South Carolina Workers' Compensation Commission
P.O. Box 1715 1333 Main Street, Suite 500
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC #: 2413917
Carrier File: 2024-002170
Carrier Code #: 500-SF
Employer FEIN #: 570847269

Cateena MCBRIDE 250-47-9058
540 Dundee Drive, Bennettsville, SC 29512
(843) 479-1882 (home) () - (work)

MARLBORO COUNTY DSN
PO Box 1212, Bennettsville, SC 29512

Preparer's name: Christina Hudak (803) 896-5889

State Accident Fund, Insurance Carrier

Date of injury: 08/13/2024 Date of notice to employer of injury: 08/14/2024

I. **Payment of Temporary Compensation** (choose A, B, or C) (X) Initial period ( ) Additional period ( ) Corrected compensation rate

A. Temporary Total at the compensation rate of $ per week. For this period of disability, disability began on and the date of first payment was .

B. Temporary Partial at the compensation rate of $229.84 per week. Note: When Temporary Partial compensation rate will vary, report first payment here. Supplement throughout the period of Temporary Partial compensation by filing Form 15S with the Form 18, which shall be filed six months after the date of injury and each six months thereafter until the file is closed. For this period of disability, disability began on 09/18/2024 and the date of first payment was 10/14/2024.

Calculation of Temporary Partial rate:		
	Average weekly wage before injury	$822.64
	MINUS Current weekly wage	$477.90
	Difference in wages before injury and now	$344.74
	Temporary Partial Compensation Rate	$229.84

C. Salary in lieu of Temporary compensation in the amount of $ per week. For this period of disability, disability began on and the date of first payment was .

THIS SECTION MAY BE USED ONLY WITHIN 150 DAYS AFTER NOTICE TO EMPLOYER OF THE INJURY, ATTACH DOCUMENTATION AS TO THE REASON FOR THE TERMINATION.

II. **Termination of Temporary Compensation.** Temporary compensation payments were stopped on for the following reason:

( ) Claimant has returned to work at least 15 days and no temporary partial compensation is due.
( ) Claimant agrees he/she is able to return to work and has signed a Form 17.
( ) Based on a good faith investigation, the claim is denied. Reason for denial:
( ) Claimant has been released to return to work without restrictions and employment has been offered.
( ) Claimant has been released to return to work at limited duty and employer has provided limited duty work consistent with the terms upon which the Employee has been released.
( ) Claimant has refused medical treatment, examination, or evaluation. Note: Benefits must be resumed if claimant accepts the treatment, examination, or evaluation. Additional report must be filed if compensation is resumed.

I certify that this form has been served on the claimant per R.67-211.

Signature of Claims Administrator Date

III. Notice to Injured Worker or Legal Representative when Temporary Compensation Has Been Stopped:

The employer's representative may stop temporary compensation within 150 days of the date of notice for the above reasons. However, if you believe that temporary compensation should not have been stopped, you may request a hearing by signing below and returning this form to the SCWCC Judicial Department at the address at the top of the form. A hearing will be held within 60 days of receipt of your request to determine if temporary compensation has been properly terminated.

MY SIGNATURE BELOW INDICATES THAT I DO NOT AGREE WITH THE TERMINATION OF TEMPORARY COMPENSATION. I REQUEST A HEARING TO DETERMINE WHETHER I AM ENTITLED TO FURTHER TEMPORARY COMPENSATION PAYMENTS.

Check one: Form 15(II) ☐ has ☐ has not been received.

Signature of claimant or legal representative Date

Employer's representative must complete and file Form 15 with Claims Department within ten days after compensation begins or is terminated. Employer's representative must serve the Form 15 on the claimant when compensation begins per R.67-211. Employer's representative must prepare and serve Form 20 within thirty days of beginning compensation per R.07-1603. Employer's representative must serve per R.67-211 two copies of the Form 15 on claimant immediately on termination of compensation with documentation attached as to the reason for the termination. Injured worker may contest termination of compensation by completing section III of the Form 15 and filing it with Judicial Department.