

**EMPLOYEE'S APPLICATION FOR ADDITIONAL MEDICAL
COMPENSATION (G.S. § 97-25.1)****(APPLICABLE TO INJURIES BY ACCIDENT OR OCCUPATIONAL DISEASES
CONTRACTED ON OR AFTER 5 JULY 1994)**

IC File # _____

Emp. Code # _____

Carrier Code # _____

Employee's Name _____ Email Address _____

Address _____

City _____ State _____ Zip _____

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Home Telephone _____ Work Telephone _____

XXX-XX- _____ ☐ M ☐ F / /

Last 4 Digits of SSN _____ Sex _____ Date of Birth _____

Employer's Name _____ Email Address _____ Telephone Number _____

Employer's Address _____ City _____ State _____ Zip _____

Insurance Carrier _____

Carrier's Address _____ City _____ State _____ Zip _____

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Carrier's Telephone Number _____ Adjuster's Name _____ Email Address _____

SECTION A. TO BE COMPLETED BY EMPLOYEE:

1. The above-named employee claims additional medical compensation as a result of an injury by accident or an occupational disease which occurred on or by _____ (Date) because _____

(Reason for Additional Medical Compensation)

2. Additional medical and/or other supporting documentation ☐ is / ☐ is not attached (optional).
(Place your I.C. File # on each attachment.)

SIGNATURE OF EMPLOYEE _____

DATE COMPLETED _____

Name and address of employee's attorney, if any: _____

**EMPLOYEE: SEND THE ORIGINAL OF THIS FORM AND ANY SUPPORTING DOCUMENTATION TO THE INDUSTRIAL COMMISSION
AS INSTRUCTED AT THE BOTTOM OF THIS FORM AND SEND A COPY TO THE EMPLOYER OR CARRIER/ADMINISTRATOR.**

SECTION B. TREATING PHYSICIAN'S STATEMENT (OPTIONAL):

This is to certify that:

1. I am the above-named employee's treating physician. My area of medical practice is _____, and my treatment of the employee began on _____. (mo/day/yr)
2. In my opinion, there is a substantial risk that the employee will need the following additional medical care or monitoring (including medical, surgical, hospital, nursing, rehabilitation services, medicines, sick travel, replacement of artificial members, medical and surgical supplies, and other treatment): _____

The need for this medical treatment results from the injury by accident or occupational disease as set forth in Section A. above.

SIGNATURE OF TREATING PHYSICIAN _____

PRINTED NAME _____

DATE _____

ADDRESS _____

CITY _____

STATE _____

ZIP _____

ATTORNEYS/CARRIERS:
FILE VIA ELECTRONIC DOCUMENT FILING
PORTAL [HTTPS://WWW.IC.NC.GOV/](https://www.ic.nc.gov/docfiling.html)
[DOCFILING.HTML](https://www.ic.nc.gov/docfiling.html)

EMPLOYEE FILING OPTIONS:
E-MAIL TO EXECSEC@IC.NC.GOV
FAX TO (919) 715-0282
MAIL TO NCIC-EXECUTIVE SECRETARY
1236 MAIL SERVICE CENTER
RALEIGH, NC 27699-1236

HELPLINE: (800) 688-8349
WEBSITE: [HTTPS://WWW.IC.NC.GOV](https://www.ic.nc.gov)