

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

INDUM         INDUM <td< th=""><th></th><th>UBIODICTION</th><th>CLAD4#/</th><th></th><th>-</th><th></th><th>CLADA</th><th>TYDE</th><th>CODE</th><th>1_</th><th></th><th></th><th></th><th></th><th></th></td<>		UBIODICTION	CLAD4#/		-		CLADA	TYDE	CODE	1_						
UNDER ADMACLAIM # (UNSURBE CLAIM #)         DECAMING UNCLAIM # (UNSURBE CLAIM #)           UP000000000000000000000000000000000000		JURISDICTION CLAIM # (STATE FILE #)					CLAIM TYPE CODE			THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE						
Biggsong Denta TORICARE #         International and Deal (Descale and Deal) (Descale and Deal)	-	CLAIMS ADM CLAIM # (INSURER CLAIM #)														
CLAMS ADUSTER NAME     CLAMS AD PHONE #     PROVIDE ASSISTANCE, CALL I-500-332-2607 (TDD), ALCHARGE USA       EMPLOYER NAME     EMPLOYER FEIN     SIC CODE     PHONE NUMBER       EMPLOYER ADDRESS LINE I AND LINE 2     CTTY     STATE     ZIP       EMPLOYER ADDRESS LINE I AND LINE 2     NATURE OF HIGHNESS     EMPLOYER FEIN     SIC CODE     PHONE NUMBER       EMPLOYER ADDRESS LINE I AND LINE 2     NATURE OF HIGHNESS     EMPLOYER FEIN     SIC CODE     PHONE NUMBER       EMPLOYER ADDRESS LINE I AND LINE 2     STATE     ZIP     NATURE OF HIGHNESS     EMPLOYER ADDRESS LINE I AND LINE 2       EMPLOYER ADDRESS LINE I AND LINE 2     STATE     ZIP     NATURE OF HIGHNESS     EMPLOYER ADDRESS LINE I AND LINE 2       EMPLOYER ADDRESS LINE I AND LINE 2     STATE     ZIP     PHONE NTATALES     EMPLOYER ADDRESS LINE I AND LINE 2       EMPLOYER LAST NAME     PHONE NTATALES     CODE     PHONE NTATALES     EMPLOYER ADDRESS LINE I AND LINE 2       MARE     PHONE NTATALES     MALE     SCAMONAL     PHONE NTATALES     SCAMONAL       MARE     PHONE NTATALES     MALE     ADPRENTICE PHILINE     AMPLOYER ADDRESS LINE I AND LINE 2       MARE     PHONE NTATALES     NOTICE OF SIGNAL     PHONE NTATALES     SCAMONAL       MARE     PHONE NTATE     NATURE OF NULLY     NOTICE OF SIGNAL       NOTICE PHONE     STATE <td>~</td> <td colspan="4"></td> <td colspan="3">—</td> <td colspan="5"></td>	~					—										
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CLAMS ADUSTER NAME     CLAMS AD PHONE #     PROVIDE ASSISTANCE, CALL I-500-332-2607 (TDD), ALCHARGE USA       EMPLOYER NAME     EMPLOYER FEIN     SIC CODE     PHONE NUMBER       EMPLOYER ADDRESS LINE I AND LINE 2     CTTY     STATE     ZIP       EMPLOYER ADDRESS LINE I AND LINE 2     NATURE OF HIGHNESS     EMPLOYER FEIN     SIC CODE     PHONE NUMBER       EMPLOYER ADDRESS LINE I AND LINE 2     NATURE OF HIGHNESS     EMPLOYER FEIN     SIC CODE     PHONE NUMBER       EMPLOYER ADDRESS LINE I AND LINE 2     STATE     ZIP     NATURE OF HIGHNESS     EMPLOYER ADDRESS LINE I AND LINE 2       EMPLOYER ADDRESS LINE I AND LINE 2     STATE     ZIP     NATURE OF HIGHNESS     EMPLOYER ADDRESS LINE I AND LINE 2       EMPLOYER ADDRESS LINE I AND LINE 2     STATE     ZIP     PHONE NTATALES     EMPLOYER ADDRESS LINE I AND LINE 2       EMPLOYER LAST NAME     PHONE NTATALES     CODE     PHONE NTATALES     EMPLOYER ADDRESS LINE I AND LINE 2       MARE     PHONE NTATALES     MALE     SCAMONAL     PHONE NTATALES     SCAMONAL       MARE     PHONE NTATALES     MALE     ADPRENTICE PHILINE     AMPLOYER ADDRESS LINE I AND LINE 2       MARE     PHONE NTATALES     NOTICE OF SIGNAL     PHONE NTATALES     SCAMONAL       MARE     PHONE NTATE     NATURE OF NULLY     NOTICE OF SIGNAL       NOTICE PHONE     STATE <td>SAI</td> <td colspan="5"></td> <td colspan="3"></td> <td colspan="4"></td>	SAI															
