NORTH CAROLINA STATE GOVERNMENT WORKERS' COMPENSATION PROGRAM
EMPLOYEE STATEMENT AND LEAVE OPTIONS

Supervisors should provide all injured employees with this form to complete the information concerning the accident/incident and use of leave options for any time lost from work which may result from injury. Form should be completed in detail to give an accurate account of the case. Once form is completed by the employee, supervisor completes bottom portion and submits to agency WC Administrator.

EMPLOYEE STATEMENT

Employee Name: _____ **SS#:** - -

Department: _____

Division/Unit: _____

Location: _____ **County:** _____

Date of Injury: _____ **Date Injury Reported:** _____

Name of Person Notified of Injury: _____

Part(s) of Body Injured: _____

Description of Accident: _____

Cause of Accident: _____

I understand the information above will be used by my employer to help determine liability for the injury. I acknowledge that the above statement is a true and accurate representation of this information.

_____ , _____

Employee's Signature Date

USE OF LEAVE OPTIONS

This is to certify that the use of leave options available in conjunction with the lost time from work as a result of an on-the-job injury which occurred on _____, _____ have been fully explained to me. I understand these options are available to me only if the agency determines the claim to be compensable and accepts liability. I understand that once I elect an option, that election shall be irrevocable as to each individual incident. After careful consideration, I elect the option(s) marked below.

Place an X in the space provided to select the option(s) you desire.

☐ **Option 1:** Elect to take sick or vacation leave during the required seven-day waiting period and then go on worker's compensation leave and begin drawing workers' compensation weekly benefits.

☐ **Option 2:** Elect to go on workers' leave immediately with no pay for the seven-day waiting period and then began drawing workers' compensation weekly benefits.

Note: In either option above if the injury results in disability of more than 21 days, the workers' compensation weekly benefit shall be allowed from the date of the disability.

☐ **Option 3:** Elect to supplement the workers' compensation weekly benefit with the use of partial earned sick or vacation leave in accordance with the schedule provided by the Office of State Personnel. Use of the supplemental leave benefit applies only while drawing temporary total disability compensation.

Note: All elections involving the use of earned sick or vacation leave are subject to their availability at the time of the incident.

_____ _____

Employee Signature Division/Unit

_____ _____

Employee SS# Date

****

Supervisor Completes This Section

The above named employee was injured on _____, _____ and was placed on workers' compensation leave on _____, _____. A Supervisor's Accident Report or Accident Investigation Report has been completed and is attached to the IC Form 19.

_____ _____

Supervisor's Signature Date

North Carolina Industrial Commission EMPLOYER: FUND: DEPT: IC File #_____

EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

Emp. Code #_____

Carrier Code #_____

Employer FEIN_____

Carrier File #_____

To the Employer:
The filing of this report is required by law. It does not satisfy the employee's obligation to file a claim. **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, 4334 Mail Service Center, Raleigh, NC 28799-4334 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 and the date your doctor told you that you have a work-related disease, whichever is later.

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	☐ M ☐ F Sex / / Date of Birth	( ) - Carrier's Telephone Number	( ) - Fax Number	

Employer	1.	Give nature of employer's business
Time And Place	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.
	5.	Was employee paid for entire day 6. Date disability began / / ☐ A.M. ☐ P.M.
	7.	Date you or the supervisor first knew of injury / / 8. Name of supervisor
Person Injured	9.	Occupation when 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
Nature _____
Body _____
Cause _____
SIC _____
Coder _____

FORM 19

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:
NCIC - CLAIMS ADMINISTRATION
4334 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4334
MAIN TELEPHONE: (919) 807-2500
OMBUDSMAN: (800) 688-8349

Employer must furnish a copy of this form, as completed, to the employee or the employee's representative when submitted to the Insurance Carrier or Claims Administrator for transmission to the Commission. Every question must be answered. This report must be transmitted to the Commission through your insurance carrier/claims administrator, and is required by law to be filed within 5 days after knowledge of accident.

IMPORTANT INFORMATION FOR EMPLOYEE

Reporting an Injury

If you do not agree with the description or time of the accident given on this form, you should make a written report of injury to the employer within thirty (30) days of the injury.

