



Claimant's Name: TONY SANDERS Employer's Name: GENUINE PARTS COMPANY
Address: 2542 GRANTHAM PLACE DRIVE Address: 2999 WILDWOOD PARKWAY
City: FORT MILL State: SC Zip: 29715 City: ATLANTA State: GA Zip: 30339
Home Phone: (803) 372-8933 Work Phone: _____ Insurance Carrier: SAFETY NATIONAL CASUALTY CORP
Preparer's Name: STEVEN REYNEN Law Firm: _____ Preparer's Phone #: (813) 371-6843

1. Date of injury: 09/16/2023 2. Total Weeks Compensation Paid: 28 WEEKS
(m/d/yyyy)

3. Type of Compensation Paid (TP or TT)/Periods of Payment:

Type:	From:	To:
<u>TT</u>	<u>02/28/2024</u>	<u>09/10/2024</u>
Type: _____	From: _____	To: _____
Type: _____	From: _____	To: _____
Type: _____	From: _____	To: _____

4. Date of First Payment: 03/11/2024
(m/d/yyyy)

5. Total Amount Paid (a) Compensation: \$ 15582.28
(b) Medical (Include Nursing, Hospital, Drugs, Etc.): \$ 31749.57

STEVEN REYNEN (813) 371-6843 09/13/2024
Employer's Representative Phone Date

Type or print all information. File this form six months after the alleged injury date and each six months until the Commission's File is closed. Form 18 must be filed whether or not compensation is ongoing. Refer to R.67-413, and R.67-804 for further information.