

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
Division of Workers' Compensation
710 James Robertson Parkway, Second Floor
Nashville, Tennessee 37243-0661

REQUEST FOR ASSISTANCE

(Failure To Complete All Items On This Form Will Cause Delay In Processing And May Result In The Form Being Returned To The Requesting Party)

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.

A.) DATE OF INJURY: _____

B.) ASSISTANCE IS REQUESTED FOR: (Check all that apply)

Temporary Disability Benefits: _____ Medical Care Benefits: _____
Permanent Disability Benefits: _____ Benefit Review Conference (See p.2)
Other (specify) _____

C.) INJURED EMPLOYEE'S NAME: _____

SSN: _____ Date Of Birth: _____
Street Address: _____
City: _____ State: _____ Zip: _____
County: _____ Telephone: _____
Is Employee Represented By An Attorney? _____
Attorney's Name: _____
Mailing Address: _____
Telephone: _____ Fax: _____

D.) EMPLOYER'S NAME: _____

Street Address: _____
City: _____ State: _____ Zip: _____
County: _____ Telephone: _____
Do Five or More Employees Work for Employer? _____

E.) WORKERS' COMPENSATION INSURANCE COMPANY NAME: _____

Adjuster's Name: _____ Telephone: _____
Street Address: _____
City: _____ State: _____ Zip: _____

F.) BRIEF DESCRIPTION OF INJURY:

Nature of Injury (carpal tunnel, broken arm, etc.) _____
How injury occurred (fell, lifting, driving, etc.) _____
When Did Employee Report Injury To Employer? _____
To Whom? _____ Person's Title: _____
How Long Has Employee Worked For Employer? _____
County of Injury: _____

G.) MEDICAL TREATMENT:

Was Employee Given A Choice Of Three Or More Treating Doctors? _____

List The Names Of All Doctors Seen: _____

Has A Doctor Placed Employee on Light Duty Work Restrictions? _____

Has A Doctor Taken Employee Completely Off Work? _____

If Answer Is Yes To Either Question, Provide The Doctor's Name: _____

H.) LITIGATION:

Has suit been filed ? _____ Style of Case: _____

County: _____ Docket#: _____

Employer/insurance Attorney's Name: _____

Mailing Address: _____

Telephone: _____ Fax: _____

Is Second Injury Fund Involved? _____

If so, who is attorney? _____

1.) DESCRIBE COMPLAINT

If you are asking for permanent disability benefits and/or would like a Benefit Review Conference, please complete the following section. Employee must have reached Maximum Medical Improvement before a BRC can be scheduled pursuant to TCA§50-6-236(h).

REQUEST FOR BENEFIT REVIEW CONFERENCE

A.) DATE OF MAXIMUM MEDICAL IMPROVEMENT BY TREATING DOCTOR: _____

B.) PERMANENT PARTIAL IMPAIRMENT RATING(S):

C.) BODY PART (ARM, LEG, ETC.) _____

An incomplete Request For Benefit Review Conference will cause a delay in processing and scheduling the BRC.

I hereby request the Department of Labor to assist in any disputed workers' compensation issues related to the above-detailed injury. I also authorize the Department of Labor to contact any person who has information regarding that injury.

PRINTED NAME OF REQUESTING PARTY

DATE

SIGNATURE OF REQUESTING PARTY

(rev 8/99)