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

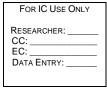
IC File #	
Emp. Code #	
Carrier Code #	
Employer FEIN_	

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

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.

				()	-	
Employee's Name		Employer's Name		Tele	ohone Nur	nber
ddress		Employer's Address		City	State	Zip
City	State Zip	Insurance Carrier	Po	licy Number		
Iome Telephone	Work Telephone	Carrier's Address	Cit	у	State	Zip
M F Focial Security Number Sex	/ / Date of Birth	Carrier's Telephone Numb	er Ca	rrier's Fax Num	ber	
occupational disease or your claim accident or as soon as practicable claims; however, for asbestosis, silutorice is hereby given, as required by law described as follows: Time of Injury accluding the specific body part involved (expectation of the company of	and within 30 da icosis and byssin that the above-nam / / at Date (required) e.g., right hand, left ha	ys. (This form shoul osis, Form 18B is to ed employee sustained and County and)	d also be used for be used.) an injury or contracted	occupation occupation	onal di onal dis	seas ease,
Occupation when injured:		e of employer's business	S:			
ledical treatment received? ☐Yes ☐	□No					
		d per day:	Days worked	per week:		
Medical treatment received? Yes Veekly wage: \$ Nu NOTE: If employee is unable to sign black ink, if possible. Employee shows Commission at the address below, and the sign of	this form, another rould retain one sign	may sign for him. This ned copy of this notiled copy to employer.	form should be type	ed or printed to the state of t	he Índ	ustria -
Medical treatment received? Yes [Veekly wage: \$ Nu NOTE: If employee is unable to sign black ink, if possible. Employee sho	this form, another rould retain one sign of provide one sign	may sign for him. This ned copy of this noti	form should be type	ed or printed to the state of t		ustria -
Neekly wage: \$ Nu NOTE: If employee is unable to sign black ink, if possible. Employee shows Commission at the address below, ar	this form, another rould retain one sign of provide one sign	may sign for him. This ned copy of this notiled copy to employer.	s form should be type ce, mail one signed	ed or printe I copy to 1 (Tele	he Índ	ustria - lumbe

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FORM 18

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 SEC

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/