illness *(Check all that apply)*

____ Contact with Electrical Equipment
____ Fall from Elevation / Same Level *(circle one)*
____ Struck by / against *(circle one)*
____ Fork Lift/Vehicle Accident
____ Caught in, Under or Between
____ Back Injury from Lifting / Non Lifting *(circle one)*
____ Chemical Exposure
____ Noise
____ Other (be specific) _____
____ Repetitive Motion
____ Burn or Scald (Heat)
____ Sprain / Strain
____ Skin Irritation
____ Laceration or Puncture
____ Head Injury
____ Eye Injury
____ Upper Torso Injury
____ Leg, Foot, or Ankle Injury

Shade Location of Injury/Illness



Time of Incident _____ AM / PM Day of the Week: S M T W Th F S

Location of Incident (Be specific) _____

What Personal Protective Equipment were you wearing? _____

Describe work conditions that may have contributed to the incident (if any) _____

Did the injury occur after your regular work hours? ___ Yes ___ No

List all names of witnesses to the incident _____

Did you report the incident promptly to your immediate supervisor? ___ Yes ___ No

If *No*, to whom did you report the incident and when? _____

Has this part of your body ever been injured before? ___ Yes ___ No If *Yes*, provide explanation on reverse side

EMPLOYEE CERTIFICATION

I have read the Incident Report and attest that the information I have provided is true, accurate, and complete. I agree to cooperate with my employer in the investigation of this incident and with any such additional information as my employer may require. Furthermore, I understand that any material misrepresentation of fact may subject me to disciplinary action. By my signature below, I do hereby authorize and give permission to all healthcare providers who have rendered medical related services to me and to give to my employer, Hunter Auto Group, and/or any person acting on my behalf, with this written authorization, complete access to all medical records pertaining to the diagnosis and treatment of my medical case. My permission is also given to Hunter Auto Group to discuss the prognosis of my medical condition with the appropriate medical provider and/or medical personnel.

Employee Signature _____ Date ____/____/____

North Carolina Industrial Commission

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

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.

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

Employee's Name

Address

City State Zip

( ) - ( ) -
Home Telephone Work Telephone

- - ☐ M ☐ F / /
Social Security Number Sex Date of Birth

Employer's Name ( ) -
Telephone Number

Employer's Address City State Zip

Insurance Carrier Policy Number

Carrier's Address City State Zip

( ) - ( ) -
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 typed or printed by hand in black ink, 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.

FORM 18
8/1/08
PAGE 1 OF 1

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

FORM 18

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/

North Carolina Industrial Commission

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

IC File #_____

*Emp. Code #_____

*Carrier Code #_____

Employer FEIN_____

Carrier File #_____

***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.

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, 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.

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 | ( ) - Fax Number

Employer	1.	Give nature of employer's business
Time And Place	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 : ☐ A.M. ☐ P.M.
	5.	Was employee paid for entire day 6. Date disability began / / ☐ A.M. ☐ P.M.
	7.	Date you or the supervisor first knew of injury / / 8. Name of supervisor
Person Injured	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 (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
Cause And Nature Of Injury	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
Fatal Cases	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: : ☐ A.M. ☐ P.M.	If off-site medical treatment provided, answer entire next line.	
Name of facility:		Address: Street/City/Zip/Telephone	ER visit? ☐ Yes ☐ No	Overnight stay? ☐ Yes ☐ 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: _____

FORM 19

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/