Making A Claim

To be sure you have filed a claim, complete a Form 18, Notice of Accident, within two years of the date of the injury and send a copy to the Industrial Commission and to your employer. The employer is required by law to file this Form 19, but the filing of the Form 19 does not satisfy the employee's obligation to file a claim. The employee must file a Form 18 even though the employer may be paying compensation without an agreement, or the Commission may have opened a file on this claim. A claim may also be made by a letter describing the date and nature of the injury or occupational disease. This letter must be signed and sent to the Industrial Commission and to your employer.

FOR ASSISTANCE OR TO OBTAIN A FORM 18 FROM THE INDUSTRIAL COMMISSION, YOU MAY CALL (800) 688-8349

USE YOUR I.C. FILE NUMBER (IF KNOWN) OR SOCIAL SECURITY NUMBER ON ALL FUTURE CORRESPONDENCE WITH THE COMMISSION

[SPANISH TRANSLATION]

INFORMACIÓN IMPORTANTE PARA LOS EMPLEADOS

Reporte de una Lesión (Reporting an Injury)

Si usted no está de acuerdo con la descripción o la hora del accidente que aparece en el formulario, debe hacer un reporte de la lesión por escrito y dárselo a su empleador dentro de un período de treinta (30) días a partir de la fecha de la lesión.

Cómo Presentar una Reclamación (Making a Claim)

Para ceriorarse de que ha presentado una reclamación, complete el Formulario 18 Notificación de Accidente dentro de un período de dos años a partir de la fecha de la lesión y envíe una copia a la Comisión Industrial y una copia a su empleador. Por ley, el empleador debe presentar el Formulario 19, sin embargo, el presentar el Formulario 19 no cumple con la obligación que tiene el empleado de presentar una reclamación. El empleado debe presentar el Formulario 18 aunque el empleador esté pagando compensación sin tener un acuerdo o si la Comisión ha creado un expediente con respecto a esta reclamación. También se puede presentar una reclamación por medio de una carta explicando la fecha y la naturaleza de la lesión o la enfermedad ocupacional. Esta carta se debe firmar y enviar a la Comisión Industrial así como al empleador.

PARA RECIBIR ASISTENCIA O PARA OBTENER EL FORMULARIO 18 DE LA COMISIÓN INDUSTRIAL, USTED PUEDE HABLAR AL (800) 688-8349

EN TODA LA CORRESPONDENCIA QUE ENVÍE A LA COMISIÓN INDUSTRIAL POR FAVOR ESCRIBA EL NÚMERO DE CASO DESIGNADO POR LA COMISIÓN *[I.C. FILE NUMBER]* (SI LO SABE) O SU NÚMERO DE SEGURO SOCIAL.

Employee Signature:		Date: / /

FORM 19

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:
NCIC - CLAIMS ADMINISTRATION
4334 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4334
MAIN TELEPHONE: (919) 807-2500
OMBUDSMAN: (800) 688-8349

SUPERVISOR'S ACCIDENT/INCIDENT INVESTIGATION REPORT

FILE NO.: **DATE: / /**

Date of Accident: / / **Time of Day : AM : PM** **Date Reported: / /** **Accident Occurred On Employer's Premises?: ☐ Yes ☐ No**	
Supervisor's Name:	**Telephone No.:** ( ) -
Dept./Univ.:	**Address:**
Division:	**City:**
Location of Accident (specify site within facility):	
Witnesses Name:	**Day Telephone Number: ( ) -**
Witnesses Name:	**Day Telephone Number: ( ) -**

PERSONAL INJURY

1. Name of Injured:
2. Social Security #: - - Home # ( ) - Work #: ( ) -
3. Home Address:
4. Sex: ☐ Male ☐ Female 5. Age: 6. Job Title:
7. Employment Date: / / 8. Hrs Wrk Day: Hrs Wrk/Week:
9. Time on Current Job: (yrs) (mos) ☐ Full-time ☐ Part-time ☐ Temporary ☐ Seasonal

Employee Required: ☐ First-Aid Only ☐ Medical Treatment ☐ Fatality / / (date of death) ☐ OSHA Recordable

