

**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 <input type="checkbox"/> MED ONLY <input type="checkbox"/> INDEMNITY <input type="checkbox"/> BECAME LOST TIME <input type="checkbox"/> BECAME MED ONLY <input type="checkbox"/> NOTIFY ONLY <input type="checkbox"/> TRANSFER		<p>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.</p> <p>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.</p> <p>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).</p>	
	CLAIMS ADM CLAIM # (INSURER CLAIM #)		CARRIER FEIN 62-1074045			
	OSHA LOG CASE #		FEIN OF CLMS ADM 59-2863407			
	NAME OF INSURANCE CARRIER TML Risk Management Pool		CLMS ADJ PHONE # 615-370-4180 800-288-0829			
	CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER) TML Pool Claims		CITY Brentwood			
	CLAIMS ADJUSTER NAME FAX 877-469-7611		STATE TN			
CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2 5100 Maryland Way		ZIP 37027		CITY Brentwood		
EMPLOYER	EMPLOYER NAME Highland Rim Economic Corporation		EMPLOYER FEIN 62-0757461		STATE TN	
	EMPLOYER ADDRESS LINE 1 AND LINE 2 PO Box 208		CITY Erin		ZIP 37061	
	CITY Erin		STATE TN		ZIP 37061	
POLICY	INSURED NAME (PARENT CO IF DIFFERENT THAN EMPLOYER)		POLICY NUMBER		EFF DATE 07/01/17	
	EMPLOYEE LAST NAME		PHONE INCL AREA CODE		EMPLOYMENT STATUS CODE <input type="checkbox"/> FULL TIME/REGULAR <input type="checkbox"/> PART TIME <input type="checkbox"/> PIECE WORKER <input type="checkbox"/> SEASONAL <input type="checkbox"/> VOI UNTEER <input type="checkbox"/> APPRENTICE FULL TIME <input type="checkbox"/> APPRENTICE PART TIME	
EMPLOYEE	FIRST		MI		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	
	ADDRESS LINE 1 & 2		DEPARTMENT REGULARLY WORKED		OCCUPATION DESCRIPTION	
	CITY		STATE		ZIP	
	SSN		DATE OF BIRTH		DATE OF HIRE	
	WAGE \$		PERIOD <input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> DAILY <input type="checkbox"/> MONTHLY		NUMBER OF DAYS WORKED PER WEEK	
ACCIDENT/INJURY	DATE OF INJURY		TIME OF INJURY <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> COULD NOT BE DETERMINED		TIME EMPLOYEE BEGAN WORK ON INJURY DATE <input type="checkbox"/> AM <input type="checkbox"/> PM	
	DATE EMPLOYER NOTIFIED OF INJURY		BODY PART AFFECTED CODE N/A		NATURE OF INJURY CODE N/A	
	DATE CLAIM ADM NOTIFIED OF INJURY		CAUSE OF INJURY CODE N/A		DATE EMPLOYEE BEGAN WORK ON INJURY DATE	
	DATE LAST DAY WORKED		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 DISABILITY BEGAN					
	RETURN TO WORK DATE (IF APPLICABLE)					
	DATE OF DEATH (IF APPLICABLE)		IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP <input type="checkbox"/> WIDOW <input type="checkbox"/> FATHER <input type="checkbox"/> SISTER <input type="checkbox"/> DAUGHTER <input type="checkbox"/> BROTHER <input type="checkbox"/> SON <input type="checkbox"/> HANDICAPPED CHILD			
	DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		TOTAL # DEPENDENTS			
	ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)					COUNTY OF INJURY
	CITY		STATE		ZIP	
TREATMENT	PHYSICIAN NAME		HOSPITAL OR OFF SITE TREATMENT NAME			
	ADDRESS LINE 1 AND 2		ADDRESS LINE 1 AND 2			
	CITY		STATE		ZIP	
	INITIAL TREATMENT <input type="checkbox"/> NO MEDICAL TREATMENT		<input type="checkbox"/> MINOR BY EMPLOYER <input type="checkbox"/> MINOR BY CLINIC/HOSPITAL		<input type="checkbox"/> HOSPITALIZED > 24 HRS <input type="checkbox"/> EMERGENCY CARE	
DATE PREPARED		PREPARER'S NAME & TITLE		PREPARER'S COMPANY NAME		
PHONE NUMBER						



DIVISION OF WORKERS' COMPENSATION
TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
220 French Landing Dr.
Nashville, Tennessee 37243-1002

AGREEMENT BETWEEN EMPLOYER/EMPLOYEE CHOICE OF PHYSICIAN

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.

