

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

C20

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><i>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.</i></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>		
	CLAMS ADM CLAIM # (INSURER CLAIM #)		CARRIER FEIN				
	OSHA LOG CASE #		FEIN OF CLMS ADM				
	NAME OF INSURANCE CARRIER		CLMS ADJ PHONE #				
	CLAIMS ADMIN FIRM NAME (if different from carrier)		CITY			STATE	ZIP
	CLAIMS ADJUSTER NAME		CITY			STATE	ZIP
	CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2		CITY			STATE	ZIP
E EMPLOYER	EMPLOYER NAME		EMPLOYER FEIN		SIC CODE	PHONE NUMBER	
	EMPLOYER ADDRESS LINE 1 AND LINE 2		NATURE OF BUSINESS				
	CITY	STATE	ZIP	INSURED REPORT NUMBER	EMPLOYER LOCATION #		
POLICY	INSURED NAME (parent co. if different than employer)		POLICY NUMBER		EFF DATE	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"/> VOLUNTEER <input type="checkbox"/> APPRENTICE FULL TIME <input type="checkbox"/> APPRENTICE PART TIME	
	SELF INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO		EXP DATE				
EMPLOYEE	EMPLOYEE LAST NAME		PHONE INCL AREA CODE		GENDER	OCCUPATION DESCRIPTION	
	FIRST	MI	DEPARTMENT REGULARLY WORKED		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN		
	ADDRESS LINE 1 & 2		MARRIAGE STATUS <input type="checkbox"/> UNMARRIED, SINGLE, DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN				
	CITY	STATE	ZIP	NCCI CLASS CODE			
	SSN	DATE OF BIRTH	DATE OF HIRE				
WAGE	WAGE \$	PERIOD <input type="checkbox"/> HOURLY <input type="checkbox"/> DAILY	<input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> MONTHLY	NUMBER OF DAYS WORKED PER WEEK	SALARY CONTINUED IN LIEU OF COMPENSATION <input type="checkbox"/> YES <input type="checkbox"/> NO		
					FULL WAGES PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO		
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		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 <input type="checkbox"/> WIDOW <input type="checkbox"/> FATHER <input type="checkbox"/> SISTER <input type="checkbox"/> DAUGHTER <input type="checkbox"/> BROTHER <input type="checkbox"/> MOTHER <input type="checkbox"/> SON <input type="checkbox"/> HANDICAPPED CHILD TOTAL # DEPENDENTS				
	DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> 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 <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	<input type="checkbox"/> FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED			
OTHER	DATE PREPARED	PREPARER'S NAME & TITLE		PREPARER'S COMPANY NAME	PHONE NUMBER		