Employee Disposition Status ☐ Returned to Work ☐ Sent Home ☐ To Doctor ☐ To Hospital	☐ Other *Explain:*

PROPERTY DAMAGE

☐ Does not apply ☐ Major ☐ Serious ☐ Minor

[ ] Vehicle [ ] Equipment [ ] Private Property

Vehicle I.D:.
Model: **Age: (yrs) (mos)**
Driver's License #:

Equipment I.D.:
Model: **Age: (yrs) (mos)**

Name & Title of person with most direct responsibility for employee involved in this accident:	**Employee Description of Accident/Incident:**

IMMEDIATE CAUSE(s) ☐ Equipment ☐ Personnel ☐ Environment ☐ Mgt. ☐ Hazardous Conditions ☐ Unsafe Act	*Explain:*
BASIC CAUSE & CONTRIBUTING FACTOR(s) ☐ Environmental conditions ☐ Personnel ☐ Hazardous conditions ☐ Management ☐ Lack of safety instruction & training	*Explain:*
CORRECTIVE ACTION: I have taken the following: ☐Temporary / ☐Permanent immediate actions to reduce recurrence	*Explain:*
I recommend the following actions(s) to prevent recurrence; and anticipate completion by: / / date	
Managers Comments: (Appropriateness of Cause & Corrective Action)	**Signature:**_____ **Title:** **Telephone: ( ) - Date: / /**
Corrective Action/Follow up By Department Manager/Safety Officer:	**Date: / /**
Reviewed by Director:	**Date: / /**

Distribution: Director, WC Administrator, Safety & Health Director

COMPLETE FOLLOWING CHECKLISTS

ACCIDENT OR INCIDENT BREAKDOWN BY CHARACTERISTIC

NATURE OF INJURY

- ☐ No Physical Injury
- ☐ Amputation
- ☐ Angina Pectoris (Heart Disease)
- ☐ Burn (heat, chemical)
- ☐ Concussion
- ☐ Contusion (bruise, hematoma)
- ☐ Crushing
- ☐ Dislocation (nerve, disc, tear)
- ☐ Electric Shock (electrocuted)
- ☐ Enucleation
- ☐ Foreign Body (lint in eye)
- ☐ Fracture
- ☐ Freezing (frost bite)
- ☐ Loss of Hearing (traumatic)
- ☐ Heat Prostration
- ☐ Hernia (from lifting)
- ☐ Infection
- ☐ Inflammation
- ☐ Laceration
- ☐ Myocardial Infarction
- ☐ Poisoning (not cumulative)
- ☐ Puncture (needle stick)
- ☐ Rupture
- ☐ Severance
- ☐ Sprain
- ☐ Strain
- ☐ Syncope (fainting, etc.)
- ☐ Asphyxiation
- ☐ Vascular (includes strokes)
- ☐ Vision Loss
- ☐ All Other Specific Injuries
- ☐ Dust Disease
- ☐ Asbestosis (lung disease)
- ☐ Black Lung (coal)
- ☐ Byssinosis (cotton)
- ☐ Silicosis (silica dust)
- ☐ Respiratory Disorders
- ☐ Poisoning - chemical
- ☐ Poisoning - metal
- ☐ Dermatitis (any skin irritation)
- ☐ Mental Disorder
- ☐ Radiation (tissue, bones, etc.)
- ☐ Other Occupational Diseases
- ☐ Loss of Hearing
- ☐ Infectious Disease
- ☐ Cancer
- ☐ AIDS
- ☐ VDT Related Disease
- ☐ Mental Stress
- ☐ Carpal Tunnel Syndrome
- ☐ Other Cumulative Injuries
- ☐ Multiple Physical Injuries Only
- ☐ Multiple Injuries, Physical & Psych.

