

Tennessee Employer's First Report of Work Injury

Name of Insurance Carrier
Name/Address of Claims Handling Office
City State Zip
Phone #

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

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).

EMPLOYER

1. Name Federal Employer Identification #
2. Address City State Zip Code
3. Nature of business Phone #

INJURED EMPLOYEE

4. Name Social Security #
5. Address City State Zip Code
6. Phone # Occupation or title Department
7. Age DOB Male Female Married Single
8. Number of hours worked; per day per week; Number of days per week
9. Wages; per hour \$ per day \$ per week \$ Extra wages \$

DESCRIPTION OF THE INJURY OR OCCUPATIONAL DISEASE

10. Did the injury or exposure occur on the employer's premises? yes no If no, give the address of where it occurred
11. Describe what the employee was doing when the injury or exposure occurred; list tools, equipment or materials involved
12. Describe fully how & why the injury or exposure occurred
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)
14. Date of the Injury / / Hour of day am/pm Give the date of the notice of the injury or exposure to the employer, if different than the date it occurred / /
15. Was the employee paid in full for the date of injury or exposure? Yes No
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? Yes No If yes, give date last worked / /
17. Has employee returned to work? Yes No If yes, give date / / / Returning wage; Per hour \$ Per day \$ Per week \$
18. Did employee die? Yes No If yes, give date / / name/address of nearest relative

19. Name/Address of physician
20. If hospitalized, name/address of hospital
Date report written / / Prepared by Title/Position

I certify that the information given in this form is true, correct, and complete to the best of my knowledge.

Signature of Injured employee If employee is unable or refuses to sign, state reason

DO NOT WRITE IN THIS COLUMN

Carrier #(6)

County #(3)

Occupation(3)

Industry(4)

Ownership(2)

Nature(3)

Body Part(3)

Type(3)

Source(4)

Agency(4)

Disability(I)