

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

IC File # _____

Emp. FEIN _____

Carrier FEIN _____

Carrier File # _____

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, N.C. Industrial Commission, 1235 Mail Service Center, Raleigh, NC 27699-1235 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.

The 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.

Social Security Number Disclosure Statement

The North Carolina Public Records Act (N.C. Gen. Stat. § 132-1.10) permits the North Carolina Industrial Commission to request a social security number when doing so is imperative to the performance of its duties and responsibilities. The purpose of requesting a social security number on this form is for the Industrial Commission to verify the correct employer with the North Carolina Department of Commerce, Division of Employment Security and to identify workers' compensation insurance coverage. The disclosure of a social security number to the Industrial Commission is voluntary. Social security numbers are confidential and exempt from public disclosure by the Industrial Commission. The Industrial Commission may not share a social security number unless otherwise permitted to do so pursuant to N.C. Gen. Stat. § 132-1.10.

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 _____		
Sex ☐ M ☐ F			Date of Birth / / _____			City _____	State _____	Zip _____
Social Security Number _____			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.						
Person Injured	5. Was employee paid for entire day _____ 6. Date disability began / /							
	7. Date you or the supervisor first knew of injury / / 8. Name of supervisor _____							
	9. Occupation when injured _____							
	10. (a) Date employment began _____ (b) Wages per hour \$ _____							
Cause And Nature Of Injury	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							
	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							
Fatal Cases	16. At what occupation _____ 17. Employee's salary continued in full? _____							
	18. Was employee treated by a physician _____							
	19. Has injured employee died _____ 20. If so, give date of death (Submit Form 29) / /							

Employer name _____ Date Completed / /
Signed by _____ Official Title _____

FOR IC USE ONLY

RESEARCHER: _____
CC: _____
EC: _____
DATA ENTRY: _____

FORM 19

7/2025

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FORM 19

SELF-INSURED EMPLOYER OR CARRIER, FILE AS FROI VIA EDI:
HTTP://WWW.IC.NC.GOV/EDIFORM19.HTML

UNINSURED EMPLOYERS OR LUNG DISEASE CLAIMS:
E-MAIL TO: FORMS@IC.NC.GOV OR MAIL TO: NCIC - CLAIMS SECTION,
1235 MAIL SERVICE CENTER, RALEIGH, NC 27699-1235
MAIN TELEPHONE: (919) 807-2500 HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

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.				

IMPORTANT INFORMATION FOR EMPLOYER

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 Form 19 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. Employer must also give employee a blank Form 18.

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 cerciorarse 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.