

**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		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		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		<b>EMPLOYMENT STATUS CODE</b> <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				
EMPLOYEE	EMPLOYEE LAST NAME		PHONE INCL AREA CODE		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN				
	FIRST	MI	DEPARTMENT REGULARLY WORKED		OCCUPATION DESCRIPTION				
	ADDRESS LINE 1 & 2		CITY		STATE	ZIP	MARITAL STATUS <input type="checkbox"/> UNMARRIED, SINGLE, DIVORCED	<input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN NCCI CLASS CODE	
	SSN		DATE OF BIRTH	DATE OF HIRE					
	WAGE \$		PERIOD <input type="checkbox"/> WEEKLY <input type="checkbox"/> HOURLY <input type="checkbox"/> DAILY	NUMBER OF DAYS WORKED PER WEEK		SALARY CONTINUED IN LIEU OF COMPENSATION <input type="checkbox"/> YES <input type="checkbox"/> NO			
						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                      _____ SISTER                      TOTAL # DEPENDENTS <input type="checkbox"/> WIDOWER                      _____ DAUGHTER                      _____ BROTHER <input type="checkbox"/> MOTHER                      _____ SON                      _____ HANDICAPPED CHILD						
	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	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		PREPARER'S COMPANY NAME		PHONE NUMBER		