

**TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
EMPLOYER'S FIRST REPORT OF WORK INJURY OR ILLNESS**



| | | | | | | | | | |
|---|---|---|--|--------------|---|-------------------------|--|-----------------|-----|
| CLAIMS ADM/CARRIER | JURISDICTION CLAIM # (STATE FILE #) | | CLAIM TYPE CODE MED ONLY INDEMNITY BECAME LOST TIME BECAME MED ONLY NOTIFY ONLY TRANSFER | | 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). | | | | |
| | CLAIMS ADM CLAIM # (INSURER CLAIM #) | | CARRIER FEIN | | | | | | |
| | OSHA LOG CASE # | | FEIN OF CLMS ADM | | | | | | |
| | NAME OF INSURANCE CARRIER | | CLMS ADJ PHONE # | | | | | | |
| | CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER) | | CITY | | | | | STATE | ZIP |
| | CLAIMS ADJUSTER NAME | | STATE | | | | | ZIP | |
| | CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2 | | | | | | | | |
| 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 | | EFF DATE | | EMPLOYMENT STATUS CODE FULL TIME/REGULAR PART TIME PIECE WORKER SEASONAL VOLUNTEER APPRENTICE FULL TIME APPRENTICE PART TIME | | |
| | | | SELF INSURED? YES NO | | EXP DATE | | | | |
| EMPLOYEE | EMPLOYEE LAST NAME | | PHONE INCL AREA CODE | | GENDER MALE FEMALE UNKNOWN | | | | |
| | FIRST | MI | DEPARTMENT REGULARLY WORKED | | OCCUPATION DESCRIPTION | | | | |
| | ADDRESS LINE 1 & 2 | | | | | | | | |
| | CITY | | STATE | ZIP | MARITAL STATUS UNMARRIED, SINGLE, DIVORCED | | MARRIED SEPARATED UNKNOWN | NCCI CLASS CODE | |
| | SSN | | DATE OF BIRTH | DATE OF HIRE | | | | | |
| WAGE | WAGE \$ | PERIOD WEEKLY HOURLY BI-WEEKLY DAILY 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 FATHER _____ SISTER TOTAL # DEPENDENTS WIDOWER _____ DAUGHTER _____ BROTHER MOTHER _____ SON _____ HANDICAPPED CHILD | | | | | | |
| | DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? YES NO | | | | | | | | |
| ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES) | | | | | | COUNTY OF INJURY | | | |
| CITY | | | STATE | ZIP | CITY | | | STATE | ZIP |
| 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 | |