

<b>Form AR-C</b>	<b>ARKANSAS WORKERS' COMPENSATION COMMISSION</b> 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472 1-800-622-4472 (Little Rock Office) 1-800-852-5376 (Springdale Office)	<b>C</b>
	Authority: Ark. Code Ann. § 11-9-702  Revised: 1-1-2001 Updated: 6-16-14	

## CLAIM FOR COMPENSATION

### EMPLOYEE INFORMATION (Please Print in Ink)

Employee's Last Name	First Name	M. I.	Social Security Number	Date of Birth	(Area Code) Home Phone No.
Street Address or P.O. Box			City	State	Zip Code
Child Support Obligation: <input type="checkbox"/> Current <input type="checkbox"/> Past Due Payable to:					

### EMPLOYER INFORMATION (Please Print)

Employer's Name (name under which doing business)				(Area Code) Employer's Telephone No.
Employer's Street Address	Employer's City	State	Zip Code	

### ACCIDENT INFORMATION (Please Print)

Employer's Workers' Compensation Insurance Carrier (if known)	Place of Accident (City, State)	Date of Accident
Briefly describe the cause of injury and the part of body injured: _____ _____ _____		

### CLAIM INFORMATION (Please Print)

If this claim is for **initial** benefits (no benefits, either medical or indemnity, have been received), what compensation benefits are you claiming?  
 Temporary Total Disability     Temporary Partial Disability     Permanent Partial Disability     Permanent Total Disability  
 Rehabilitation     Attorney Fees     Medical Expenses     Other (Explain): \_\_\_\_\_

If this claim is for **additional** benefits, what specific benefits are you claiming?  
 Additional Temporary Total     Additional Temporary Partial Disability     Additional Permanent Partial     Additional Medical Expenses  
 Rehabilitation     Attorney Fees     Other (Explain): \_\_\_\_\_

If employee is deceased and claim is for death benefits, list name and address of all persons claiming death benefits: \_\_\_\_\_  
 \_\_\_\_\_

List person or entity (with address, phone number) which has paid benefits under a group health, disability or loss of income policy for the injury reported on this form: \_\_\_\_\_  
 \_\_\_\_\_

I hereby authorize any hospital, physician, psychotherapist or practitioner of the healing arts to furnish the bearer any information, including, but not limited to, copies of medical records concerning my past, present or future physical, mental or emotional condition. I hereby waive my physician- and psychotherapist-patient privilege. A photostatic copy of this authorization shall be as effective and valid as the original.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

If claimant is represented by an attorney, that legal representative must sign below pursuant to Ark. Code Ann. §11-9-717.

\_\_\_\_\_  
Name and Address of Attorney

\_\_\_\_\_  
Signature

AWCC Form C  
(Claim for Compensation)

**Ark. Code Ann. § 11-9-702** allows employees or their dependents to file claims for compensation and sets time limits for those filings.

This is the AWCC's prescribed form for this action. It is filed directly with the AWCC, usually by claimants or their attorneys.

Care must be taken on **Form C**:

1. Type or print in ink. Do not use pencil.
2. Information must be complete.
3. Employer's business name is needed, not the name of the foreman or supervisor.
4. Date of injury is essential. If specific date unavailable, as in the case of diseases, list date employee knew of the condition.
5. Street address of employer must be given to allow the AWCC to contact the correct employer.
6. Employee's signature at bottom is required.

**Questions on a specific Form C may be answered by the Legal Advisor Division (1-800-250-2511 or 501-682-3930). General information is available from the Support Services Division (1-800-622-4472 or 501-682-3930).**

**Ark. Code Ann. §11-9-106(a):** Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission.

**Ark. Code Ann. §11-9-115** requires applicants for workers' compensation benefits to state if child support payments are due, to whom, and if payments are current or past due.

**Ark. Code Ann. §11-9-717:** Any person or attorney signing a claim, request for benefits, controversion of benefits, request for hearing or other paper of a party, certifies the action is taken after reasonable inquiry; is well grounded in fact; is warranted by existing law or a good faith argument for extension, modification or reversal of existing law; and is not interposed for any improper purpose or for delay. Violators of this provision may be subject to sanctions, which may include payment of reasonable expenses incurred by others and reasonable attorney fees for responding to the claim, request or motion, or for failure to appear at a hearing, deposition or other scheduled matter.