South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5675

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

Claimant's Name: ____________________ SSN: ____________
Address: ________________________________
City: ______________ State: ____ Zip: ________
Home Phone: ____________ Work Phone: ____________

Employer's Name: ________________________________
Address: ________________________________
City: ______________ State: ____ Zip: ________
Insurance Carrier: ________________________________

Preparer's Name: ____________________ Law Firm: ____________________ Preparer's Phone #: ____________

HEARING POSTPONED

Employee ________________________________
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Employer ________________________________
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Carrier ________________________________
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Attorneys ________________________________
____
____

Other Parties ________________________________
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TO THE PARTIES ADDRESSED:

You are hereby notified that hearing on the above-stated case is postponed.

When the case has been reassigned for hearing, the interested parties will be duly advised of the date.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

By: ________________________________

Code numbers furnished each employer and carrier should be inserted before mailing. Refer to Docket File No. in all correspondence about this injury.