



CLAIMS ADM/CARRIER	JURISDICTION		CLAIM				THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF									
	CLAIMS ADM CLAIM # (INSURER CLAIM #)						☐ INDEMNITY ☐ BECAME LOST TIME ☐ BECAME MED ONLY ☐ NOTIFY ONLY			TENNESSEE WORKERS' COMPENSATION LAW AND MUST BE COMPLETED AND FILED WITH YOUR INSURANCE CARRIER						
	OSHA LOG CASE #									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						
	NAME OF INSURANCE CARRIER					TRANSFER CARRIER FEIN										
	CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM								FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.							
	CLAIMS ADMIN CARRIER)		FEIN OF CLMS				IF YOU HA	AVE QUEST	TONS, T	ONS, THE STATE NOW HAS A BENEFIT R WORKERS' COMPENSATION SPECIALIST						
	CLAIMS ADJUS		CLMS ADJ PHO				PROVIDE A						CAN			
	CLAIM HANDL	NE 2	E 2					CITY			STATE ZIP					
E MPLOYER	EMPLOYER NA		EMPLC	EIN		SIC CODE			PHONE NUMBER		E NUMBER					
	EMPLOYER ADDRESS LINE 1 AND LINE 2									NAT			URE OF BUSINESS			
	CITY	STATE ZIP					INSURED REPORT		RT#		EM	PLOYER LOCATION				
	INSURED NAME (PARENT CO. IF DIFFERENT THAN													AND OVER THE CITE A TOY OF CORD		
POLICY	EMPLOYER)						EFF DATE			FULL 1	MPLOYMENT STATUS CODE FIME/REGULAR					
					ES NO		EXP DATE		_ □		WORKER					
EMPLOYEE	EMPLOYEE LAST NAME					PHONE INCL			E	GENDER MALE			SEASO VOLUI	ONAL INTEER		
	FIRST					MI DEPARTMEN WORKED			T REGULARLY		FEMALE UNKNOWN		APPRENTICE FULL TIME APPRENTICE PART TIME			
	ADRRESS LINE 1 & 2					- Words				OCCUPATION DESCRIPTION						
	CITY					STATE ZIP				MARITAL S			=	RRIED		
	SSN DATE OF				BIRTH DATE OF			HIRE	UNMARRIE DIVORCEI			_ =		ARATED KNOWN		
	WAGE PERIOD WEEKLY \$ HOURLY BI-WEEKLY DAILY MONTHLY					NUMBER OF DAYS WORKE WEEK			WORKED PER		SALARY CONTINUED IN LIEU OF COMPENSATION YES NO					
WAGE										FULL WAG	ES PAID FO	OR DATE OF INJURY YES NO				
ACCIDENT/INJURY	DATE OF INJURY					TIME OF INJURY				M PM	TIME EM	MPLOYEE BEGAN WORK ON INJURY DATE				
	DATE EMPLOYER NOTIFIED OF INJURY					BODY PART AFFECTED					NATURE OF INJURY CODE			AM PM CAUSE OF INJURY CODE		
	DATE CLAIM ADM NOTIFIED OF INJURY					HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE INCIDENT INCLUDING WHAT THE EMPLOYEE W										
	DATE LAST DAY WORKED					JUST BEFORE, THE PART OF THE BODY AFFECTED AND HOW, AND OBJECT OR SUBSTANCE THAT DIRECTLY HARMED THE EMPLOYEE.										ECTLY
	DATE DISABILITY BEGAN															
	RETURN TO WORK DATE (IF APPLICABLE)															
	DATE OF DEATH (IF APPLICABLE)					IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP										
	DID INJURY/ILLNESS OCCUR ON EMPLOYER'S					WIDOW WIDOWER			FATE DA		HER SISTE .UGHTER BROT				TOTAL # DEPENDENTS	
	PREMISES? YES NO					MOTHER			SO				D CHI		Corpus of human	
	ADDRESS WHERE INJURY OCCURRED (IF OTHER							CITY	· · · · · · · · · · · · · · · · · · ·			ZIP			COUNTY OF INJURY	
TREATMENT	PHYSICIAN NAME							HOSPITAL OR OFF SITE TREATMENT NAME								
	ADDRESS LINE							SS LINE	S LINE 1 AND 2							
	CITY STATE			ZIP			CITY				STA		ATE	TE ZIP		
ŢŢ				DR BY EMPLOYER			=		D > 24 HRS	_	FUTURE MAJOR MED		ICAL/LOST TIME			
~	DATE PREPARED PREPARER'S NA.					Y CLINIC/HOSPITAL ME & TITLE			GENCY R'S COM	CARE IPANY NAME	AN PHONE	TICIPA NUME				
OTHER																