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

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

Employer's Name ( ) Telephone Number

Employer's Address City State Zip

Insurance Carrier

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 as soon as the accident occurred or as soon thereafter 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: _____

Disability began: _____ (Date) Return to work date or period of estimated disability: _____ (Date)

Weekly wage: _____ Number of hours worked per day: _____ Days worked per week: _____

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.

Signature of (Check One) ☐ Employee, ☐ Attorney, ☐ Representative, or ☐ Dependent

( ) Telephone Number

Address City State Zip Date Completed

NOTE –If injured is unable to sign this, 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 Industrial Commission at the address below, and furnish employer with one signed copy.

For IC use ONLY
Nature_____
Body_____
Cause_____
SIC_____
Coder

FORM 18
2/01
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FORM 18

MAIL TO:

NCIC - STATISTICS SECTION

4334 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4334
MAIN TELEPHONE: (919) 807-2500
OMBUDSMAN: (800) 688-8349