

**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)		CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2					CITY	STATE	ZIP
	CLAIMS ADJUSTER NAME									
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 <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, <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	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		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 <input type="checkbox"/> DAUGHTER _____ BROTHER _____ SON _____ 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)						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 <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			