TNRMT
TENNESSEE RISK MANAGEMENT TRUST

SEC | SAFETY ENGINEERING & CLAIMS MANAGEMENT

WORKERS' COMPENSATION CHECKLIST

Employee Name: _____

Date of Injury: _____

First Report of Injury

Verified Wage Statement

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

TNRMT
TENNESSEE RISK MANAGEMENT TRUST
404 BNA Drive, Suite 208, Nashville TN 37217
(888)743-4336

SEC | SAFETY ENGINEERING & CLAIMS MANAGEMENT
111 Hazel Path, Hendersonville, TN 37075
(615) 826-4274

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

CLAIMS ADM/CARRIER

JURISDICTION CLAIM # (STATE FILE #)

CLAIMS ADM CLAIM # (INSURER CLAIM #)

OSHA LOG CASE #

CLAIM TYPE CODE
- ☐ MED ONLY
- ☐ INDEMNITY
- ☐ BECAME LOST TIME
- ☐ BECAME MED ONLY
- ☐ NOTIFY ONLY
- ☐ TRANSFER

NAME OF INSURANCE CARRIER

CARRIER FEIN

CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)

FEIN OF CLMS ADM

CLAIMS ADJUSTER NAME

CLMS ADJ PHONE #

CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2

CITY | STATE | ZIP

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE TENNESSEE WORKERS' COMPENSATION LAW AND MUST BE COMPLETED AND FILED WITH YOUR INSURANCE CARRIER IMMEDIATELY AFTER NOTICE OF INJURY.

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.

IF YOU HAVE QUESTIONS, THE STATE NOW HAS A BENEFIT REVIEW SYSTEM WHERE A WORKERS' COMPENSATION SPECIALIST CAN PROVIDE ASSISTANCE. CALL 1-800-332-2667 (TDD).

EMPLOYER

EMPLOYER NAME

EMPLOYER FEIN

SIC CODE

PHONE NUMBER

EMPLOYER ADDRESS LINE 1 AND LINE 2

NATURE OF BUSINESS

CITY | STATE | ZIP

INSURED REPORT #

EMPLOYER LOCATION

POLICY

INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)

POLICY NUMBER

SELF INSURED? ☐ YES ☐ NO

EFF DATE

EXP DATE

EMPLOYMENT STATUS CODE
- ☐ FULL TIME/REGULAR
- ☐ PART TIME
- ☐ PIECE WORKER
- ☐ SEASONAL
- ☐ VOLUNTEER
- ☐ APPRENTICE FULL TIME
- ☐ APPRENTICE PART TIME

EMPLOYEE

EMPLOYEE LAST NAME

PHONE INCL AREA CODE

FIRST | MI

DEPARTMENT REGULARLY WORKED

GENDER
- ☐ MALE
- ☐ FEMALE
- ☐ UNKNOWN

ADRRESS LINE 1 & 2

OCCUPATION DESCRIPTION

CITY | STATE | ZIP

MARITAL STATUS
- ☐ UNMARRIED, SINGLE, DIVORCED
- ☐ MARRIED
- ☐ SEPARATED
- ☐ UNKNOWN

NCCI CLASS CODE

SSN | DATE OF BIRTH | DATE OF HIRE

WAGE

WAGE $

PERIOD
- ☐ HOURLY
- ☐ DAILY
- ☐ WEEKLY
- ☐ BI-WEEKLY
- ☐ MONTHLY

NUMBER OF DAYS WORKED PER WEEK

SALARY CONTINUED IN LIEU OF COMPENSATION ☐ YES ☐ NO

FULL WAGES PAID FOR DATE OF INJURY ☐ YES ☐ NO

ACCIDENT/INJURY

DATE OF INJURY

TIME OF INJURY ☐ AM ☐ PM ☐ COULD NOT BE DETERMINED

TIME EMPLOYEE BEGAN WORK ON INJURY DATE ☐ AM ☐ PM

DATE EMPLOYER NOTIFIED OF INJURY

BODY PART AFFECTED CODE | NATURE OF INJURY CODE | CAUSE OF INJURY CODE

DATE CLAIM ADM NOTIFIED OF INJURY

HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE INCIDENT INCLUDING WHAT THE EMPLOYEE WAS DOING JUST BEFORE, THE PART OF THE BODY AFFECTED AND HOW, AND OBJECT OR SUBSTANCE THAT DIRECTLY HARMED THE EMPLOYEE.

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
- ☐ WIDOW
- ☐ WIDOWER
- ☐ MOTHER
- ☐ FATHER
- ____ DAUGHTER
- ____ SON
- ____ SISTER
- ____ BROTHER
- ____ HANDICAPPED CHILD

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

COUNTY OF INJURY

TREATMENT

PHYSICIAN NAME

HOSPITAL OR OFF SITE TREATMENT NAME

ADDRESS LINE 1 AND 2

ADDRESS LINE 1 AND 2

CITY | STATE | ZIP

CITY | STATE | ZIP

INITIAL TREATMENT
- ☐ NO MEDICAL TREATMENT
- ☐ MINOR BY EMPLOYER
- ☐ MINOR BY CLINIC/HOSPITAL
- ☐ HOSPITALIZED > 24 HRS
- ☐ EMERGENCY CARE
- ☐ FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED

OTHER

DATE PREPARED | PREPARER'S NAME & TITLE | PREPARER'S COMPANY NAME | PHONE NUMBER

STATE OF TENNESSEE
BUREAU OF WORKERS' COMPENSATION
220 FRENCH LANDING DRIVE
NASHVILLE, TENNESSEE 37243-1002
(615) 741-2395
(800) 332-2667

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.

Tennessee Department of Labor and Workforce Development; Authorization number 337586, May 2018. This document was promulgated for electronic use only.

FORM C-41

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

Division of Workers' Compensation

220 French Landing Dr.

Nashville, Tennessee 37243-1002

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: _____

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

Name of Preparer & Title _____

Phone, Fax, Email _____

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 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 Exaccare/ 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 _____

TNRMT
TENNESSEE RISK MANAGEMENT TRUST

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.

Please submit with First Report of Injury Form within 24 hours

TNRMT
TENNESSEE RISK MANAGEMENT TRUST

SEC | SAFETY ENGINEERING & CLAIMS MANAGEMENT

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

TNRMT
TENNESSEE RISK MANAGEMENT TRUST

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
TENNESSEE RISK MANAGEMENT TRUST

SEC | SAFETY ENGINEERING & CLAIMS MANAGEMENT

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