South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5700 www.wcc.sc.gov

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ SSN: ___-___-___ Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) ___-____ Work Phone: (___) ___-____ Insurance Carrier: _____

Preparer's Name: _____ Law Firm: _____ Preparer's Phone #: (___) ___-____

REQUEST FOR COMMISSION REVIEW

Request for Commission Review by ☐ Claimant ☐ Employer (check one) Date of Injury or Illness: _____ (m/d/yyyy)

The undersigned makes application for review of the findings of the Commissioner in the above-captioned case. The request for review is based on the following grounds: (State the grounds of your appeal in the form of questions presented. Each question presented must contain a concise statement of one proposition of law or fact. Refer to evidence by title and exhibit number. Use additional pages if necessary).

(Check one) Oral argument ☐ is ☐ is not requested. Appellant's request for oral argument is waived if not indicated on this form.
I certify I have served this document pursuant to Reg. 67-211. See attached certificate of service.

Preparer's Signature _____ Title _____ Email _____ Date _____

Check this box if you are not represented by an attorney ☐

Questions about the use of this form should be directed to the Judicial Department at 803.737.5675 or appeals@wcc.sc.gov.

If the claimant appeals and is not represented by counsel, the Judicial Department will properly serve this form pursuant to Reg. 67-607 C. Pursuant to Reg. 67-205 and Reg. 701, the appeal must be postmarked no later than 14 days from the date of service of the Decision and Order of the Hearing Commissioner along with the filing fee. Attach a Form 32, if you are unable to pay the filing fee. Refer to Reg. 67-211 and Reg. 67-701 through 711.