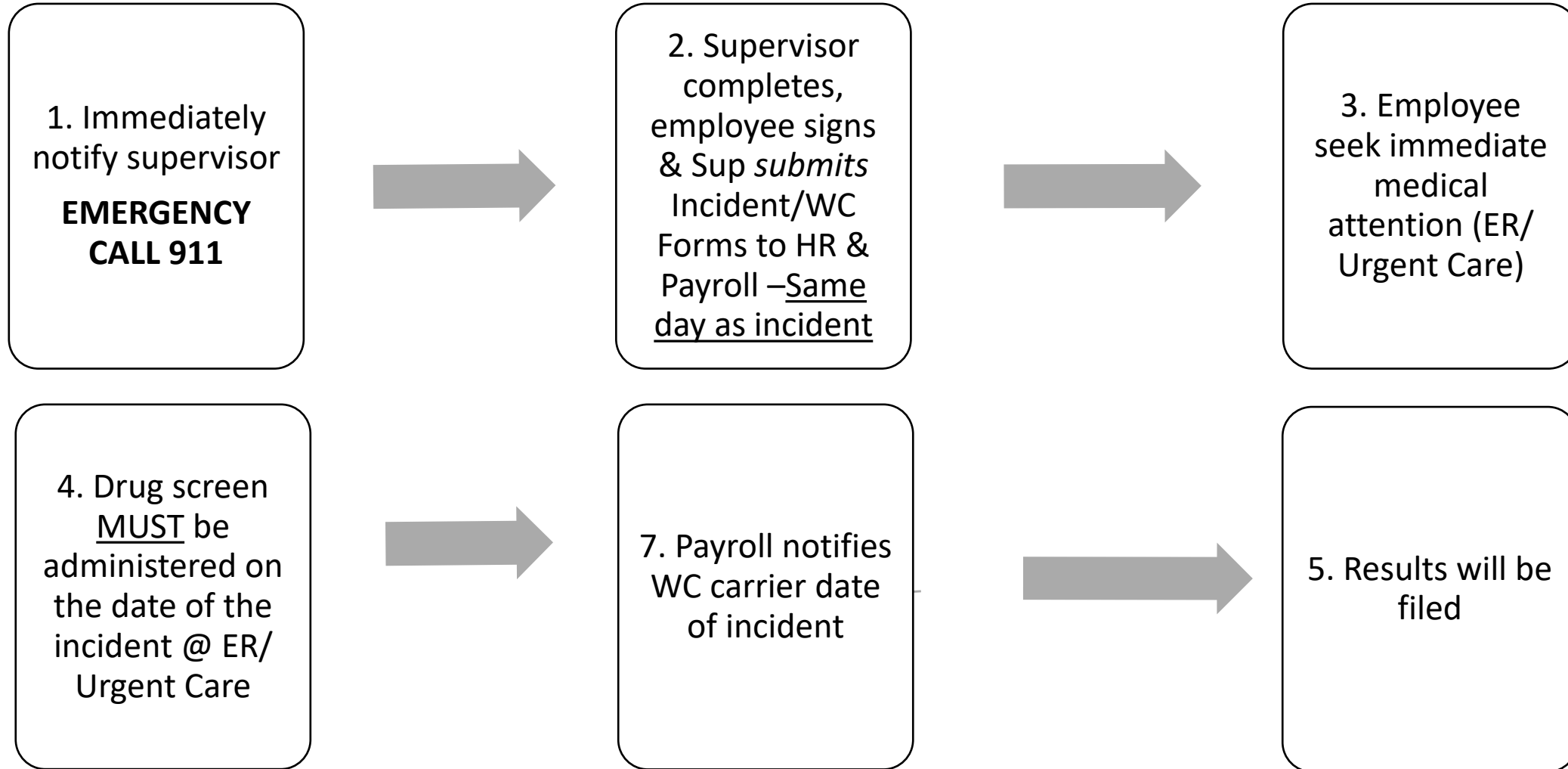


# Workplace Accident Injury Steps



# 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)

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

Shade Location of Injury/Illness

Back Front

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 \_\_\_\_/\_\_\_\_/\_\_\_\_

# 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.

**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	<input type="checkbox"/> M <input type="checkbox"/> F Sex	/ / 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 _____
	3. Date of injury / / 4. Day of week _____ Hour of day : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
<b>Time And Place</b>	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 _____
	9. Occupation when injured _____
<b>Person Injured</b>	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 _____
	12. Describe fully how injury occurred and what employee was doing when injured: _____  (Statement made without prejudice and without vouching for correctness of information)
<b>Cause And Nature Of Injury</b>	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: \_\_\_\_\_

## 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.

NOTICE OF ACCIDENT TO EMPLOYER AND CLAIM OF EMPLOYEE, REPRESENTATIVE, OR DEPENDENT

IC File # \_\_\_\_\_

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

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

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, 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.

Notice is hereby given, as required by law, that the above-named employee sustained an injury or contracted an occupational disease, described as follows: \_\_\_\_\_ on \_\_\_\_ / \_\_\_\_ / \_\_\_\_ at \_\_\_\_\_. 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. Signature of (Check One) [ ] Employee, [ ] Attorney, [ ] Representative, or [ ] Dependent, Printed Name of Signer, E-mail Address, Telephone Number, Address, City, State, Zip Code, Date Completed, EMPLOYER: This notice is being sent to you in compliance with requirements of the North Carolina Workers' Compensation Act...

FOR IC USE ONLY RESEARCHER: \_\_\_\_\_ CC: \_\_\_\_\_ EC: \_\_\_\_\_ DATA ENTRY: \_\_\_\_\_

ATTORNEYS: FILE WITH AN IC FILE NUMBER VIA EDFP HTTP://WWW.IC.NC.GOV/DOCFILING.HTML OR IF NO IC FILE NUMBER, FOLLOW EMPLOYEE FILING OPTIONS. EMPLOYEES: 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 WEBSITE: HTTP://WWW.IC.NC.GOV/

