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 #)		
OSHA LOG CASE #		
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

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	
ADRRESS LINE 1 & 2			OCCUPATION DESCRIPTION
CITY / STATE / ZIP			MARITAL STATUS ☐ MARRIED ☐ UNMARRIED, SINGLE, DIVORCED ☐ SEPARATED ☐ UNKNOWN
SSN / DATE OF BIRTH / DATE OF HIRE			NCCI CLASS CODE

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 ☐ 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) 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