TNRMT
TENNESSEE RISK MANAGEMENT TRUST

101 Tamaras Way, Hendersonville, TN 37075
888-743-4336 | Fax: 615-953-6292
wcclaims@tnrmt.com

SEC | SAFETY ENGINEERING & CLAIMS MANAGEMENT

111 Hazel Path, Hendersonville, TN 37075
615-826-4274 | Fax 615-826-6378
wcclaims@sectn.com

# EMPLOYEE ACCIDENT REPORT

**Employee Name:** _____

**Address:** _____

**Phone:** _____ **Email Address:** _____

**DOB:** _____ **SS #:** _____ **Date of Hire:** _____

**Job Title:** _____ **School:** _____

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

**Location of Accident:** _____

**Body Parts Injured:**
**Please specify whether right or left side for each body part. (example: right hand, left knee, low back)**
**Specific Fingers/Toes: Index/First, Middle/Second, Ring/Third, Pinky/Fourth, Thumb/Great Toe**

_____

_____

_____

**Describe Exactly What Happened:** _____

_____

_____

**Medical Treatment:**
**None at this time** ____ **Minor by Employer** ____ **Hospital** ____ **Minor by Doctor/Clinic** ____

**Name of Supervisor** _____ **Was the injury reported to your supervisor?** _____

**When was the injury reported?** _____ **To whom was the injury reported?** _____

**What did your supervisor do?** _____

**List All Witnesses** _____

_____

**Employee Signature** _____ **Date** _____

***Please submit all paperwork via fax or email after reporting claim online.***

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# ACCIDENT WITNESS REPORT

**Witness Name:** _____

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

**Witness Email Address:** _____

**Job Title:** _____ **Shift Start Time:** _____

**Date of Accident:** _____ **Time of Accident:** _____

**Location of Accident:** _____

**Identify the Employee Involved in the Accident:** _____

**Did you see the accident happen?** **Yes** _____ **No** _____

**If no, explain what you were told.** _____

_____

_____

**If yes, describe exactly what you saw.** _____

_____

_____

**List Any Other Witnesses:** _____

_____

**Witness Signature** _____ **Date** _____

***Please submit all paperwork via fax or email after reporting claim online.***

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## SUPERVISOR ACCIDENT INVESTIGATION REPORT

**Supervisor Name:** _____

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

**Job Title:** _____ **Department:** _____

**Identify the Employee Involved in the Accident:** _____

**Date of Accident:** _____ **Time of Accident:** _____

**Location of Accident:** _____

**Did the employee report the accident to you?** **Yes** _____ **No** _____

**If no, who reported the accident to you?** _____

**When did the employee report the accident to you?** _____

**What was reported to you about the accident?** _____

_____

_____

**Did the injured employee receive first aid?** **Yes** _____ **No** _____

**Was injury report or first aid delayed?** **Yes** _____ **No** _____

**If yes, why?** _____

**Was the employee referred for outside medical treatment?** **Yes** _____ **No** _____

**If so, where?** _____

**Was the employee provided a workers' comp panel?** **Yes** _____ **No** _____

**List Any Witnesses:** _____

_____

**Was corrective action required?** **Yes** _____ **No** _____

**If yes, what correction action was taken?** _____

**Supervisor Signature** _____ **Date** _____

***Please submit all paperwork via fax or email after reporting claim online.***

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# 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***

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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

**FORM C-42**

TENNESSEE
BUREAU OF WORKERS' COMPENSATION

# EMPLOYEE'S CHOICE OF PHYSICIAN
Medical Panel

**Employer**

- List at least three physicians and provide this panel to employee upon the report of a workplace injury.
- Keep the completed original form on file and send a copy to the employee for their records.
  - Do *not* send this form to the State unless requested.

**Employee**

- Fill out the bottom portion of this form to indicate which physician you choose.
  - If you refuse to accept medical services from the chosen physician, your rights to benefits may be delayed.
  - Traveling more than 15 miles (one way) to (or from) medical treatment? Employees may seek reimbursement of their travel expenses from the insurance carrier.
- Send completed form back to your employer.

## TO BE COMPLETED BY THE **EMPLOYER**:

Employee Name _____ Date Panel Provided _____

Employer Coffee County School System Date of Injury _____

Employer Contact Melisa Westmoreland Phone 931-222-1202 Email westmorelandm@k12coffee.net

| **Physician 1** | **Physician 2** | **Physician 3** |
|---|---|---|
| Name Dr. Denny Daniels | Name Dr. Charles Tessier | Name Dr. Glenn Davis & Dr. William Daniel |
| Phone 931-954-5605 | Phone 931-723-1705 | Phone 931-728-4718 |
| Address Fast Pace Urgent Care | Address Family Urgent Care | Address Manchester Rural Healthcare |
| 1415 Hillsboro Blvd | 909 Hillsboro Blvd | 482 Interstate Drive |
| City Manchester | City Manchester | City Manchester |
| State TN Zip 37355 | State TN Zip 37355 | State TN Zip 37355 |
| Is Telehealth available with Physician #1? Yes ☐ No ☒ | Is Telehealth available with Physician #2? Yes ☐ No ☒ | Is Telehealth available with Physician #3? Yes ☐ No ☒ |
| If yes, web address | If yes, web address | If yes, web address |

(Optional) Telehealth-Only **Physician 4** Name _____ Phone _____

Telehealth Provider email address _____ Web address _____

## TO BE COMPLETED BY THE **EMPLOYEE**:

**I have selected the following physician from the list provided to me by my employer:**

Physician Name _____ Appt Date/Time _____

I select: In-person treatment ☐ **or** Treatment by Telehealth ☐ Were you offered in-person treatment? Yes ☐ No ☐

Employee Signature _____ Date _____