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PROVIDE ASSISTANCE. CALL 1-800-352-2667 (TDD).      CLAM HANDLING OPPICE ADDRESS LINE 1 AND LINE 2      CTY STATE ZP      CTY STATE ZP      INFORMATION OF READRESS LINE 1 AND LINE 2      INFORMATION OF READR	с Г															
Begins         During of the state         During of the state         During of the state         During of the state           000000000000000000000000000000000000		CLAINS ADJUSTER NAME					CLM5 ADJ PHONE #									
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ADDOD       INSTRED NAME (PARENT CO. IF DIFFERENT THAN       FOLCY NUMBER       EFE DATE       FULL TIME REGULAR         BINDOYER)       FULL TIME REGULAR       FULL TIME REGULAR       FULL TIME REGULAR         BINDOYER)       FUNDATE       FULL TIME REGULAR         FURDATE       FUNDATE       FULL TIME REGULAR         FURDATE       FUNDATE       FULL TIME REGULAR         FURDATE       FUNDATE       FUNDATE         FUNDATE       FUNDATE       FUNDATE         FUNDATE       FUNDATE       FUNDATE         FUNDATE       FUNDATE       FUNDATE         ADREESTING       MARENT       FUNDATE         FUNDATE       FUNDATE       FUNDATE         ADREESTING       TATE       ZIP         NORED       FUNDATE       SUPARATED         SN       DATE OF BINTH       DATE OF HIRE       FUNDATE         SN       DATE OF BUNNY       NUMBER OF DAYS WORKED PER       SUPARATED         DATE OF INURY       HARE OF INURY       TIME OF INURY       SUP	~	EMPLOYER NAME EMPLOYER						OYER F	EIN	SIC	CODE			PHON	E NUMBER	
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Borloyter, Nome       SRLF INSURED?       ENP DATE       HARDARE         Borloyter, LAST NAME       PHONE INCLAREA CODE       GENDER       HART TIME         Borloyter, LAST NAME       PHONE INCLAREA CODE       GENDER       HART TIME         Borloyter, LAST NAME       PHONE INCLAREA CODE       GENDER       HART TIME         Borloyter, LAST NAME       PHONE INCLAREA CODE       GENDER       HART TIME         ADBRESS LINE I & 2       OCCUPATION NON       APPRENTICE FART TIME         CTTY       STATE       ZIP       MARRED, SINGLE,       BEFARTION         SN       DATE OF BIRTH       DATE OF HIRE       DIVORCED       INNAMEND IN CELLARS CODE         SN       DATE OF BIRTH       DATE OF HIRE       DIVORCED       INNAMEND IN CELLARS CODE         SN       DATE OF INURY       BUEKELY       WEEK       SALARY CONTINUED IN LEU OF COMENSATION       YES INO         DATE OF INURY       BUREKELY       NUMBER OF DAYS WORKED PER       SALARY CONTINUE IN CLUD IN COMENSATION       YES INO         DATE OF INURY       BUREKELY       NUMER OF INURY       AM I PM       THE EMPLOYEE BEGAN WORK ON INURY OR LINES AND CODE       CALES OF INURY CODE       CALES OF INURY CODE         DATE OF INURY       BODY PART APECTED CODE       NATURE OF INURY CODE       CALES OF INURY CODE	ΕN	CITY				STATE ZIP		ZIP		INS	INSURED REPORT		г #		IPLOYER LOCATION	
