

EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION**To the Employer:**

A copy of this Form 19 accompanied by a blank Form 18 must be given to the employee. It does not satisfy the employee's obligation to file a claim. The filing of this report is required by law. 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, - 4335 Mail Service Center, Raleigh, NC 27699-4335 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 or the date your doctor told you that you have a work-related disease, whichever is later.

This # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

Carrier FEIN _____

Carrier File # _____

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Employer's Name/Employer's Name _____

Telephone Number _____

Address/Employer's Address City State Zip _____

City State _____

Zip Insurance Carrier Policy Number _____

Home Telephone/Fax 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 _____ | |
| | 2. Location of plant where injury occurred _____ | |
| | Time County _____ | Department State if employer's premises _____ |
| | And 3. Date of injury / / 4. Day of week Hour of day : <input type="checkbox"/> <input type="checkbox"/> | |
| | Place 5. Was employee paid for entire day <input type="checkbox"/> <input type="checkbox"/> | |
| | 7. Date you or the supervisor first knew of injury / / 8. Name of supervisor _____ | |
| | 9. Occupation when injured _____ | |
| | Person 10. (a) Time employed by you (b) Wages per hour \$ _____ | |
| | Injured 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 () : _____ | |
| | 14. Date & hour returned to work / / at : M. , at what wages \$ _____ per _____ | |
| | 15. At what _____ is category continued in full? | |
| | 16. Was employee treated by a physician _____ | |
| Fatal Cases 19. Has injured employee died, 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 with this date of placement provided, _____ answer entire next line. |
| Name of facility: _____ | Address: Street/City/Zip/Telephone _____ ER visit? <input type="checkbox"/> Yes <input type="checkbox"/> No Overnight stay? <input type="checkbox"/> Yes <input type="checkbox"/> 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 HOUSE ONLY

 RESEARCHER _____
 OC _____
 EC _____
 DATA ENTRY _____
FORM 19
 SELF-INSURED EMPLOYER OR CARRIER FILE AS FROI VIA EDI:
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 UNINSURED EMPLOYERS OR LUNG DISEASE CLAIMS:
 E-MAIL TO: FORMS@IC.NC.GOV OR MAIL TO: NCIC - CLAIMS SECTION,
 4335 MAIL SERVICE CENTER, RALEIGH, NC 27699-4335
 MAIN TELEPHONE: (919) 607-2500 HELPLINE: (800) 688-6349
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Employers Report Of Injury Nc

CL Gary



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North Carolina Reports North Carolina. Supreme Court,1914 Cases argued and determined in the Supreme Court of North Carolina **General Statutes of North Carolina Annotated** North Carolina,2005 North Carolina Court of Appeals Reports North Carolina. Court of Appeals,2005 **Pamphlet Volumes** Chamber of Commerce of the United States of America,1914 Occupational Disease Reporting Victoria M. Trasko,1953 *Injuries to Construction Laborers* ,1986
Area Wage Survey ,1986 **Report of the ... Annual Meeting of the North Carolina Bar Association** North Carolina Bar Association,1916 **Records & Briefs New York State Appellate Division** ,1961 Bulletin of the United States Bureau of Labor Statistics ,1986 **Injuries to Warehouse Workers** United States. Bureau of Labor Statistics,1986
Proceedings of the Annual Meeting (varies Slightly) International Association of Industrial Accident Boards and Commissions,1930 **Bulletin** ,1946 Bulletin United States. Bureau of Labor Standards, Bulletin - United States, Department of Labor, Bureau of Labor Standards United States. Bureau of Labor Standards, **Discussion of Industrial Accidents and Diseases** International Association of Industrial Accident Boards and Commissions,1944 New York Court of Appeals. Records and Briefs. New York (State)., **Injuries to warehouse workers** ,1986 **Hidden Tragedy** United States. Congress. House. Committee on Education and Labor,2008 *Industrial Accidents and Hygiene Series* United States. Bureau of Labor Statistics,1920

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web it has to do with the density or the mass per volume of the ship and its cargo compared to the density of water in this science activity you will make little boats out of aluminum foil to explore how their size affects how much weight they carry and how this relates to the density of water

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