TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

EMPLOYER'S FIRST REPORT OF WORK INJURY OR ILLNESS

CLAIMS ADM/CARRIER

Field	Value
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	Preferred Professional Insurance Co
CARRIER FEIN	47-0580977
CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)	Vericlaim, Inc.
FEIN OF CLMS ADM	36-3105904
CLAIMS ADJUSTER NAME	Jhonna Ghrigsby
CLMS ADJ PHONE #	615-590-1550 X2203
CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2	131 Saundersville Road, Suite 220
CITY	Hendersonville
STATE	TN
ZIP	37075

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).

EMPLOYER

Field	Value
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

Field	Value
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

Field	Value
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
NCCI CLASS CODE	
SSN	
DATE OF BIRTH	
DATE OF HIRE	

WAGE

Field	Value
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

Field	Value
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	
DATE LAST DAY WORKED	
DATE DISABILITY BEGAN	
RETURN TO WORK DATE (IF APPLICABLE)	
DATE OF DEATH (IF APPLICABLE)	
DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES?	☐ YES ☐ NO

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.

IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP: ☐ WIDOW ☐ WIDOWER ☐ MOTHER ☐ FATHER ____ DAUGHTER ____ SON ____ SISTER ____ BROTHER ____ HANDICAPPED CHILD — TOTAL # DEPENDENTS

Field	Value
ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)	
CITY	
STATE	
ZIP	
COUNTY OF INJURY	

TREATMENT

Field	Value
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

LB-0021 (REV. 12/07)

RDA 10183