Borloyter, Nome       SRLF INSURED?       ENP DATE       HARDARE         Borloyter, LAST NAME       PHONE INCLAREA CODE       GENDER       HART TIME         Borloyter, LAST NAME       PHONE INCLAREA CODE       GENDER       HART TIME         Borloyter, LAST NAME       PHONE INCLAREA CODE       GENDER       HART TIME         Borloyter, LAST NAME       PHONE INCLAREA CODE       GENDER       HART TIME         ADBRESS LINE I & 2       OCCUPATION NON       APPRENTICE FART TIME         CTTY       STATE       ZIP       MARRED, SINGLE,       BEFARTION         SN       DATE OF BIRTH       DATE OF HIRE       DIVORCED       INNAMEND IN CELLARS CODE         SN       DATE OF BIRTH       DATE OF HIRE       DIVORCED       INNAMEND IN CELLARS CODE         SN       DATE OF INURY       BUEKELY       WEEK       SALARY CONTINUED IN LEU OF COMENSATION       YES INO         DATE OF INURY       BUREKELY       NUMBER OF DAYS WORKED PER       SALARY CONTINUE IN CLUD IN COMENSATION       YES INO         DATE OF INURY       BUREKELY       NUMER OF INURY       AM I PM       THE EMPLOYEE BEGAN WORK ON INURY OR LINES AND CODE       CALES OF INURY CODE       CALES OF INURY CODE         DATE OF INURY       BODY PART APECTED CODE       NATURE OF INURY CODE       CALES OF INURY CODE		INCLIDED NAM			ENT THAN				DED							
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	POL									EXP DATE				PART TIME		
PB000     Image: market m										GENDER						
Image:		EMPLOYEE LAST NAME					THONE	ince .	AREA CODE							
ADRRESS LINE 1 & 2     OCCUPATION DESCRIPTION     ON ONE DATE OF INURY     OATE OF INURY		FIRST				MI	MI DEPARTME		T REGULARLY							
CITI       DATE	EE					WORKED		ED		UNKNOWN				ENTICE PAR	T TIME	
CITI       DATE	LOY	ADRRESS LINE	1&2							OCCUPATI	ON DESCRIF	PTION	ſION			
SSN     DATE OF BIRTH     DATE OF HIRE     DIVORCED     UNKNOWN       BY     WAGE     PERIOD     WEEKLY     NUMBER OF DAYS WORKED PER     SALARY CONTINUED IN LIEU OF COMPENSATION     YES     NO       BY     HOURLY     BH-WEEKLY     NUMBER OF DAYS WORKED PER     SALARY CONTINUED IN LIEU OF COMPENSATION     YES     NO       DATE OF INJURY     DATE OF INJURY     MONTHLY     MONTHLY     MONTHLY     TIME OF INJURY     AM     PM       DATE OF INJURY     DATE OF INJURY     IDATE OF INJURY     IDATE OF INJURY     AM     PM     TIME EMPLOYEE BEGAN WORK ON INJURY DATE       DATE OF INJURY     DATE OF INJURY     BOBY PART AFFECTED CODE     NATURE OF INJURY CODE     CAUSE OF INJURY CODE       DATE CALMA DAN NOTIFIED OF INJURY     HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE INCIDENT INCLUDING WHAT THE EMPLOYEE WAS DOING       DATE OF DEATH (IF APPLICABLE)     HOW INJURY OF ITHE PART OF THE BODY AFFECTED AND HOW, AND OBJECT OR SUBSTANCE THAT DIRECTLY       HARMED THE EMPLOYEE.     DAUGHTER     SISTER     TOTAL # DEPENDENTS       DATE OF DEATH (IF APPLICABLE)     IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP     TOTAL # DEPENDENTS       IDID INJURY/ILLNESS OCCUR ON EMPLOYER'S     WIDOW     FATHER     SISTER     TOTAL # DEPENDENTS       PHYSICIAN NAME     HOOPYLICABLE     IDI ONURKY/ILLNESS OCCUR ON EMPLOYER'S     HOUDWER     SIO	EMF	CITY				STATE ZIP				MARITAL		M	NCCI CLASS CODE			
VAGE       PERIOD       WEEKLY       NUMBER OF DAYS WORKED PER       SALARY CONTINUED IN LIEU OF COMPENSATION       YES       NO         P       BOW       BOWERLY       NUMBER OF DAYS WORKED PER       SALARY CONTINUED IN LIEU OF COMPENSATION       YES       NO         P       DATE OF INJURY       HOURLY       BOWERLY       NUMBER OF DAYS WORKED PER       SALARY CONTINUED IN LIEU OF COMPENSATION       YES       NO         DATE OF INJURY       DATE OF INJURY       TIME OF INJURY       IMM ONTIFIED OF INJURY       BODY PART AFFECTED CODE       NATURE OF INJURY CODE       CAUSE OF INJURY CODE       CAUSE OF INJURY CODE         DATE CLAIM ADM NOTIFIED OF INJURY       BODY PART AFFECTED CODE       NATURE OF INJURY CODE       CAUSE OF INJURY CODE       CAUSE OF INJURY CODE         DATE CLAIM ADM NOTIFIED OF INJURY       HOW INJURY OR ILLNESS OCCURED. DESCRIBE THE INCLUDENT INCLUDING WHAT THE EMPLOYEE WAS DOING JUST BEFORE, THE PART OF THE BODY AFFECTED AND HOW, AND OBJECT OR SUBSTANCE THAT DIRECTLY         HARMED THE EMPLOYER       HOW INJURY OR ILLNESS OCCURED.       