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

CLAIMS ADM/CARRIER

JURISDICTION CLAIM # (STATE FILE #)

CLAIMS ADM CLAIM # (INSURER CLAIM #)

OSHA LOG CASE #

CLAIM TYPE CODE
- ☐ MED ONLY
- ☐ INDEMNITY
- ☐ BECAME LOST TIME
- ☐ BECAME MED ONLY
- ☐ NOTIFY ONLY
- ☐ TRANSFER

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

SELF INSURED? ☐ YES ☐ NO

EFF DATE

EXP DATE

EMPLOYMENT STATUS CODE
- ☐ FULL TIME/REGULAR
- ☐ PART TIME
- ☐ PIECE WORKER
- ☐ SEASONAL
- ☐ VOLUNTEER
- ☐ APPRENTICE FULL TIME
- ☐ APPRENTICE PART TIME

EMPLOYEE

EMPLOYEE LAST NAME

PHONE INCL AREA CODE

FIRST | MI

DEPARTMENT REGULARLY WORKED

GENDER
- ☐ MALE
- ☐ FEMALE
- ☐ UNKNOWN

ADRRESS LINE 1 & 2

OCCUPATION DESCRIPTION

CITY | STATE | ZIP

MARITAL STATUS
- ☐ UNMARRIED, SINGLE, DIVORCED
- ☐ MARRIED
- ☐ SEPARATED
- ☐ UNKNOWN

NCCI CLASS CODE

SSN | DATE OF BIRTH | DATE OF HIRE

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

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 Germantown Municipal School District Date of Injury _____

Employer Contact Gina Eddleman Phone 901-752-7890 Email gina.eddleman@gmsdk12.org

Physician 1	Physician 2	Physician 3
Name GMSD Health and Wellness Center	Name Nova Medical Center	Name Methodist Minor Medical Center
Phone 901-334-0320	Phone 901-620-3900	Phone 901-758-6035
Address 7655 Poplar Ave., Suite 385	Address 3965 S. Mendenhall, Suite 20	Address 8035 Club Parkway
City Germantown	City Memphis	City Cordova
State TN Zip 38138	State TN Zip 38115	State TN Zip 38016
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 N/A 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 _____

LB-0382 (REV 10/21)

RDA 10183

Have employee complete only if NOT choosing medical treatment or choosing to seek medical treatment at their personal physician at the own expense.

I, _____chose not to seek medical attention:

Employee's signature: _____

Date: _____

I, _____have been given the options to seek medical attention at one of the panel of physicians on the C-42 Form. I elect to go to the physician of my choice understanding the Germantown Municipal School District will not pay for my medical treatment since I chose not to go to one of the panel of physicians:

Employee's signature: _____

Date: _____

GERMANTOWN
MUNICIPAL SCHOOL DISTRICT
Excellence. Always.

Germantown Municipal School District Accident Report

Staff completing report: _____

School: _____ **Room:** _____

Date of Incident: _____ **Time of Incident:** _____

Location of the incident:

_____

_____

_____

Person(s) injured in the incident:

Staff	**Student**
_____	_____
_____	_____
_____	_____
_____	_____

Detailed description of the incident:

_____

_____

_____

_____

Immediate action in responding to the incident:

_____

_____

_____

Witnesses to the incident:

_____	_____
_____	_____
_____	_____

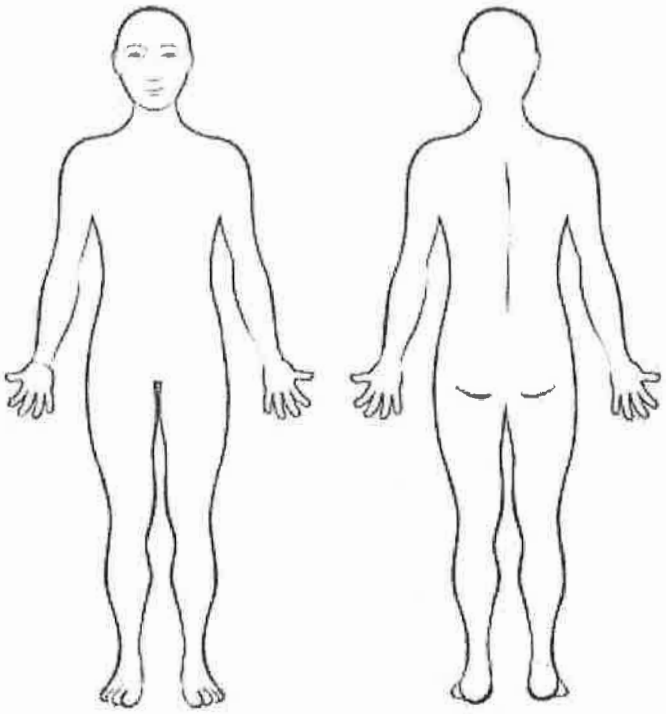
Nature of Injury

Abrasion	☐	Fracture	☐
Amputation	☐	Laceration	☐
Bite	☐	Poisoning	☐
Bruise	☐	Puncture	☐
Burn	☐	Shock Et.	☐
Cut	☐	Sprain	☐
Dislocation	☐		

Other (specify)

Ankle	☐	Hand	☐
Arm	☐	Head	☐
Back	☐	Knee	☐
Ear	☐	Nose	☐
Face	☐	Scalp	☐
Finger	☐	Teeth	☐
Foot	☐	Wrist	☐

Other (specify)



Teacher in charge when accident occurred. (Enter Name):

Present at scene of accident: Yes ☐ No ☐

Immediate Action Taken

First Aid treatment	☐	By (Name)
Sent to school nurse	☐	By (Name)
Sent home	☐	By (Name)
Sent to physician	☐	By (Name) Physician's Name
Sent to hospital	☐	By (Name) Name of hospital

Was a parent or other individual notified? Yes ☐ No ☐

When? _____ Phone # _____

Name of individual notified _____ By Whom? (Enter name) _____

Injured Staff Member's Signature: _____

Reporting Staff Member's Signature: _____

Nurse's Signature: _____

Principal's Signature: _____