*North Carolina Industrial Commission*

# *EMPLOYER'S ADMISSION OF EMPLOYEE'S RIGHT TO PERMANENT PARTIAL DISABILITY (G.S. § 97-31)*

IC File # _____

Emp. Code# _____

Carrier Code# _____

Carrier File #_____

Employer FEIN _____

**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 |
| ( ) Home Telephone ( ) Work Telephone | Carrier's Address City State Zip |
| XXX-XX- Last 4 Digits of SSN □ M □ F Sex / / Date of Birth | ( ) Carrier's Telephone Number ( ) Carrier's Fax Number |

**WE, THE UNDERSIGNED, DO HEREBY AGREE AND STIPULATE AS FOLLOWS:**

1. All the parties hereto are subject to and bound by the provisions of the Workers' Compensation Act and _____ is the Carrier/Administrator for the Employer.

2. The employee sustained an injury by accident or the employee contracted an occupational disease arising out of and in the course of employment on _____.

3. The injury by accident or occupational disease resulted in the following injuries: _____.

4. The employee □ was □ was not paid for the 7 day waiting period.
If not, was salary continued? □ yes □ no. Was employee paid for the date of injury? □ yes □ no

5. The average weekly wage of the employee at the time of the injury, including overtime and all allowances, was $_____.
This results in a weekly compensation rate of $_____.

6. The employee □ has □ has not returned full time to work for _____
on _____, at an average weekly wage of $_____.

7. Claimant was released □ with permanent restrictions □ without permanent restrictions.

8. Permanent partial disability compensation will be paid to the injured worker as follows:

____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)
____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)
____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)

Total amount of permanent partial disability compensation is $_____. Date of first payment:_____.

9. State any further matters agreed upon, including disfigurement, loss of teeth, election of temporary partial disability, waiting period or other: _____.

10. An overpayment is claimed in the amount of $_____. Overpayment was calculated as follows:_____.

***ATTORNEYS/CARRIERS/SELF-INSURED EMPLOYERS:***
***FILE VIA ELECTRONIC DOCUMENT FILING PORTAL***
**HTTP://WWW.IC.NC.GOV/DOCFILING.HTML**



**Form 26A**

**HELPLINE: (800) 688-8349**
**WEBSITE: HTTP://WWW.IC.NC.GOV/**

If overpayment claimed, a Form 28B, *Report of Compensation and Medical Compensation Paid*, is attached. □ yes □ no

11. If applicable, the Second Injury Fund Assessment is $ _____. A check □ is □ is not included.

**The undersigned hereby certify that the relevant medical and vocational reports related to the injury have been provided to the employee or the employee's attorney and have been filed with the Industrial Commission for consideration pursuant to G.S. § 97-82(a) and Rule 04 NCAC 10A .0501.**

| Name of Employer | Signature | Title | Date |
|---|---|---|---|

| Name of Carrier/ Administrator | Signature | Direct phone number | Title | Date |
|---|---|---|---|---|

**By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on page 3 of this form.**

| Signature of Employee | Address | Date |
|---|---|---|

| Signature of Employee's Attorney | Address | Date |
|---|---|---|

□ Check box if no attorney retained.

North Carolina Industrial Commission

The FOREGOING AGREEMENT IS HEREBY APPROVED:

_____
NCIC Claims Examiner/ Special Deputy/ Other

$_____
ATTORNEY FEE APPROVED



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## IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM PAYMENTS

Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial Commission in writing within two years from the date of receipt of your last compensation check or your rights to these benefits may be lost.

## IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5,1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

## IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several factors. Your right to payment of future medical compensation will terminate two years after your employer or carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think you will need future medical compensation, you must apply to the Industrial Commission in writing within two years, or your right to these benefits may be lost. To apply you may also use Industrial Commission Form 18M, *Employee's Application for Additional Medical Compensation (G.S. § 97-25.1)*, available at http://www.ic.nc.gov/forms.html.

## IMPORTANT NOTICE TO EMPLOYER

The employee must be provided a copy when the agreement is signed by the employee. Pursuant to Rule 04 NCAC 10A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or carrier/administrator must submit the agreement to the Industrial Commission, or show cause for not submitting the agreement. The employer or carrier/administrator shall file a Form 28B, *Report of Compensation and Medical Compensation Paid*, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.

## NEED ASSISTANCE?

If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at (800) 688-8349.



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