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

WORKERS' COMPENSATION CHECKLIST

Employee Name: _____

Date of Injury: _____

Employee Accident Report

Accident Witness Report

Supervisor's Accident Investigation Report

Panel of Physicians – completed and signed by employee

HIPAA Release – signed by employee

C-31 Medical Waiver

Verified Wage Statement

- Gross wages for 52 weeks preceding and including date of injury
- Fully complete Wage Statement
- Total Paid
- Rate per Day or Rate per Hour
- Average per Week

Written Job Description

Employee's Prior Employment History as contained within your personnel records

Employee's Highest Level of Education

Preparer's Name: _____

Phone Number: _____

Email Address: _____

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

A Beginner's Guide to Tennessee Workers' Compensation

Basic facts about the Tennessee Workers' Compensation System for dates of Injury ***on or after July 1, 2014.***

How the Doctor is Selected

You will select your **Authorized Treating Physician** from a panel of three doctors that your employer gives you. That physician will provide the medical care needed to help you return to your health and to your job.

Medical treatment for your work-related injury is provided at the employer's expense. Sign an **Agreement between Employer/Employee Choice of Physician** (Form C-42), which should be provided to you by your supervisor, to indicate which doctor you select to become the authorized treating physician. If emergency treatment is required, the supervisor should provide the panel after the injury is stabilized.

Keep up with your records

Request and keep a copy of your signed Form C-42 for your records. If you do not sign the form, but accept medical treatment from a doctor on the form, it may be considered that you have chosen that doctor.

Have Questions?

Call the Ombudsman Program of the Tennessee Bureau of Workers' Compensation at **800-332-COMP (2667)** if you have any questions.

An ombudsman will assist with any questions from employees, employers and insurance companies that do not have attorney representation.

Learn more online and download forms at: **www.tn.gov/workerscomp**

Keep in Touch

Stay in contact with your employer if you are taken off work by the doctor.

Benefits that Injured Employees May Be Entitled to Receive

Employees who have suffered a compensable injury, meaning that the authorized treating physician has determined the injury to be work-related, may be entitled to receive the following:

Medical treatment, at no cost to the employee

This treatment must be provided for as long as required by the authorized treating physician. Medical treatment recommended by the authorized treating physician that is denied by the insurance company's utilization review agent can be submitted to the Bureau's Utilization Review Program for additional review and consideration.

Travel Expenses

Reimbursement for mileage to and from medical treatment may be requested if travel exceeds 15 miles one way.

Temporary Disability Benefits (Wage Replacement)

Disability begins when the authorized treating physician takes you off work. Temporary disability benefits replace lost wages and are due beginning on the eighth day of the disability. If the disability lasts fourteen (14) days or longer, benefits will be paid back to the first day of disability. Temporary disability benefits are usually two-thirds of your average weekly wages earned during the 52 weeks prior to the injury. The Bureau of Workers' Compensation does not pay these benefits. Benefits are paid by your employer's insurance carrier.

If you are able to work, but your average weekly earnings are reduced because of work restrictions, you may be entitled to partial disability benefits.

If the authorized treating physician restricts your ability to work, such as limiting the number of hours worked or the type of work performed, it is very important that the physician's instructions and restrictions are followed at all times. **Failure to report for light duty offered by your employer may terminate your temporary disability benefits.**

If Your Claim is Denied

When a claim is denied, it means your employer's workers' compensation insurance adjuster believes your injury is not compensable, meaning that your injury was not caused by the work that you perform and it is not covered by workers' compensation. If the adjuster denies your claim, you have a right to challenge the decision. If a dispute regarding compensability occurs, you may seek help resolving the dispute from the Bureau. Call an ombudsman at **(800) 332-2667**.

Protect Your Rights

The right to receive workers' compensation benefits does not stay open forever. To protect your rights, file a **Petition for Benefit Determination (PBD) form**. The form is available on the Bureau's website. In most cases, the deadline to file the form is one year from:

A. The date the injury occurred; or,

B. The date the last temporary disability benefits were paid or medical benefits were provided for the injury, whichever is latest.

Can I Be Fired for Reporting a Work Injury?

It is illegal for an employer to fire an employee for reporting a work injury. If you are fired and believe it was for reporting a work injury, you may wish to consult an attorney. The Bureau of Workers' Compensation does not have authority to resolve wrongful termination claims.

Learn more and download forms from our website:
www.tn.gov/workerscomp

Frequently Asked Questions:

Do I have to pay for medical treatment for a compensable injury?

