

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

Employer	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 : ☐ A.M. ☐ P.M.
Time And Place	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 _____
Person 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, FILE AS FROI VIA EDI:
HTTP://WWW.IC.NC.GOV/EDIFORM19.HTML

UNINSURED EMPLOYERS OR LUNG DISEASE CLAIMS:
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/