

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 #)						
	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				
CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2 1320 W Main Street, Suite 108					CITY Franklin	STATE TN	ZIP 37064
EMPLOYER	EMPLOYER NAME Williamson County Government		EMPLOYER FEIN 62-6000913		SIC CODE	PHONE NUMBER 615-790-5466	
	EMPLOYER ADDRESS LINE 1 AND LINE 2 1320 W Main Street, Suite 108				NATURE OF BUSINESS Government		
	CITY Franklin	STATE TN	ZIP 37064		INSURED REPORT #	EMPLOYER LOCATION	
POLICY	INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER) Williamson County Government		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 checked="" 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				
	ADDRESS LINE 1 & 2				OCCUPATION DESCRIPTION		
	CITY		STATE	ZIP	MARITAL STATUS <input type="checkbox"/> UNMARRIED, SINGLE, <input type="checkbox"/> 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"/> BI-WEEKLY <input type="checkbox"/> DAILY <input type="checkbox"/> MONTHLY	NUMBER OF DAYS WORKED PER WEEK		SALARY CONTINUED IN LIEU OF COMPENSATION <input type="checkbox"/> YES <input type="checkbox"/> NO	
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"/> 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						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	
OTHER	DATE PREPARED		PREPARER'S NAME & TITLE		PREPARER'S COMPANY NAME		PHONE NUMBER