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Description automatically generated

**EMPLOYEE STATEMENT**

# Name: Date of Injury: Time of Injury AM/PM

**Home Address: Date of Birth: SSN:**

**City: State: Zip:**

**Employee's Home Phone: Employee's Mobile/Cell Phone:**

**What Happened?**

**Where did the incident occur?**

**Witness(es): Witness' Telephone:**

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**Please list all Witnesses. If additional space is needed, attach a separate sheet.**

**Injuries: All Body Parts Injured:**

**(Right, Left, Upper, Middle, and/or lower)**

1. **Use of Leave -** If you lose time from work, you may choose one of the following:
   1. Elect to take earned sick leave for the required waiting period; go on workers compensation leave and begin drawing W/C weekly benefits.
   2. Elect to go on worker’s compensation leave with no pay for the required waiting period; begin drawing W/C weekly benefits.
   3. Elect to supplement the worker’s compensation weekly benefits with the use of partially earned sick leave, in accordance with the State Board of Education Worker’s Compensation Policy. **All elections involving the use of earned sick leave are subject to their availability.**
2. **Waiting Period –** No compensation shall be paid for the first seven days of disability, unless the disability continues for more than 21 days. (Sick leave may be used for the first seven days.)
3. **Worker’s compensation Rate –** Two-thirds of your average weekly wage during the 52 weeks preceding the date of the injury; it is not to exceed the maximum established by the N.C. Industrial Commission annually.
4. **Medical Services/Referrals –** FastMed Urgent Care and Emerge Ortho are the only providers approved for workers’ compensation. All referrals for specialty care must be approved by the Third-Party Administrator.
5. **Nursing Services** – Nursing services are provided only at the request of the treating physician. Housekeeping services in your home and/or childcare are not considered nursing care.
6. **Prescription Drugs** – All prescription drugs must be on Form 25P giving the name of the doctor, name of the drug, claimant’s social security number, and receipts from the Pharmacy attached before reimbursement can be made. Cash Register receipts are not acceptable
7. **Travel *–*** Employees are entitled to mileage for medical treatment if travel exceeds a 20-mile radius (round-trip) from point of origin. The Date of Injury determines the rate. (Form 25T must be completed for reimbursement.)

# Witness – Workers’ Comp Claims Processor (1) Signature of Employee Date

1. **I understand that it is my responsibility to complete the Form 18 (if applicable) and mail it to the North Carolina Industrial Commission.**

**(2) Signature of Employee Date**

* 1. **Your signature above certifies that you have read and understand the rules and procedures regarding the waiting period, how your average weekly wage is calculated, and the facility at which you MUST treat.**