

Tennessee Employer's First Report of Work Injury

Wausau	<p><b>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.</b></p> <p><i>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.</i></p> <p><b>If you have questions, the state now has a benefit review system where a Tennessee Department of Labor Workers' Compensation Specialist can provide assistance. Call 1-800-332-2667 (TDD).</b></p>
Name of Insurance Carrier	
Marsha Allen	
Name/Address of Claims Handling Office	
City State Zip	
(615) 292-8177	
Phone #	

<p><b><u>EMPLOYER</u></b></p> <p>1. Name Federal Employer Identification #</p> <p>2. Address City State Zip Code</p> <p>3. Nature of business Phone#</p> <p><b><u>INJURED EMPLOYEE</u></b></p> <p>4. Name Social Security #</p> <p>5. Address City State Zip Code</p> <p>6. Phone# Occupation (job title) Department</p> <p>7. Age DOB <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Married <input type="checkbox"/> Single</p> <p>8. Number of hours worked: per day ; per week ; number of days per week</p> <p>9. Wages: per hour \$ ; per day \$ ; per week \$ ; extra wages \$</p> <p><b><u>DESCRIPTION OF THE INJURY OR OCCUPATIONAL DISEASE</u></b></p> <p>10. Did the injury or exposure occur on the employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, give the address of where it occurred City State Zip County</p> <p>11. Describe what the employee was doing when the injury or exposure occurred; list tools, equipment or materials involved</p> <p>12. Describe fully how &amp; why the injury or exposure occurred</p> <p>13. Describe the injury or exposure in detail, giving the body part affected (examples: amputation of right index finger, fell down injuring low back, exposed to chemicals causing breathing problems)</p> <p>14. Date of the injury ; Hour of day am/pm. Give the date of the notice of the injury or exposure to the employee, if different than the date it occurred</p> <p>15. Was the employee paid in full for the date of injury or exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Has employee missed work because of the injury or exposure on any day after the date it occurred, including weekends or regularly scheduled days off? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give date last worked.</p> <p>17. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give date</p> <p>18. Did employee die? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give date Name/address of nearest relative</p> <p>19. Name/Address of physician</p> <p>20. If hospitalized, name/address of hospital</p> <p>Date report written Prepared by Title/Position</p> <p>I certify that the information given in this form is true, correct, and complete to the best of my knowledge.</p> <p>Signature of injured employee _____ Date: _____ If employee is unable or refuses to sign, state reason</p>	<p><b><u>DO NOT WRITE IN THIS COLUMN</u></b></p> <p>Carrier#(6)</p> <hr/> <p>County #(3)</p> <hr/> <p>Occupation (3)</p> <hr/> <p>Industry(4)</p> <hr/> <p>Ownership(2)</p> <hr/> <p>Nature(3)</p> <hr/> <p>Body Part (3)</p> <hr/> <p>Type (3)</p> <hr/> <p>Source (4)</p> <hr/> <p>Agency (4)</p> <hr/> <p>Disability (1)</p>
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