



Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002
800-332-2667

FORM C-31

MEDICAL WAIVER AND CONSENT

This form is not required for injuries occurring on or after July 1, 2014

THIS MEDICAL AUTHORIZATION FORM ONLY PERMITS THE EMPLOYER OR THE BUREAU OF WORKERS' COMPENSATION TO OBTAIN MEDICAL INFORMATION THROUGH ORAL OR WRITTEN COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, CHARTS, FILES, RECORDS, AND REPORTS IN THE POSSESSION OF A MEDICAL PROVIDER AUTHORIZED BY THE EMPLOYER PURSUANT TO T.C.A. § 50-6-204 AND A MEDICAL PROVIDER THAT IS REIMBURSED BY THE EMPLOYER FOR THE EMPLOYEE'S TREATMENT.

I, _____, having filed a claim for workers' compensation benefits, do hereby authorize
(Printed Patient Name)

_____ to furnish to my employer or my employer's
(Name of Medical Provider)

representative, and/or the Bureau of Workers' Compensation any information or written material reasonably related to my work-related injury of _____ for which I am claiming compensation. I further authorize the release of
(Date of Injury)

the same information to me or my attorney. The authorization includes, but is not restricted to, a right to review and obtain copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

A photocopy of the authorization may be accepted in lieu of the original.

Patient Signature

Date

Date of Birth

EMPLOYEE ACCIDENT REPORT

Employee Name: _____

Address: _____

Phone: _____

Job Title: _____ **Department:** _____

Date of Accident: _____ **Shift Start Time:** _____

Time of Accident: _____ **A.M.** _____ **or P.M.** _____

Supervisor: _____

Location of Accident: _____

Describe the Nature of the Injury: _____

Describe Exactly What Happened: _____

List Any Witnesses: _____

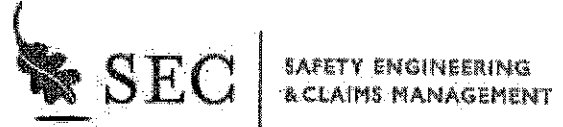
To Whom Did You Report the Accident/Injury? _____

What did you tell your Supervisor? _____

What did your Supervisor Do? _____

Employee Signature

Date



MEDICAL AUTHORIZATION

RE: Name: _____

DOB: _____

SSN: _____

1. In accordance with the provisions of the Privacy Rule for the Health Insurance Portability and Accountability Act, I, _____, do hereby expressly authorize any and all hospitals, physicians, clinics, chiropractors, pharmacists, therapists, and any and all other medical personnel and health care providers, to provide my medical records and/or medical information to my Employer, Insurer, Tennessee Risk Management Trust, its Third Party Administrator, Safety Engineering Consultants, Inc., and/or nurse case manager; said records including, but not limited to, all reports, records, clinical notes, diagnostic tests, operative notes, billing, and all other documentation or information produced by the aforesaid providers and pertaining to my medical care; and said aforesaid providers are hereby authorized and ordered to release said records to my Employer, Insurer, Tennessee Risk Management Trust, its Third Party Administrator, Safety Engineering Consultants, Inc., and/or nurse case manager for inspection and use, and any records obtained pursuant to this Authorization shall not be used or released to any third party not connected with my workers' compensation claim. This authorization specifically authorizes the aforementioned hospitals, physicians, clinics, chiropractors, pharmacists, therapists, and any and all other medical personnel and health care providers, to have communications, either in person, via telephone, or in writing, with my Employer, Insurer, Tennessee Risk Management Trust, its Third Party Administrator, Safety Engineering Consultants, Inc., and/or nurse case manager, regarding any aspect of my medical condition, including but not limited to diagnosis, etiology, medical restrictions, medical impairment, and prognosis.
2. A photocopy of this Medical Authorization shall be deemed as effective and valid as the original.
3. I understand that this Medical Authorization allows the disclosure of reports, records, clinical notes, diagnostic tests, operative notes, and other documentation or information pertaining to psychotherapy treatment.
4. I understand that I have the right to revoke this authorization at any time. I understand that if I do revoke this authorization, I must do so in writing and present my written revocation to My Employer, Insurer, Tennessee Risk Management Trust, its Third Party Administrator, Safety Engineering Consultants, Inc., and/or nurse case manager. Said revocation will be effective only when a covered entity which had previously been authorized to make disclosure receives the written notification of revocation. A revocation will not be effective to the extent that a covered entity has already taken action in reliance thereon.
5. Unless otherwise revoked, this Authorization will be effective during the pendency of my workers' compensation claim.

