WORKERS' COMPENSATION CHECKLIST

Employee Name: __________________________________________________________

Date of Injury: __________________________________________________________

First Report of Injury

Verified Wage Statement
  o Gross wages for 52 weeks preceding and including date of injury
  o Fully complete Wage Statement
  o Total Paid
  o Rate per Day or Rate per Hour
  o Average per Week

Panel of Physicians – signed by employee

HIPAA Release – signed by employee

C-31 Medical Waiver

Employee Accident Report

Supervisor’s Accident Investigation Report

Written Job Description

Employee’s Prior Employment History as contained within your personnel records

Employee’s Highest Level of Education

Preparer’s Name: __________________________________________________________

Phone Number: __________________________________________________________

Email Address: __________________________________________________________

Please submit with First Report of Injury Form within 24 hours
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
TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
EMPLOYER'S FIRST REPORT OF WORK INJURY OR ILLNESS

<table>
<thead>
<tr>
<th>JURISDICTION CLAIM # (STATE FILE #)</th>
<th>CLAIM TYPE CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MED ONLY</td>
</tr>
<tr>
<td></td>
<td>INDEMNITY</td>
</tr>
<tr>
<td></td>
<td>BECAME LOST TIME</td>
</tr>
<tr>
<td></td>
<td>BECAME MED ONLY</td>
</tr>
<tr>
<td>OSHA LOG CASE #</td>
<td>NOTIFY ONLY</td>
</tr>
<tr>
<td>NAME OF INSURANCE CARRIER</td>
<td>TRANSFER</td>
</tr>
<tr>
<td>CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)</td>
<td>PEIN OF CLMS ADM</td>
</tr>
<tr>
<td>CLAIMS ADJUSTER NAME</td>
<td>CLMS ADJ PHONE #</td>
</tr>
<tr>
<td>CLAIM HANDLING OFFICE ADDRESS LINE 1 AND 2</td>
<td>CITY</td>
</tr>
<tr>
<td></td>
<td>STATE</td>
</tr>
<tr>
<td></td>
<td>ZIP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMPLOYER NAME</th>
<th>EMPLOYER FEIN</th>
<th>SIC CODE</th>
<th>PHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYER ADDRESS LINE 1 AND 2</td>
<td>CITY</td>
<td>STATE</td>
<td>ZIP</td>
</tr>
<tr>
<td>NATURE OF BUSINESS</td>
<td>EMPLOYER LOCATION</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)</th>
<th>POLICY NUMBER</th>
<th>EFF DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SELF INSURED?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>EXP DATE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMPLOYEE</th>
<th>POLICY</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHONE INCL AREA CODE</td>
<td></td>
</tr>
<tr>
<td>DEPARTMENT REGULARLY WORKED</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OCCUPATION DESCRIPTION</th>
<th>MARITAL STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MARRIED</td>
</tr>
<tr>
<td></td>
<td>UNMARRIED, SINGLE, DIVORCED</td>
</tr>
<tr>
<td></td>
<td>SEPARATED</td>
</tr>
<tr>
<td></td>
<td>UNKNOWN</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WAGE</th>
<th>PERIOD</th>
<th>WEEKLY</th>
<th>NUMBER OF DAYS WORKED PER WEEK</th>
<th>SALARY CONTINUED IN LIEU OF COMPENSATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE OF INJURY</th>
<th>TIME OF INJURY</th>
<th>AM</th>
<th>PM</th>
<th>TIME EMPLOYEE BEGAN WORK ON INJURY DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>COULD NOT BE DETERMINED</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE EMPLOYER NOTIFIED OF INJURY</th>
<th>BODY PART AFFECTED CODE</th>
<th>NATURE OF INJURY CODE</th>
<th>CAUSE OF INJURY CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ACCIDENT INJURY

DATE CLAIM ADM NOTIFIED OF INJURY
DATE LAST DAY WORKED
DATE DISABILITY BEGAN
RETURN TO WORK DATE (IF APPLICABLE)

DATE OF DEATH (IF APPLICABLE)
IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP
TOTAL # DEPENDENTS

DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? YES NO

ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)
CITY | STATE | ZIP

PHYSICIAN NAME
HOSPITAL OR OFF SITE TREATMENT NAME

<table>
<thead>
<tr>
<th>TREATMENT</th>
<th>INITIAL TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MINOR BY EMPLOYER</td>
</tr>
<tr>
<td></td>
<td>NO MEDICAL TREATMENT</td>
</tr>
<tr>
<td></td>
<td>MINOR BY CLINIC/HOSPITAL</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER</th>
<th>DATE PREPARED</th>
<th>PREPARER'S NAME &amp; TITLE</th>
<th>PREPARER'S COMPANY NAME</th>
<th>PHONE NUMBER</th>
</tr>
</thead>
</table>

LB-0021 (REV. 12/07)
NOTICE OF REPORTED INJURY

The Tennessee Bureau of Workers' Compensation has been notified you were injured on the job. This notice does not mean that your claim has been accepted or that you are eligible to receive benefits. This only confirms that your claim has been reported by your employer to its insurance company and to the Bureau.

Your employer should help you obtain all needed medical care related to your injury, at no cost to you, from a doctor you select from their approved list. The doctor selected becomes your authorized treating physician.