LINES ACCURED.       INTOTAL # DEPENDENTS FOR EACH RELATIONSHIP         DATE OF DEATH (IF APPLICABLE)       IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP       TOTAL # DEPENDENTS         PREMISES?       YES       NO       MOTHER       SSITER       TOTAL # DEPENDENTS         DATE OF DEATH (IF APPLICABLE)       IF D												LE,	=			
B       BOURLY       BI-WEEKLY       WEEK       FULL WAGES PAID FOR DATE OF INJURY       VES       NO         DATE OF INJURY       DATE OF INJURY       IMME OF INJURY       AM       PM       TIME EMPLOYEE BEGAN WORK ON INJURY DATE         DATE OF INJURY       DATE OF INJURY       BODY PART AFFECTED CODE       NATURE OF INJURY CODE       CAUSE OF INJURY CODE         DATE CLAIM ADM 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 OCCURED. 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.       HARMED THE EMPLOYEE.       NO         DATE DISABILITY BEGAN       RETURN TO WORK DATE (IF APPLICABLE)       IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP         DATE OF DEATH (IF APPLICABLE)       IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP       TOTAL # DEPENDENTS         DATE OF DEATH (IF APPLICABLE)       IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP       TOTAL # DEPENDENTS         DATE OF DEATH (IF APPLICABLE)       IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP       SON HEARDTHER         DATE OF DEATH (IF APPLICABLE)       IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP       SON HEARDTHER         PHYSICIAN NAME       ADDRESS		SSN			DATE OF	BIRTH	DA	ATE OF	HIRE	DIVO	RCED		L UN	IKNOWN		
B       BOURLY       BI-WEEKLY       WEEK       FULL WAGES PAID FOR DATE OF INJURY       VES       NO         DATE OF INJURY       DATE OF INJURY       IMME OF INJURY       AM       PM       TIME EMPLOYEE BEGAN WORK ON INJURY DATE         DATE OF INJURY       DATE OF INJURY       BODY PART AFFECTED CODE       NATURE OF INJURY CODE       CAUSE OF INJURY CODE         DATE CLAIM ADM 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 OCCURED. 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.       HARMED THE EMPLOYEE.       NO         DATE DISABILITY BEGAN       RETURN TO WORK DATE (IF APPLICABLE)       IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP         DATE OF DEATH (IF APPLICABLE)       IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP       TOTAL # DEPENDENTS         DATE OF DEATH (IF APPLICABLE)       IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP       TOTAL # DEPENDENTS         DATE OF DEATH (IF APPLICABLE)       IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP       SON HEARDTHER         DATE OF DEATH (IF APPLICABLE)       IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP       SON HEARDTHER         PHYSICIAN NAME       ADDRESS		WAGE	PERIOD	Πw	FEKI V	NU	MBER OF	DAVS	WORKED PER	SALARYC	ONTINUED	INTE	UOECO	MPENSATI		
ADTE OF INJURY       IMC OF INJURY	GE	\$														
VOUCTOOL     Image: Could not be determined     Image: Could not be determi	WA							FULL WAG		ULL WAGES FAID FOR DATE OF INJUR			ES INO			
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## FORM C-42

