

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	<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 KNOWLINGLY 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 #)			<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					
	OSHA LOG CASE #								
	NAME OF INSURANCE CARRIER Self-Insured			CARRIER FEIN 62-6000913					
	CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)			FEIN OF CLMS ADM 62-6000913					
	CLAIMS ADJUSTER NAME			CLMS ADJ PHONE # 615-790-5466					
EMPLOYER	CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2 1320 W Main Street, Suite 108			CITY Franklin	STATE TN	ZIP 37064			
	EMPLOYER NAME Williamson County Government			EMPLOYER FEIN 62-6000913	SIC CODE 615-790-5466	PHONE NUMBER 615-790-5466			
	EMPLOYER ADDRESS LINE 1 AND LINE 2 1320 W Main Street, Suite 108			NATURE OF BUSINESS Government					
POLICY	CITY Franklin		STATE TN	ZIP 37064	INSURED REPORT #	EMPLOYER LOCATION			
	INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER) Williamson County Government		POLICY NUMBER SELF INSURED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		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			
EMPLOYEE	EMPLOYEE LAST NAME		PHONE INCL AREA CODE		EXP DATE				
	FIRST		MI	DEPARTMENT REGULARLY WORKED		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN			
	ADDRESS LINE 1 & 2			OCCUPATION DESCRIPTION					
	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	SALARY CONTINUED IN LIEU OF COMPENSATION <input type="checkbox"/> YES <input type="checkbox"/> NO				
ACCIDENT/INJURY	WAGE \$		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		
	DATE OF INJURY			TIME OF INJURY <input type="checkbox"/> COULD NOT BE DETERMINED		<input type="checkbox"/> AM <input type="checkbox"/> PM	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					
	DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> WIDOW	<input type="checkbox"/> FATHER	<input type="checkbox"/> SISTER	TOTAL # DEPENDENTS		
				<input type="checkbox"/> WIDOWER	<input type="checkbox"/> DAUGHTER	<input type="checkbox"/> BROTHER			
			<input type="checkbox"/> MOTHER	<input type="checkbox"/> SON	<input type="checkbox"/> HANDICAPPED CHILD				
TREATMENT	ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)						COUNTY OF INJURY		
	CITY			STATE	ZIP				
	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		