Your employer will also help you contact their workers' compensation insurance adjuster who will administer your claim and help you with your recovery. The adjuster's name and contact information are on a separate letter enclosed with this notice.

The adjuster has fifteen (15) calendar days (from the date you provided notice of your injury to your employer) to conduct an investigation and to either accept or deny your claim.

If your claim is accepted, you may be eligible to receive medical treatment including prescriptions, mileage reimbursement for attending appointments with your authorized treating physician and partial wage replacement benefits (also known as temporary disability benefits) as described in the enclosed "Beginner's Guide to Tennessee Workers' Compensation".

- If you are eligible for temporary total disability benefits, the first payment must be sent to you within fifteen (15) calendar days of when your disability begins (the date you are taken off work by your authorized treating physician) and then every subsequent payment must be made within the following fifteen (15) calendar days until you are allowed to return to work.
- If you are eligible for temporary partial disability benefits because your authorized treating physician allows you to continue to work but restrictions reduce the amount of money you earn, the payments must be sent as near as possible to the same schedule as your normal paychecks are paid.

If your claim is denied, the adjuster assigned to your claim will send you a Notice of Denial that provides the reason for the denial.

Most employers and adjusters provide all required benefits for an accepted claim, also known as "compensable" claim, without assistance from the Bureau. If you have questions about your claim, you should contact your employer and your adjuster first. If, after contacting your employer and your adjuster, you have questions or are not getting the benefits you are due, you can request assistance from the Bureau by calling (800) 332-2667. The Bureau will work with you, your employer, and your adjuster to help resolve any issues. The Bureau's role is to ensure workers' compensation claims are handled in a fair and professional manner and is available to assist you, if needed.
WAGE STATEMENT

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

Employee: ____________________________  SSN: ____________________________  State File #: ____________________________

Insurer Claim #: ____________________________  Date of Injury: ____________________________

In order to determine the correct rate of compensation to be paid to the above injured party, please fill in the schedule below and return it promptly. This information is required by law and no agreement for payment of compensation can be made until it has been received. Please complete 52 weeks prior to date of accident.

Please describe allowances of any character made in lieu of wages that must be deemed a part of employee's earnings: ____________________________

If the average weekly wage is not based on fifty-two weeks of earnings proceeding the date of injury, please show your computation below:

<table>
<thead>
<tr>
<th>WEEK</th>
<th>NO. DAYS</th>
<th>WEEK ENDING</th>
<th>GROSS WAGES</th>
<th>WEEK</th>
<th>NO. DAYS</th>
<th>WEEK ENDING</th>
<th>GROSS WAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>27</td>
<td>2</td>
<td></td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td>29</td>
<td>4</td>
<td></td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td>31</td>
<td>6</td>
<td></td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td>33</td>
<td>8</td>
<td></td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td>35</td>
<td>10</td>
<td></td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td>37</td>
<td>12</td>
<td></td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
<td>39</td>
<td>14</td>
<td></td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td>41</td>
<td>16</td>
<td></td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td></td>
<td></td>
<td>43</td>
<td>18</td>
<td></td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td></td>
<td></td>
<td>45</td>
<td>20</td>
<td></td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td></td>
<td></td>
<td>47</td>
<td>22</td>
<td></td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td></td>
<td></td>
<td>49</td>
<td>24</td>
<td></td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td></td>
<td></td>
<td>51</td>
<td>26</td>
<td></td>
<td>52</td>
<td></td>
</tr>
</tbody>
</table>

TOTAL PAID

Rate per Day ____________________________  Rate per Hour ____________________________  Average per Week ____________________________

I hereby certify that the above is a true and correct account, as taken from our time books or payroll records, of the wages paid to the above-named injured employee for the periods indicated.

Date: ____________________________  Employer: ____________________________
Name of Preparer & Title: ____________________________  Employer: ____________________________
Phone, Fax, Email: ____________________________  Employer: ____________________________
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: Cumberland County Board of Education
Date of Injury
Employer Contact: Terri Alford
Phone: 931-484-6135
Email: talford@ccschools.k12tn.net

Physician Name: Pinnacle Health Center/ Dr. Jill Wallner
Phone: 931-456-7992
Address: 58 West First Street
City: Crossville
State: TN
Zip: 38555

Physician Name: Quality Medical Center/ Dr. Vish
Phone: 931-484-1100
Address: 15 Walker Hill Circle
City: Crossville
State: TN
Zip: 38555

Physician Name: Exacare/ Dr. Carlton & Dr. Lewis
Phone: 931-210-5577
Address: 229 Interstate Drive, Suite 103
City: Crossville
State: TN
Zip: 38555

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
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.

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

*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
SUPERVISOR ACCIDENT INVESTIGATION REPORT

Employee Name: ________________________________

Job Title: ___________________________ Department: ________________

Date of Accident: ___________________________ Shift Start Time: _________

Time of Accident: ___________________________

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: _____________________________________________

Recommended Corrective Action: _________________________________

Corrective Action Taken? Yes _________ No _________

Work Order Written? Yes _________ No _________

Supervisor Signature ___________________________ Date _____________

Please submit with First Report of Injury Form within 24 hours