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
CLAIMS ADM CLAIM # (INSURER CLAIM #)	
OSHA LOG CASE #	

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).

NAME OF INSURANCE CARRIER	CARRIER FEIN
Self-Insured	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	CITY	STATE	ZIP
1320 W Main Street, Suite 108	Franklin	TN	37064

EMPLOYER

EMPLOYER NAME	EMPLOYER FEIN	SIC CODE	PHONE NUMBER
Williamson County Board of Educaton	62-6000915		615-790-5466

EMPLOYER ADDRESS LINE 1 AND LINE 2	NATURE OF BUSINESS
1320 W Main Street, Suite 202	County School System

CITY	STATE	ZIP	INSURED REPORT #	EMPLOYER LOCATION
Franklin	TN	37064		

POLICY

INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)	POLICY NUMBER	EFF DATE	EMPLOYMENT STATUS CODE
Williamson County Government	SELF INSURED? ☒ YES ☐ NO	EXP DATE	☐ FULL TIME/REGULAR ☐ PART TIME ☐ PIECE WORKER

EMPLOYEE

EMPLOYEE LAST NAME	PHONE INCL AREA CODE	GENDER ☐ MALE ☐ FEMALE ☐ UNKNOWN	☐ SEASONAL ☐ VOLUNTEER ☐ APPRENTICE FULL TIME ☐ APPRENTICE PART TIME
FIRST	MI	DEPARTMENT REGULARLY WORKED	
ADRRESS LINE 1 & 2		OCCUPATION DESCRIPTION	

CITY	STATE	ZIP	MARITAL STATUS ☐ UNMARRIED, SINGLE, DIVORCED	☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	NCCI CLASS CODE
SSN	DATE OF BIRTH	DATE OF HIRE			

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 ☐ WIDOWER ☐ MOTHER ☐ FATHER ___ DAUGHTER ___ SON ___ SISTER ___ BROTHER ___ HANDICAPPED CHILD	TOTAL # DEPENDENTS
DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO		

ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)	COUNTY OF INJURY
CITY STATE ZIP	

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

LB-0021 (REV. 12/07)   RDA 10183