## GENERAL INFORMATION ON THE FORM 18

### **1. What does a Form 18 do?**

A Form 18 establishes a legal claim of injury on your behalf if filed within two years of the date of injury or occupational disease, and gives the required written notice to the employer if a copy is submitted to the employer within 30 days of the injury. The employer is required by law to file a Form 19 if the employee misses more than one day of work due to the injury or if the medical bills exceed \$2,000.00. However, the employer's filing of a Form 19 does not satisfy the employee's obligation to file a claim. In order to ensure the employee's rights are protected, the employee must file a Form 18 even though the employer may be paying compensation or the Industrial Commission may have opened a file for the injury.

### **2. To whom should the Form 18 be sent?**

The original Form 18 should be submitted to the Industrial Commission. The injured worker should keep one copy for his or her records and one copy should be submitted to the employer at the time of the injury.

### **3. What numbers do I write in the upper right corner?**

You do not need to fill in the spaces on the upper right corner of the Form 18. If you know that your employer has already filed a report of injury, (Form 19) and you know what your I.C. (Industrial Commission), File Number is, you may write the number in the "I.C. File No." space. If you do not already have an I.C. File Number, the Industrial Commission will assign one upon receipt of the Form 18. The other two spaces "Emp. Code No." and "Carrier Code No." are for internal use only.

### **4. What if I do not know who my employer's insurance carrier is?**

If you do not know who the employer's insurance carrier is you may either ask your employer for the information, call the Industrial Commission's Claims Administration Section at (800) 688-8349 then press "1" after the prompt, or simply leave the line blank.

### **5. When listing the number of days out of work, do I count partial days?**

Yes, you include partial as well as whole calendar days not worked. However, the days do not need to be consecutive.

### **6. What happens after I file the Form 18?**

The Industrial Commission will mail an acknowledgement letter to you after your Form 18 is processed. Processing time varies according to current workload. The Industrial Commission will mail a copy of the acknowledgement letter to the employer or its workers' compensation insurance carrier asking them to contact you and inform you if compensation will be paid to you voluntarily.