South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723 www.wcc.sc.gov

WCC File #: 2246209
Carrier File #:
Carrier Code #:
Employer FEIN #:

Claimant's Name: Ima Getpayed SSN: 656042415
Address: 555 Nunya Business Dr.
City: Ridgeway State: SC Zip: 29130
Home Phone: 803-246-4616 Work Phone: ( ) -

Employer's Name: Yuma Ade Itup Staff Leasing
Address: 210 Southwest Rd
City: Fairfeild State: SC Zip: 29108
Insurance Carrier: Gonna Denny Ur Claims, Mutually

Preparer's Name: League B. Creech, Esq. Law Firm: Parker Law Group Preparer's Phone #: (803) 903-1781

A claim for workers' compensation benefits is made based on the following grounds:

☒ Injury ☐ Illness ☐ Repetitive Trauma ☐ Occupational Disease ☐ Physical Brain Injury ☐ Concurrent Jurisdiction

1. The claimant sustained an injury to see below (Part(s) of Body Injured) on 01/2/22 (Month/Day/Year) in Green Sea county, state of SC.
2. Body part(s) affected are: PTSD, auto immune response, lymph nodes and skin
   Briefly describe how the accident occurred. Claimant was trapped in her car during an accident. A kindle of kittens entered the car before EMS arrived. Claimant's faced was licked excessively and she got catch scratch fever
3. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
4. The relationship of employer and employee existed at the time of injury.
5. At the time of the injury the claimant was performing services arising out of and in the course of employment.
6. Notice of the accidental injury was given to the Employer on 01/02/22 (Month/Day/Year) in the following manner:
   Verbally by Claimant's wife.

☒ 7. Due to injury, the claimant is in need of (check one):

☒ (a) medical examination and treatment for: Skin, lymph nodes, PTSD.

☒ (b) additional medical examination and treatment for: Skin, lymph nodes/immune system and PTSD/sleeplessness

☒ 8. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:
January 3rd 2022 to present and ongoing.

☒ 9. Due to the injury, the Claimant has permanent disability of the following nature and extent (check one):

☐ (1) General Disability: ☐ Total ☐ Partial ☐ (2) Specific Disability: ☐ Total ☐ Partial ☐ (3) Wage Loss

9a. Claimant at MMI: ☐ Yes ☒ No

☐ 10. Due to the injury, the Claimant has a serious bodily disfigurement consisting of:
Facial skins burns from their sand paper like little tongues.

10a. At the time of the injury, the Claimant was paid weekly wages of $750.00, and demands accounting of days worked and wages earned as provided by law.

10b. Give names and addresses of all employers for whom the Claimant has worked since the date of the accident:
N/A

11. Further grounds or unusual aspects of claim:
Claimant is requesting Dr. Jones report be kept out of evidence because he is a cat lover and sympathizer, or alternatively that the hearing be postponed to take his deposition.

11a. List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident:
Dr. Jones, Dr. Brown, Dr. Davidson and Green Sea Memorial Hosp.

11b. To the best of your knowledge, did you have any prior permanent disability? N/A Claimant contends she is not at MMI
If yes, describe: Kitten incident durring US military service.

12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.

☐ 13. **I am filing a claim. I am not requesting a hearing at this time.** Estimated time needed for hearing: 30 minute

☒ 14. **I am requesting a hearing. A $50 fee is required.**

☐ **Mediation**

☐ a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
☐ b. Mediation is required pursuant to Reg. 67-1802.
☐ c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
☐ d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to **mediation@wcc.sc.gov.**

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to Peter Leventis, Esq. & See certificate of ser
address _____ **on the** 14 **day of** Nov. **20** 2, **by** ☒ **first class postage** ☐ **certified mail** ☐ **personal service** ☐ **electronic service**

I verify the contents of this form are accurate and true to the best of my knowledge.

Preparer's Signature	Attorney Title	LCreech@parkerlawgroupsc.com Email	Nov. 14, 2022 Date

Questions about the use of this form should be directed to the Claims Department at 803.737.5723. Refer to Regulations 67-204 through 67-211 and Regulations 67-601 through 67-615 as well as Reg. 67-1801.