North Carolina Industrial Commission IC File #_____

EVALUATION FOR PERMANENT IMPAIRMENT

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE WORKERS' COMPENSATION ACT.

Employee's Name

Address

City State Zip

( ) ( )
Home Telephone Work Telephone

XXX-XX- ☐M ☐F / /
Last 4 Digits of Social Security Number Sex Date of Birth

Date of Injury: _____

Employer's Name ( ) Telephone Number

Employer's Address City State Zip

Insurance Carrier

Carrier's Address City State Zip

( ) ( )
Carrier's Telephone Number Fax Number

EMPLOYEE'S WORK-RELATED INJURY WILL RESULT IN:

MEMBER	% OF IMPAIRMENT (IF AMPUTATION, DESCRIBE ON REVERSE.)
1) Thumb	
2) Index Finger	
3) Middle Finger	
4) Ring Finger	
5) Little Finger	
6) Great Toe	
7) Toes (other than great toe)	
8) Hand	
9) Arm	
10) Foot	
11) Leg	
12) Back	

In regard to this rated body part:

1) Is employee at maximum medical improvement? _____
2) Was employee released with restrictions? _____

Physician Signature

Printed Name

Fed. Tax ID Number

Date

Address

TEETH: Age of employee: _____
List all crowns by number : _____
List all extractions by number : _____
Has dental work been completed? ☐Yes ☐No

VISION: List vision reading without the use of a corrective lens.
Distance: _____ Near: _____

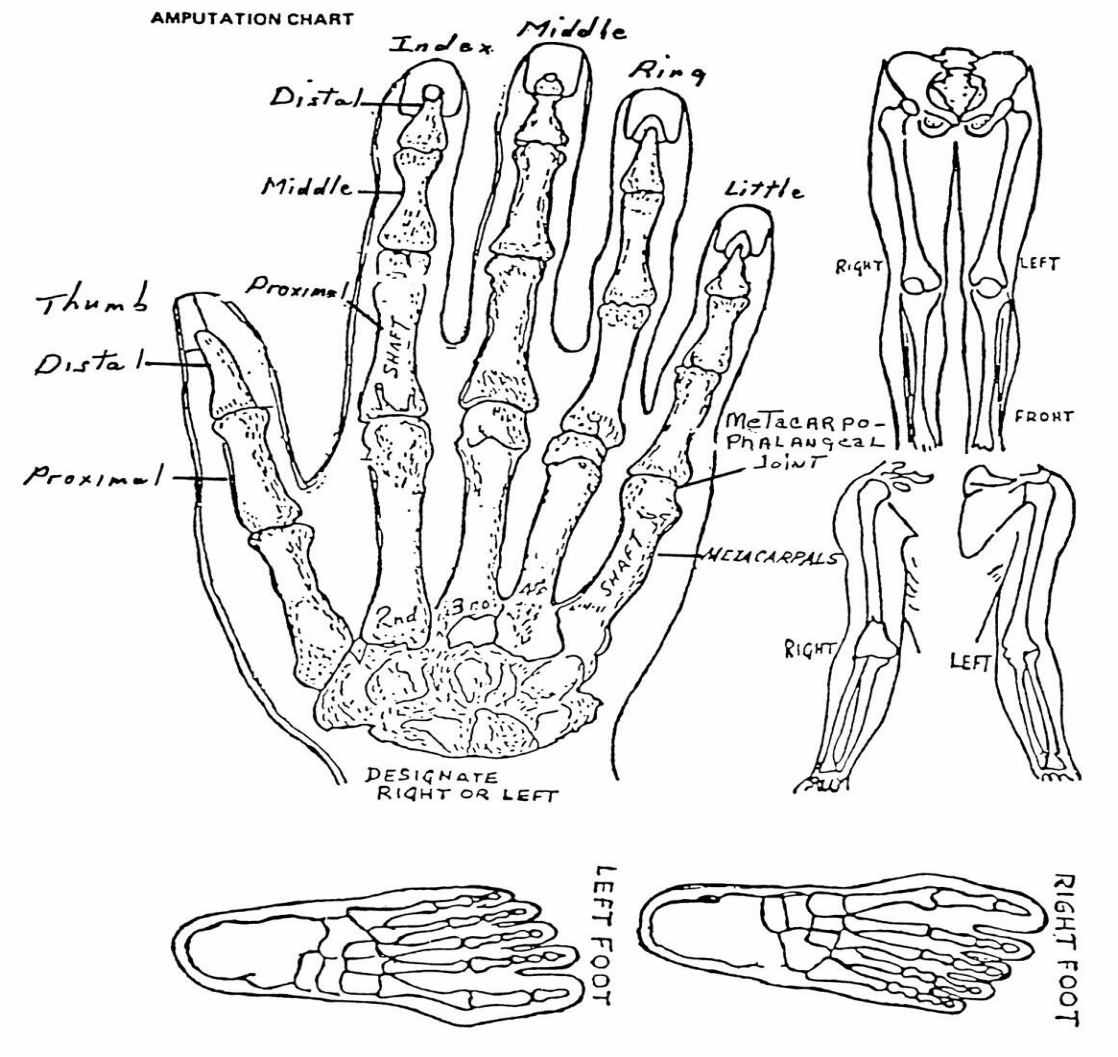
HEARING: Scale used: _____ Percentage of loss: Right ear _____
PLEASE ATTACH AUDIOGRAMS AND CALCULATIONS OF HEARING LOSS Left ear _____

OTHER: Permanent injury to or impairment of any other organ or part of body (identify) : _____
Disfigurement: ☐Yes ☐No Location: ☐face ☐head ☐body

FORM 25R

CARRIERS – FILE VIA ELECTRONIC DOCUMENT FILING PORTAL

CONTACT INFORMATION:
NCIC-CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV



Comments:

A copy of this form must be provided to the employee or the employee's attorney of record if any.
Medical Providers – Please return the completed form to the carrier.

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