

**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 <input type="checkbox"/> MED ONLY <input type="checkbox"/> INDEMNITY <input type="checkbox"/> BECAME LOST TIME <input type="checkbox"/> BECAME MED ONLY <input type="checkbox"/> NOTIFY ONLY <input type="checkbox"/> TRANSFER		<p>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.</p> <p>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.</p> <p>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).</p>				
	CLAIMS ADM CLAIM # (INSURER CLAIM #)		NAME OF INSURANCE CARRIER					CARRIER FEIN	
	OSHA LOG CASE #		CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)					FEIN OF CLMS ADM	
	CLAIMS ADJUSTER NAME		CLAIMS ADJ PHONE #					CITY	
	CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2		STATE					ZIP	
	EMPLOYER NAME Bedford County Dept of Education		EMPLOYER FEIN 62-6000485					SIC CODE	
EMPLOYER	EMPLOYER ADDRESS LINE 1 AND LINE 2 500 Madison Street			NATURE OF BUSINESS Local Education Agency					
	CITY Shelbyville		STATE TN	ZIP 37160		INSURED REPORT #	EMPLOYER LOCATION		
POLICY	INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)		POLICY NUMBER		EFF DATE		EMPLOYMENT STATUS CODE <input type="checkbox"/> FULL TIME/REGULAR <input type="checkbox"/> PART TIME <input type="checkbox"/> PIECE WORKER <input type="checkbox"/> SEASONAL <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> APPRENTICE FULL TIME <input type="checkbox"/> APPRENTICE PART TIME		
	SELF INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO		EXP DATE		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN				
EMPLOYEE	EMPLOYEE LAST NAME		PHONE INCL AREA CODE		OCCUPATION DESCRIPTION				
	FIRST	MI	DEPARTMENT REGULARLY WORKED		MARITAL STATUS <input type="checkbox"/> UNMARRIED, SINGLE, DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN				
	ADDRESS LINE 1 & 2		STATE		ZIP		NCCI CLASS CODE		
	CITY	DATE OF BIRTH	DATE OF HIRE		SALARY CONTINUED IN LIEU OF COMPENSATION <input type="checkbox"/> YES <input type="checkbox"/> NO				
	SSN	PERIOD <input type="checkbox"/> HOURLY <input type="checkbox"/> DAILY <input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> MONTHLY	NUMBER OF DAYS WORKED PER WEEK		FULL WAGES PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO				
ACCIDENT/INJURY	DATE OF INJURY		TIME OF INJURY <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> COULD NOT BE DETERMINED		TIME EMPLOYEE BEGAN WORK ON INJURY DATE <input type="checkbox"/> AM <input type="checkbox"/> 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 <input type="checkbox"/> WIDOW <input type="checkbox"/> FATHER <input type="checkbox"/> SISTER <input type="checkbox"/> DAUGHTER <input type="checkbox"/> BROTHER <input type="checkbox"/> MOTHER <input type="checkbox"/> SON <input type="checkbox"/> HANDICAPPED CHILD TOTAL # DEPENDENTS						
	DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES) CITY STATE ZIP						
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 <input type="checkbox"/> NO MEDICAL TREATMENT		<input type="checkbox"/> MINOR BY EMPLOYER <input type="checkbox"/> MINOR BY CLINIC/HOSPITAL		<input type="checkbox"/> HOSPITALIZED > 24 HRS <input type="checkbox"/> EMERGENCY CARE		<input type="checkbox"/> FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED		
OTHER	DATE PREPARED	PREPARER'S NAME & TITLE Andrea Davis - HR Manager		PREPARER'S COMPANY NAME Bedford County DoE		PHONE NUMBER 931-684-3284 ext 2224			