

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
Division of Workers' Compensation
Nashville, Tennessee 37243-0661

FINAL REPORT OF PAYMENT AND RECEIPT OF COMPENSATION

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

State File #-		Social Security #-	
Employee First Name:	MI	Last:	
Address:			
City:		State:	Zip:
Employer's Name (doing business as):			FEIN:
Business Address:			
City:		State:	Zip:
Insurance Co/Claim Handler Name:			Insurer File #-
Insurance Co/Claim Handler Address:			
City		State	Zip
Date of Injury:	First date out of work:	Date physician returned claimant to work:	Maximum Improvement Date:
Total # of days lost	Returned to: Same Employer <input type="checkbox"/> or New Employer <input type="checkbox"/>	Wages changed? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, From \$ _____ to \$ _____	
Date of Birth:	Average Weekly Wage \$	Weekly Compensation Rate: \$	

Compensation payments were made on the following basis:

Temporary Total Amount \$	Temporary Partial Amount \$
Permanent Partial Amount \$	Permanent Total Amount \$
Permanent Partial based on: _____ weeks _____ days	Permanent Total based on: _____ weeks _____ days
Death Benefit Amount \$	Funeral Expenses \$
Total Medical Paid to Date \$	Employees legal fees \$
Was salary paid in lieu of comp? Yes <input type="checkbox"/> No <input type="checkbox"/>	Employers/Ins Co. legal fees \$
Mark appropriate box of payments listed above that was paid in lump sum (list date paid under type): Temp. Total <input type="checkbox"/> Temp Partial <input type="checkbox"/> Permanent Partial <input type="checkbox"/> Permanent Total <input type="checkbox"/> Death Benefits <input type="checkbox"/>	
State Physicians % rating and scheduled body part:	Payments based on (% rate and scheduled body part):

I certify by signing that I have received Workers' Compensation benefit amounts as itemized above. I understand that this is not a release. **Employee's Signature** _____

Reason the injured employee did not sign this report:

Insurance Carrier Representative _____ Position _____