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.
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
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
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
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 aforesaid 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.

Please submit with First Report of Injury Form within 24 hours
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 ___________________________ 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 ___________________________

LB-0382 (REV 11/15)