

**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		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		OCCUPATION DESCRIPTION MARITAL STATUS <input type="checkbox"/> UNMARRIED, SINGLE, DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN NCCI CLASS CODE		
	FIRST	MI	DEPARTMENT REGULARLY WORKED		OCCUPATION DESCRIPTION				
	ADDRESS LINE 1 & 2		CITY		STATE	ZIP			
	SSN		DATE OF BIRTH	DATE OF HIRE					
WAGE	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 <input type="checkbox"/> SISTER <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 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		



Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002

FORM C-42

EMPLOYEE'S CHOICE OF PHYSICIAN

An employer must provide a partially-completed form listing at least three physicians to an employee upon the report of a workplace injury. The employee must complete and then sign and date the section below that indicates the physician chosen. A copy of the fully-completed form should be provided to the employee with the original kept on file by the employer. If the employee refuses to accept medical services from the chosen physician, the employee's rights to benefits may be delayed. **NOTE:** Employees traveling more than 15 miles one way to or from medical treatment may seek reimbursement of their travel expenses from the insurance carrier.

TO BE COMPLETED BY THE EMPLOYER:

Employer _____ Date of Injury _____

Employer Contact _____ Phone _____ Email _____

Physician Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Physician Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Physician Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

TO BE COMPLETED BY THE EMPLOYEE:

I have selected the following physician from the list provided to me by my employer:

Physician Name _____ Date Selected _____

Employee Name _____ Appt Date/Time _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Employee Signature _____ Date _____



Oficina de Compensación a Trabajadores de Tennessee
Tennessee Bureau of Workers' Compensation
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Nashville, TN 37243-1002

FORMULARIO C-42
FORM C-42

SELECCIÓN DE MÉDICO POR UN EMPLEADO
EMPLOYEE'S CHOICE OF PHYSICIAN

Un empleador tiene que proporcionar un formulario parcialmente completado que enumere al menos tres médicos a un empleado al reportar una lesión que ocurrió en el lugar de trabajo. El empleado tiene que completar y luego firmar y fechar la sección abajo que indica el médico escogido. Una copia del formulario completado debe ser proporcionado al empleado y el original se debe mantener en los archivos del empleador. Si el empleado rehusa aceptar servicios médicos del médico escogido, los derechos a beneficios del empleado pueden ser retrasados. **NOTA:** Los empleados que viajan más de 15 millas de ida o de vuelta que tratamiento médico pueden pedir reembolso de sus gastos de viaje a la compañía aseguradora

An employer must provide a partially-completed form listing at least three physicians to an employee upon the report of a workplace injury. The employee must complete and then sign and date the section below that indicates the physician chosen. A copy of the fully-completed form should be provided to the employee with the original kept on file by the employer. If the employee refuses to accept medical services from the chosen physician, the employee's rights to benefits may be delayed. **NOTE:** Employees traveling more than 15 miles one way to or from medical treatment may seek reimbursement of their travel expenses from the insurance carrier.

**PARA SER COMPLETADO POR EL EMPLEADOR:
TO BE COMPLETED BY THE EMPLOYER:**

Empleador (Employer) _____ Fecha de Lesión (Date of Injury) _____

Contacto del Empleador (Employer Contact) _____ Teléfono (Phone) _____

Correo Electrónico (Email) _____

Nombre del Médico (Physician Name) _____ Teléfono (Phone) _____

Dirección (Address) _____ Ciudad (City) _____ Estado (State) _____

(Código Postal) Zip _____

Nombre del Médico (Physician Name) _____ Teléfono (Phone) _____

Dirección (Address) _____ Ciudad (City) _____ Estado (State) _____

(Código Postal) Zip _____

Nombre del Médico (Physician Name) _____ Teléfono (Phone) _____

Dirección (Address) _____ Ciudad (City) _____ Estado (State) _____

(Código Postal) Zip _____

**PARA SER COMPLETADO POR EL EMPLEADOR
TO BE COMPLETED BY THE EMPLOYEE:**

**He seleccionado el siguiente médico de la lista que mi empleador me proporcionó:
I have selected the following physician from the list provided to me by my employer:**

Nombre del Médico (Physician Name) _____ Fecha Seleccionada (Date Selected) _____

Nombre del Empleado (Employee Name) _____ Teléfono (Phone) _____

Dirección (Address) _____ Ciudad (City) _____ Estado (State) _____

(Código Postal) Zip _____

Teléfono (Phone) _____ Correo Electrónico (Email) _____

Firma del Empleado (Employee Signature) _____ (Fecha) Date _____



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FORM C-41

WAGE STATEMENT

EMPLOYEE: _____ SSN: _____ STATE FILE #: _____

Employer _____ Ins Claim # _____ Date of Injury: _____

Please list the wages earned by the employee named above during each of the 52 weeks prior to date of injury, if applicable.

WEEK	WEEK ENDING	GROSS WAGES	WEEK	WEEK ENDING	GROSS WAGES
1			27		
2			28		
3			29		
4			30		
5			31		
6			32		
7			33		
8			34		
9			35		
10			36		
11			37		
12			38		
13			39		
14			40		
15			41		
16			42		
17			43		
18			44		
19			45		
20			46		
21			47		
22			48		
23			49		
24			50		
25			51		
26			52		
				TOTAL PAID	

Date: _____ Name of Preparer and Title _____