No. you are not responsible for the costs of medical treatment provided by the authorized physician for a compensable claim.

What options do I have if I disagree with the authorized treating physician's findings or recommended medical treatment?

The employer or insurance company is usually not required by law to offer a second opinion, but you can always ask for it anyway. You may, however, obtain a second opinion or additional medical treatment with any doctor at your own expense.

What if I'm not receiving the benefits I deserve?

Call a Workers' Compensation Ombudsman at (800) 332-2667 to help you. Submitting a completed **Petition for Benefit Determination**, available on the Bureau's website, will speed up the process.

Will I need to use sick or vacation time while off work due to a compensable injury?

It depends. An employee taken off work by the authorized treating physician for less than 14 days is not entitled to temporary disability benefits for the first seven (7) days missed. Review your company's policies about this unpaid time. If the authorized treating physician requires you to miss more than 14 days; however, benefits are due from the first day of disability.

Am I paid for the time spent attending doctor appointments during work hours?

Not unless your company has a policy to pay for this time.

Which employers must provide workers' compensation coverage for their employees?

In most industries, any employer with five or more full- or part-time employees must carry workers' compensation insurance. In the construction or mining industry however, employers must provide coverage even if there is only one employee. Construction employers may exempt themselves from the workers' compensation coverage requirements by applying for an exemption; but, all employees in construction must be covered.

Information about the Workers' Compensation Exemption Registry is available at: **http://tnbear.tn.gov/WC/Default.aspx** or by calling the Tennessee Secretary of State's office at **(615) 741-2286**.

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
EMPLOYER'S FIRST REPORT OF WORK INJURY OR ILLNESS

CLAIMS ADM/CARRIER

JURISDICTION CLAIM # (STATE FILE #)	CLAIM TYPE CODE ☐ MED ONLY ☐ INDEMNITY ☐ BECAME LOST TIME ☐ BECAME MED ONLY ☐ NOTIFY ONLY ☐ TRANSFER
CLAIMS ADM CLAIM # (INSURER CLAIM #)	
OSHA LOG CASE #	
NAME OF INSURANCE CARRIER	CARRIER FEIN
CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)	FEIN OF CLMS ADM
CLAIMS ADJUSTER NAME	CLMS ADJ PHONE #

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).

CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2	CITY	STATE	ZIP

EMPLOYER

EMPLOYER NAME	EMPLOYER FEIN	SIC CODE	PHONE NUMBER
EMPLOYER ADDRESS LINE 1 AND LINE 2		NATURE OF BUSINESS	
CITY	STATE / ZIP	INSURED REPORT #	EMPLOYER LOCATION

POLICY

INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)	POLICY NUMBER	EFF DATE	**EMPLOYMENT STATUS CODE** ☐ FULL TIME/REGULAR ☐ PART TIME ☐ PIECE WORKER ☐ SEASONAL ☐ VOLUNTEER ☐ APPRENTICE FULL TIME ☐ APPRENTICE PART TIME
	SELF INSURED? ☐ YES ☐ NO	EXP DATE	

EMPLOYEE

EMPLOYEE LAST NAME		PHONE INCL AREA CODE	GENDER ☐ MALE ☐ FEMALE ☐ UNKNOWN
FIRST / MI		DEPARTMENT REGULARLY WORKED	
ADRRESS LINE 1 & 2			OCCUPATION DESCRIPTION
CITY	STATE / ZIP		MARITAL STATUS ☐ UNMARRIED, SINGLE, DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN
SSN	DATE OF BIRTH	DATE OF HIRE	NCCI CLASS CODE

WAGE

WAGE $	PERIOD ☐ HOURLY ☐ DAILY ☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY	NUMBER OF DAYS WORKED PER WEEK	SALARY CONTINUED IN LIEU OF COMPENSATION ☐ YES ☐ NO FULL WAGES PAID FOR DATE OF INJURY ☐ YES ☐ NO

