EMPLOYEE INJURY PAPERWORK INSTRUCTIONS

1. Have Employee, Supervisor, and any Witnesses fill out their designated forms. Please have all witnesses fill out a form.

2. Employee ***MUST*** sign and date the Physician Form. If the employee does not want to see a doctor, please have them write on the form "No Doctor Needed".
   If a doctor is needed an appointment will be scheduled for the employee by Maggie Orames at the Central Office.*

3. Please make sure ***ALL*** forms are signed, dated, and returned to the Central Office within 24 hours of the injury.

05/31/2018 mo

TNRMT

SEC SAFETY ENGINEERING & CLAIMS MANAGEMENT

EMPLOYEE ACCIDENT REPORT

Employee Name: _____

Address: _____

Phone: _____

Job Title: _____ **Department:** _____

Date of Accident: _____ **Shift Start Time:** _____

Time of Accident: _____ **A.M. or P.M.:** _____

Supervisor: _____

Location of Accident: _____

Describe the Nature of the Injury: _____

_____

Describe Exactly What Happened: _____

_____

_____

_____

List Any Witnesses: _____

_____

To Whom Did You Report the Accident/Injury? _____

What did you tell your Supervisor? _____

_____

What did your Supervisor Do? _____

_____

_____ _____

Employee Signature **Date**

Please submit with First Report of Injury Form within 24 hours

TNRMT

SEC SAFETY ENGINEERING & CLAIMS MANAGEMENT

SUPERVISOR ACCIDENT INVESTIGATION REPORT

Employee Name: _____

Job Title: _____ **Department:** _____

Date of Accident: _____ **Shift Start Time:** _____

Time of Accident: _____ **A.M.** _____ **or P.M.** _____

When Did You Learn of the Injury? _____

Did Injured Employee Receive First Aid? **Yes** _____ **No** _____

Was Injury Report or First Aid Delayed? **Yes** _____ **No** _____

If Yes, Why? _____

Was Employee Referred for Outside Medical Attention: **Yes** _____ **No** _____

If so, Where? _____

Location of Accident: _____

Describe the Nature of the Injury: _____

_____

Describe Exactly What Happened: _____

_____

_____

_____

List Any Witnesses: _____

_____

_____ _____

Supervisor Signature **Date**

Please submit with First Report of Injury Form within 24 hours

TNRMT

SEC SAFETY ENGINEERING & CLAIMS MANAGEMENT

ACCIDENT WITNESS REPORT

Employee Name: _____

Employee Address: _____

Work Number: _____ **Alternate Number:** _____

Job Title: _____ **Department:** _____

Date of Accident: _____ **Shift Start Time:** _____

Time of Accident: _____ **A.M.** _____ **or P.M.** _____

Location of Accident: _____

Identify the Employee Involved in the Accident: _____

What were you doing when the accident occurred: _____

_____

Describe Exactly What Happened: _____

_____

_____

_____

List Any Other Witnesses: _____

_____

_____ _____

Witness Signature **Date**

Please submit with First Report of Injury Form within 24 hours

TNRMT

SEC SAFETY ENGINEERING & CLAIMS MANAGEMENT

MEDICAL AUTHORIZATION

RE: Name: _____

DOB: _____

SSN: _____

1. In accordance with the provisions of the Privacy Rule for the Health Insurance Portability and Accountability Act, I,_____, do hereby expressly authorize any and all hospitals, physicians, clinics, chiropractors, pharmacists, therapists, and any and all other medical personnel and health care providers, to provide my medical records and/or medical information to my Employer, Insurer, Tennessee Risk Management Trust, its Third Party Administrator, Safety Engineering Consultants, Inc., and/or nurse case manager; said records including, but not limited to, all reports, records, clinical notes, diagnostic tests, operative notes, billing, and all other documentation or information produced by the aforesaid providers and pertaining to my medical care; and said aforesaid providers are hereby authorized and ordered to release said records to my Employer, Insurer, Tennessee Risk Management Trust, its Third Party Administrator, Safety Engineering Consultants, Inc., and/or nurse case manager for inspection and use, and any records obtained pursuant to this Authorization shall not be used or released to any third party not connected with my workers' compensation claim. This authorization specifically authorizes the aforementioned hospitals, physicians, clinics, chiropractors, pharmacists, therapists, and any and all other medical personnel and health care providers, to have communications, either in person, via telephone, or in writing, with my Employer, Insurer, Tennessee Risk Management Trust, its Third Party Administrator, Safety Engineering Consultants, Inc., and/or nurse case manager, regarding any aspect of my medical condition, including but not limited to diagnosis, etiology, medical restrictions, medical impairment, and prognosis.

2. A photocopy of this Medical Authorization shall be deemed as effective and valid as the original.

3. I understand that this Medical Authorization allows the disclosure of reports, records, clinical notes, diagnostic tests, operative notes, and other documentation or information pertaining to psychotherapy treatment.

4. I understand that I have the right to revoke this authorization at any time. I understand that if I do revoke this authorization, I must do so in writing and present my written revocation to My Employer, Insurer, Tennessee Risk Management Trust, its Third Party Administrator, Safety Engineering Consultants, Inc., and/or nurse case manager. Said revocation will be effective only when a covered entity which had previously been authorized to make disclosure receives the written notification of revocation. A revocation will not be effective to the extent that a covered entity has already taken action in reliance thereon.

5. Unless otherwise revoked, this Authorization will be effective during the pendency of my workers' compensation claim.

6. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

7. I understand that treatment, payment, enrollment, or eligibility for benefits is not conditioned on my signing this Medical Authorization.

8. My Employer, Insurer, Tennessee Risk Management Trust, its Third Party Administrator, Safety Engineering Consultants, Inc., and/or nurse case manager, are hereby released from any and all liability or responsibility which could or might result because of the disclosure of any information pursuant to this authorization including, but not limited to, liability resulting from any breach of an implied covenant of confidentiality.

9. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

_____ _____

Signature of Employee Date

Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002

FORM C-42

EMPLOYEE'S CHOICE OF PHYSICIAN

An employer must provide a partially-completed form listing at least three physicians to an employee upon the report of a workplace injury. The employee must complete and then sign and date the section below that indicates the physician chosen. A copy of the fully-completed form should be provided to the employee with the original kept on file by the employer. If the employee refuses to accept medical services from the chosen physician, the employee's rights to benefits may be delayed. **NOTE**: Employees traveling more than 15 miles one way to or from medical treatment may seek reimbursement of their travel expenses from the insurance carrier.

TO BE COMPLETED BY THE EMPLOYER:

Employer Coffee County Board of Education Date of Injury _____

Employer Contact Maggie Orames Phone 931-222-1202 Email oramesm@k12coffee.net

Physician Name Fast Pace Urgent Care/ Dr. Denny Daniel Phone 931-954-5605

Address 1415 Hillsboro Blvd., Ste. 106 City Manchester State TN Zip 37355

Physician Name Dr. Jay Trussler Phone 931-728-9000

Address 585 Interstate Drive, # B City Manchester State TN Zip 37355

Physician Name Physician Medical Care/ Dr. Martin Glynn Phone 931-728-8153

Address 1300 McArthur Street City Manchester State TN Zip 37355

TO BE COMPLETED BY THE EMPLOYEE:

I have selected the following physician from the list provided to me by my employer:

Physician Name _____ Date Selected _____

Employee Name _____ Appt Date/Time _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Employee Signature _____ Date _____