Please submit with First Report of Injury Form within 24 hours



6. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
7. I understand that treatment, payment, enrollment, or eligibility for benefits is not conditioned on my signing this Medical Authorization.
8. My Employer, Insurer, Tennessee Risk Management Trust, its Third Party Administrator, Safety Engineering Consultants, Inc., and/or nurse case manager, are hereby released from any and all liability or responsibility which could or might result because of the disclosure of any information pursuant to this authorization including, but not limited to, liability resulting from any breach of an implied covenant of confidentiality.
9. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Signature of Employee

Date

Please submit with First Report of Injury Form within 24 hours



SAFETY ENGINEERING & CLAIMS MANAGEMENT

SUPERVISOR ACCIDENT INVESTIGATION REPORT

Employee Name: _____

Job Title: _____

Department: _____

Date of Accident: _____

Shift Start Time: _____

Time of Accident: _____

A.M. _____ **or P.M.** _____

When Did You Learn of the Injury? _____

Did Injured Employee Receive First Aid? Yes _____ No _____

Was Injury Report or First Aid Delayed? Yes _____ No _____

If Yes, Why? _____

Was Employee Referred for Outside Medical Attention: Yes _____ No _____

If so, Where? _____

Location of Accident: _____

Describe the Nature of the Injury: _____

Describe Exactly What Happened: _____

List Any Witnesses: _____

Please submit with First Report of Injury Form within 24 hours



Supervisor Signature

Date

Please submit with First Report of Injury Form within 24 hours



ACCIDENT WITNESS REPORT

Employee Name: _____

Employee Address: _____

Work Number: _____ **Alternate Number:** _____

Job Title: _____ **Department:** _____

Date of Accident: _____ **Shift Start Time:** _____

Time of Accident: _____ **A.M.** _____ **or P.M.** _____

Location of Accident: _____

Identify the Employee Involved in the Accident: _____

What were you doing when the accident occurred: _____

Describe Exactly What Happened: _____

List Any Other Witnesses: _____

Witness Signature

Date

Please submit with First Report of Injury Form within 24 hours

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

Division of Workers' Compensation

220 French Landing Dr.
Nashville, Tennessee 37243-1002



WAGE STATEMENT

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.

Employee: _____ SSN: _____ State File # _____

Insurer Claim #: _____ Date of Injury _____

In order to determine the correct rate of compensation to be paid to the above injured party, please fill in the schedule below and return it promptly. This information is required by law and no agreement for payment of compensation can be made until it has been received. Please complete 52 weeks prior to date of accident.

Please describe allowances of any character made in lieu of wages that must be deemed a part of employee's earnings: _____

If the average weekly wage is not based on fifty-two weeks of earnings proceeding the date of injury, please show your computation below: _____

WEEK	NO. DAYS	WEEK ENDING	GROSS WAGES	WEEK	NO. DAYS	WEEK ENDING	GROSS WAGES
1				27			
2				28			
3				29			
4				30			
5				31			
6				32			
7				33			
8				34			
9				35			
10				36			
11				37			
12				38			
13				39			
14				40			
15				41			
16				42			
17				43			
18				44			
19				45			
20				46			
21				47			
22				48			
23				49			
24				50			
25				51			
26				52			
TOTAL PAID							

Rate per Day _____ Rate per Hour _____ Average per Week _____

I hereby certify that the above is a true and correct account, as taken from our time books or payroll records, of the wages paid to the above-named injured employee for the periods indicated.

Date _____ 20____ Employer _____

Name of Preparer & Title _____

Phone, Fax, Email _____