TENNESSEE BUREAU OF WORKERS' COMPENSATION



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.
  - o 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.
  - o If you refuse to accept medical services from the chosen physician, your rights to benefits may be delayed.

EMPLOYEE'S CHOICE OF PHYSICIAN

Medical Panel

- 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 F	Provided		
Employer Germantown Municip	al School District Da	te of Injury		
Employer Contact Gina Eddlema	nPhone901-752-7890	Email		
Physician 1 Name GMSD Health and Wellness Center Phone 901-334-0320	Physician 2 <sub>Name</sub> Nova Medical Center Phone 901-620-3900	Physician 3 Name Methodist Minor Medical Center Phone 901-758-6035 Address 8035 Club Parkway		
Address 7655 Poplar Ave., Suite 385	Address 3965 S. Mendenhall, Suite 20			
City Germantown State TN Zip 38138 Is Telehealth available with Physician #1? Yes No • If yes, web address	City Memphis State TN Zip 38115 Is Telehealth available with Physician #2? Yes No • If yes, web address	City Cordova State TN Zip 38016 Is Telehealth available with Physician #3? Yes No • If yes, web address		
	lame <u>NA</u> Web addre			
TO BE COMPLETED BY THE EMP I have selected the following physician f Physician Name	LOYEE: rom the list provided to me by my emplo	oyer:		
I select: In-person treatment <b> or</b> Trea	tment by Telehealth 🔲 Were you offere	ed in-person treatment? Yes 📃 No 📃		

LB-0382 (REV 10/21)

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

I,chose <u>not</u> to seek medi	cal attention:
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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 Accident Report

Staff completing report:		
School:		
Date of Incident: Location of the incident:	Time of Incident:	
Person(s) <u>injured</u> in the incident: Staff		
	Student	
Detailed description of the inciden	it:	
Immediate action in responding to	o the incident:	
Witnesses to the incident:		

	Reporting Staff Member's Signature:						
Injured Staff Member's Signature:							
	e of individual notified						
Was a parent or other individual notified?   Yes   No     When?    Phone #							
Imme	Sent to hospital	By (Name) ne of hospital					
diate Action Taken	First Aid treatment Sent to school nurse Sent home Sent to physician Physician	By (Name) By (Name) By (Name) By (Name) sician's Name					
	Teacher in charge when accident occurred. (Enter Name): Present at scene of accident: Yes No						
Nature of Injury	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)	Eud for Eud for Eud					
	Abrasion   Fracture     Amputation   Laceration     Bite   Poisoning						