PARTS OF BODY AFFECTED

- ☐ Head
- ☐ Skull
- ☐ Brain
- ☐ Ear(s) (eardrum)
- ☐ Eye(s)
- ☐ Nose
- ☐ Teeth
- ☐ Mouth (lips, tongue, throat)
- ☐ Facial Soft Tissue
- ☐ Facial Bones
- ☐ Neck (multiple injuries)
- ☐ Vertebrae
- ☐ Disc (neck, spinal column)
- ☐ Spinal Cord
- ☐ Larynx (vocal cords)
- ☐ Soft Tissue (neck)
- ☐ Trachea
- ☐ Upper Extremities
- ☐ Upper Arm (humerus)
- ☐ Elbow (radial head)
- ☐ Lower Arm (forearm)
- ☐ Wrist
- ☐ Hand (excluding wrist, fingers)
- ☐ Thumb
- ☐ Shoulder(s) (armpit, rotator cuff)
- ☐ Wrist(s) & Hand(s)
- ☐ Trunk (combination parts)
- ☐ Upper Back (thoracic area)
- ☐ Low Back (lumbar etc.)
- ☐ Disc (back)
- ☐ Chest (ribs, sternum etc.)
- ☐ Sacrum & Coccyx
- ☐ Pelvis
- ☐ Spinal Cord
- ☐ Internal Organs
- ☐ Heart
- ☐ Lower Extremities
- ☐ Hip
- ☐ Thigh, Upper Leg
- ☐ Knee
- ☐ Lower Leg
- ☐ Ankle
- ☐ Foot
- ☐ Toe
- ☐ Great Toe
- ☐ Lungs
- ☐ Abdomen
- ☐ Buttocks
- ☐ Lumbar & or Sacral Vertebrae
- ☐ Artificial Appliance
- ☐ Insufficient Info to Identity
- ☐ No Physical Injury
- ☐ Multiple Body Parts
- ☐ Body Systems

TYPES OF ACCIDENTS

A. Burn or Scald-Heat or Cold Exposure:
- ☐ Chemicals
- ☐ Touched Hot Pan
- ☐ Temperature Extremes
- ☐ Fire or Flame
- ☐ Boiling Water Splashed
- ☐ Dust, Gases, Fumes etc.

B. Caught In, Under or Between:
- ☐ Caught in, Under, or Between
- ☐ Welding Flash - Injury to Eyes
- ☐ Radiation
- ☐ Contact with, NOC
- ☐ Cold Objects/Substances
- ☐ Abnormal Air Pressure
- ☐ Electric Current
- ☐ Machine or Machinery
- ☐ Caught, In, Under or Between
- ☐ Collapsing Materials (earth slides)

C. Cut, Puncture, Scrape:
- ☐ Broken Glass
- ☐ Hand Tool, Utensil
- ☐ Object Being Lifted
- ☐ Powered hand Tool
- ☐ Cut, Puncture, Scrape

D. Fall, Slip or Trip:
- ☐ Fall From Different Level
- ☐ Fall From Ladder
- ☐ Fall From Liquid/Grease
- ☐ Fall Into Opening
- ☐ Fall on Same Level
- ☐ Slipped, Did Not Fall
- ☐ Fall, Slip or Trip
- ☐ Ice or Snow
- ☐ Stairs

E. Motor Vehicle:
- ☐ Crash of Water Vehicle
- ☐ Crash of Rail Vehicle
- ☐ Collision w/other Vehicle
- ☐ Collision w/fixed Object
- ☐ Crash of Airplane
- ☐ Vehicle Upset (overturned)
- ☐ Motor Vehicle, NOC

F. Strain:
- ☐ Continual Noise
- ☐ Twisting
- ☐ Jumping
- ☐ Holding or Carrying
- ☐ Lifting (including patients)
- ☐ Pushing or Pulling
- ☐ Reaching (overhead)
- ☐ Using Tool or Machine
- ☐ Strain of Injury
- ☐ Throwing or Welding
- ☐ Repetitive Motion (CTS)

G. Striking Against or Stepping On:
- ☐ Moving Machine Parts
- ☐ Object Lifted or Handled
- ☐ Standing, Scraping Operator
- ☐ Stationary Object
- ☐ Stepping on Sharp Object
- ☐ Striking or Stepping

H. Struck or Injured By (kicked, stabbed, bit):
- ☐ Fellow Worker, Patient
- ☐ Falling or Flying Object
- ☐ Hand Tool or Machine
- ☐ Motor Vehicle
- ☐ Moving Parts of Machine
- ☐ Object Lifted or Handled
- ☐ Object Handled by Others
- ☐ Struck or Injured
- ☐ Animal or Insect
- ☐ Explosion or Flare Back

