

**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 \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Social Security Number \_\_\_\_\_  M  F / / \_\_\_\_\_  
Date of Birth \_\_\_\_\_

Employer's Name \_\_\_\_\_ Phone \_\_\_\_\_  
Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Carrier \_\_\_\_\_  
Carrier's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
( ) \_\_\_\_\_ Ext. \_\_\_\_\_ ( ) \_\_\_\_\_  
Carrier's Telephone Number \_\_\_\_\_ Carrier's Fax Number \_\_\_\_\_

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

- 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.
  - The employee sustained an injury by accident or the employee contracted an occupational disease arising out of and in the course of employment on \_\_\_\_\_.
  - The injury by accident or occupational disease resulted in the following injuries: \_\_\_\_\_.
  - 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
  - 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 \$ \_\_\_\_\_.
  - The employee  has  has not returned full time to work for \_\_\_\_\_  
on \_\_\_\_\_, at an average weekly wage of \$ \_\_\_\_\_.
  - Claimant was released  with permanent restrictions  without permanent restrictions.
  - 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: \_\_\_\_\_.
- State any further matters agreed upon, including disfigurement, loss of teeth, election of temporary partial disability, waiting period or other: \_\_\_\_\_.



**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.

**IMPORTANT NOTICE TO EMPLOYER**

The employee must be provided a copy when the agreement is signed by the employee. Failure to file Form 28B, Report Of Compensation And Medical Compensation Paid, within 16 days after last payment pursuant to this agreement may subject the employer or carrier/administrator to a penalty. Pursuant to Rule 501, 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 good cause for not submitting the agreement.

**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.