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 #	
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

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).

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 ☐ FULL TIME/REGULAR ☐ PART TIME ☐ PIECE WORKER ☐ SEASONAL ☐ VOLUNTEER ☐ APPRENTICE FULL TIME ☐ APPRENTICE PART TIME
	SELF INSURED? ☑ YES ☐ NO	EXP DATE	

EMPLOYEE

EMPLOYEE LAST NAME		PHONE INCL AREA CODE	GENDER ☐ MALE ☐ FEMALE ☐ UNKNOWN
FIRST	MI	DEPARTMENT REGULARLY WORKED	
ADRRESS LINE 1 & 2			OCCUPATION DESCRIPTION
CITY	STATE	ZIP	MARITAL STATUS ☐ UNMARRIED, SINGLE, DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN
SSN	DATE OF BIRTH	DATE OF HIRE	NCCI CLASS CODE

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) 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 ☐ 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