In compliance with the Tennessee Workers' Compensation Law, T.C.A. Section 50-6-204

1. Physician's Name Telephone
Office Address City State Zip
2. Physician's Name Telephone
Office Address City State Zip
3. Physician's Name Telephone
Office Address City State Zip
4. Physician's Or Chiropractor's Name Telephone
Office Address City State Zip
5. Physician's Name Telephone
Office Address City State Zip

According to the provisions of this agreement, I hereby have selected the following physician from the list provided to me by my employer.

Physician chosen: Date of injury:
Date of selection: Date of appointment:

Employer's Name
Street Address
City State Zip
Telephone Email
Employer's Signature

Employee's Name
Street Address
City State Zip
Telephone Email
Employee's Signature
Employee's Social Security Number
State File Number



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Employer's Name
Street Address
City State Zip
Telephone Email
Employer's Signature

Employee's Name
Street Address
City State Zip
Telephone Email
Employee's Signature
Employee's Social Security Number
State File Number

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

Division of Workers' Compensation

220 French Landing Dr.

Nashville, Tennessee 37243-1002

Website: www.tn.gov/labor-wfd/wcomp.html**AGREEMENT BETWEEN EMPLOYER/EMPLOYEE CHOICE OF PHYSICIAN**

In compliance with the Tennessee Workers' Compensation Law, T.C.A. Section 50-6-204

Upon the report of a workplace injury, an employer should provide the employee, in writing an Agreement Between Employer/Employee Choice Of Physician Form C-42. The form must indicate the name of the physician chosen by the injured employee, be signed by the employee with a copy given to the employee, and the original kept on file with the employer. Employees traveling more than 15 miles one way to or from medical treatment may seek reimbursement from the insurance carrier for their travel expense.

The injured employee must submit to examination by the employer's physician at all reasonable times if requested to do so by the employer, but the employee shall have the right to have the employee's own physician present at such examination, in which case the employee shall be liable to the employee's physician for that physician's services. If the injured employee refuses to comply with any reasonable request for examination or to accept the medical or specialized medical services that the employer is required to furnish under this chapter, the injured employee's right to compensation shall be suspended and no compensation shall be due and payable while the injured employee continues to refuse.

For injuries prior to July 1, 2014, the injured employee shall accept the medical benefits afforded hereunder; provided, the employer shall designate a group of three (3) or more reputable physicians or surgeons not associated together in practice, if available in that community, from which the injured employee shall have the privilege of selecting the operating surgeon or the attending physician. If the injury is a back injury, the statutory panel must be expanded to 4, one of whom must be a chiropractor with treatment limited to 12 chiropractic visits. Further, if the injury or illness requires the treatment of a physician or surgeon who practices orthopedic or neuroscience medicine, the employer **may** appoint a panel practicing orthopedic or neuroscience medicine consisting of 5 physicians, with no more than 4 physicians affiliated in practice. If there are not enough physicians available within the community of the injured worker, names of physicians from outside the community should be added. If the employer provides this panel, the injured employee shall be entitled to have a second opinion on the issue of surgery, impairment, and a diagnosis from that same panel.

For injuries on or after July 1, 2014, the injured employee shall accept the medical benefits afforded under this section; provided, that in any case when the employee has suffered an injury and expressed a need for medical care, the employer shall designate a group of three (3) or more independent reputable physicians or surgeons, chiropractors or specialty practice groups if available in the injured employee's community, from which the injured employee shall select one (1) to be the treating physician. If three (3) or more independent reputable physicians, surgeons, chiropractors or specialty practice groups are not available in the employee's community, the employer shall provide a list of three (3) independent reputable physicians, surgeons, chiropractors or specialty practice groups, within a one hundred (100) mile radius of the employee's community. When necessary, the treating physician selected shall make referrals to a specialist physician, surgeon, or chiropractor and immediately notify the employer. The employer shall be deemed to have accepted the referral, unless the employer, within three (3) business days, provides the employee a panel of three (3) or more independent reputable physicians, surgeons, chiropractors or specialty practice groups. In this case, the employee may choose a specialist physician, surgeon, chiropractor or specialty practice group to provide treatment only from the panel provided by the employer. When the treating physician or chiropractor refers the injured employee, the employee shall be entitled to have a second opinion on the issue of surgery and diagnosis from a physician or chiropractor specified in the initial panel of physicians provided by the employer. The employee's decision to obtain a second opinion shall not alter the previous selection of the treating physician or chiropractor.

If you have any questions or need assistance in completing this form, call 1-800-332-2667.