I. Rubbed or Abraded By:
- ☐ Repetitive Motion
- ☐ Rubbed or Abraded, NOC

Distribution: Director, WC Administrator, Safety & Health Director

Hazardous Condition

- ☐ Inadequate Ventilation
- ☐ Insufficient Workspace
- ☐ Improper Illumination
- ☐ Environmental Hazard
- ☐ Use of Inherently Hazardous Material
- ☐ Use Inherently Hazardous Method or Procedure
- ☐ Use of Inadequate or Improper Tools or Equipment
- ☐ Inadequate Help for Heavy Lifting
- ☐ Improper Assignment or Personnel
- ☐ Hazardous Methods or Procedures
- ☐ Improperly Placed
- ☐ Inadequately Secured
- ☐ Unguarded, Mechanical
- ☐ Inadequate Shoring
- ☐ Ungrounded
- ☐ Uninsulated
- ☐ Uncovered Connection Switches, etc.
- ☐ Unshielded Radiation
- ☐ Inadequately Guarded, NEC
- ☐ Public Hazards (off State Premises)
- ☐ Traffic Hazards
- ☐ Hazardous Condition, NEC
- ☐ Undetermined-Insufficient Information
- ☐ No Hazardous Condition

Unsafe Act

- ☐ Cleaning, Oiling, Adjust Moving Equipment
- ☐ Welding/Repairing of Equipment Without Supervisor
- ☐ Working on Electrically Charged Equipment
- ☐ Failure to Secure or Warn
- ☐ Failure to Shut off Equipment Not in Use
- ☐ Failure to Place Warning Signs & Signals
- ☐ Releasing or Moving Loads, etc., Without Giving Adequate Warning
- ☐ Horseplay, Fighting, etc.
- ☐ Use of Equipment or Material for Other Than its Intended Purpose
- ☐ Overloading
- ☐ Gripping Object Insecurely
- ☐ Taking Wrong Hold of Object
- ☐ Using Hand Instead of Tools
- ☐ Inattention to Footing or Surroundings
- ☐ Disconnecting or Remaining Safety Devices
- ☐ Replacing Safety Devices With Those of Improper Capacity
- ☐ Jumping From Elevations, Vehicles, etc.
- ☐ Running
- ☐ Throwing Material or Tools
- ☐ Riding in Unsafe Position
- ☐ Unnecessary Exposure Under Suspended Loads
- ☐ Unnecessary Exposure to Moving Materials or Equipment
- ☐ Driving Too Fast or Too Slowly
- ☐ Entering/Leaving Vehicle on Traffic Side
- ☐ Failure to Signal When Stopping, Turning or Backing
- ☐ Failure to Yield ROW
- ☐ Backing Without Looking for Clearance
- ☐ Failure to Obey Traffic Control Signs or Signals
- ☐ Following Too Close
- ☐ Other (Explain)

Supervisory Activities

- ☐ Inadequate Training of Employee
- ☐ Faulty Instruction to Employee
- ☐ Improper Planning of Job
- ☐ Unsafe Procedures of Job
- ☐ Inadequate Knowledge/Leadership
- ☐ No Supervisory Failure

Employee Attributes

- ☐ Lack of Knowledge or Experience
- ☐ Improperly Trained
- ☐ Bodily Defects
- ☐ Lack of Respect for Hazard
- ☐ Other Insufficient Data
- ☐ DWI

Safety Equipment in Use

- ☐ Hard Hat
- ☐ Safety Glasses
- ☐ Respirator
- ☐ Movable Exhaust Hood
- ☐ Ear Protection
- ☐ Safety Shoes
- ☐ Lanyards & Lifelines
- ☐ Fluorescent Vest ☐ Flags
- ☐ Buoyant Workvest
- ☐ Chemical Apron
- ☐ Faceshields ☐ Gloves
- ☐ Warning & Control
- ☐ Seat Belts
- ☐ Shoulder Harness
- ☐ Other Restraining Devices
- ☐ Safety Equipment

PREPARE & ATTACH SKETCH AND/OR PROVIDE PHOTOS AS NECESSARY TO DESCRIBE ACCIDENT/INCIDENT