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

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

GENDER
MALE
FEMALE
UNKNOWN

FIRST | MI

DEPARTMENT REGULARLY WORKED

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
COULD NOT BE DETERMINED

TIME EMPLOYEE BEGAN WORK ON INJURY DATE

DATE EMPLOYER NOTIFIED OF INJURY

BODY PART AFFECTED CODE

NATURE OF INJURY CODE

CAUSE OF INJURY CODE

DATE CLAIM ADM NOTIFIED OF INJURY

DATE LAST DAY WORKED

DATE DISABILITY BEGAN

RETURN TO WORK DATE (IF APPLICABLE)

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 OF DEATH (IF APPLICABLE)

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

IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP
WIDOW
WIDOWER
MOTHER
FATHER
____ DAUGHTER
____ SON
____ SISTER
____ BROTHER
____ HANDICAPPED CHILD
TOTAL # DEPENDENTS

ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)

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