ACCIDENT/INJURY

DATE OF INJURY	TIME OF INJURY ☐ AM ☐ PM ☐ COULD NOT BE DETERMINED	TIME EMPLOYEE BEGAN WORK ON INJURY DATE ☐ AM ☐ PM	
DATE EMPLOYER NOTIFIED OF INJURY	BODY PART AFFECTED CODE	NATURE OF INJURY CODE	CAUSE OF INJURY CODE
DATE CLAIM ADM NOTIFIED OF INJURY	HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE INCIDENT INCLUDING WHAT THE EMPLOYEE WAS DOING JUST BEFORE, THE PART OF THE BODY AFFECTED AND HOW, AND OBJECT OR SUBSTANCE THAT DIRECTLY HARMED THE EMPLOYEE.		
DATE LAST DAY WORKED			
DATE DISABILITY BEGAN			
RETURN TO WORK DATE (IF APPLICABLE)			
DATE OF DEATH (IF APPLICABLE)	IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP ☐ WIDOW ☐ WIDOWER ☐ MOTHER ☐ FATHER ____ DAUGHTER ____ SON ____ SISTER ____ BROTHER ____ HANDICAPPED CHILD		TOTAL # DEPENDENTS
DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO			
ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES) CITY STATE ZIP			COUNTY OF INJURY

TREATMENT

PHYSICIAN NAME		HOSPITAL OR OFF SITE TREATMENT NAME	
ADDRESS LINE 1 AND 2		ADDRESS LINE 1 AND 2	
CITY / STATE / ZIP		CITY / STATE / ZIP	

INITIAL TREATMENT
☐ NO MEDICAL TREATMENT ☐ MINOR BY EMPLOYER ☐ MINOR BY CLINIC/HOSPITAL ☐ HOSPITALIZED > 24 HRS ☐ EMERGENCY CARE ☐ FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED

OTHER

DATE PREPARED	PREPARER'S NAME & TITLE	PREPARER'S COMPANY NAME	PHONE NUMBER

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

FORM C-41

WAGE STATEMENT

EMPLOYEE: _____ SSN: _____ STATE FILE #:_____

Employer _____ Ins Claim # _____ Date of Injury: _____

Please list the wages earned by the employee named above during each of the 52 weeks prior to date of injury, if applicable.

WEEK	WEEK ENDING	GROSS WAGES	WEEK	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	$0.00

Date: _____ Name of Preparer and Title _____

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 Cumberland County Schools Date of Injury _____

Employer Contact Marsha Polson Phone 931-484-6135 Email mpolson@ccschools.k12tn.net

Physician 1	Physician 2	Physician 3
Name Dr. Carlton / Dr. Lewis	Name Dr. Viswesvar Satyanarayan	Name _____
Phone 931-210-5577	Phone 931-484-1100	Phone _____
Address Exac Care	Address Quality Medical Center	Address _____
229 Interstate Drive Ste 103	15 Walker Hill Circle	_____
City Crossville	City Crossville	City _____
State TN Zip 38555	State TN Zip 38555	State _____ Zip _____
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 _____

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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.

Dr. Rebecca Farley Director of Schools

Scott VanWinkle Board Chair

Employee Refusal of Medical Treatment Form

I acknowledge that I have received an injury that may have occurred on the job per the below listed information. I do not wish to seek medical treatment at this time. However, I understand that I may seek treatment should my condition change. I will inform my supervisor immediately should the need arise.

Employee Name (print)_____

Date of injury _____

Time of injury _____

_____

Employee list specific body part(s): Example: Right hand, index finger

_____

Employee list specific injury type: Example: Scratch, burn, cut

Employee Signature _____
Date _____

Supervisor Signature_____
Date_____

**Use this form if an employee has a minor injury and they do not feel that they need medical treatment. If the employee's injury is obvious, get medical attention and/or call 911, if necessary. Remember to complete an incident report form within 1 working day of knowledge of injury.

Cumberland County Board of Education 368 Fourth Street Crossville, TN. 38555
Phone: 931-484-6135 Fax: 931-484-6491

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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.

TNRMT
TENNESSEE RISK MANAGEMENT TRUST

SEC | SAFETY ENGINEERING & CLAIMS MANAGEMENT

Mileage Request Form

I hereby certify that this claim is true and correct. Name: _____

T.C.A. 50-6-204(a)(6)(A) provides that "when an injured worker is required by the worker's employer to travel to an authorized medical provider or medical facility located OUTSIDE OF a radius of fifteen (15) miles (ONE WAY) from such insureds residence or workplace, then upon request such employee shall be reimbursed for reasonable travel expenses, as measured from the employee's residence or workplaces to the location of the medical provider's facility." Effective January 1, 2025 the reimbursement rate is $.70 per mile by the Department of Finance and Administration.

DATE		START LOCATION (HOME OR WORK)	END LOCATION (MEDICAL PROVIDER OR FACILITY NAME)	MILES ROUNDTRIP

Total Number of Miles:

Please forward to your Claims Representative