

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



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>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.</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>		
	CLAIMS ADM CLAIM # (INSURER CLAIM #)		CARRIER FEIN 22-3590451				
	OSHA LOG CASE #		FEIN OF CLMS ADM 56-2060285				
	NAME OF INSURANCE CARRIER STARNET INSURANCE COMPANY		CLMS ADJ PHONE # (800) 942-0225				
	CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER) KEY RISK MGMT SERVICES		CITY Brentwood				
	CLAIMS ADJUSTER NAME		STATE TN				
CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2 5301 Virginia Way, Suite 250		ZIP 37027					
EMPLOYER	EMPLOYER NAME SOUTHERN ADVENTIST UNIVERSITY		EMPLOYER FEIN 62-0536733		SIC CODE 8221	PHONE NUMBER 423.236.2566	
	EMPLOYER ADDRESS LINE 1 AND LINE 2 ATTN: RISK MANAGEMENT 4881 TAYLOR CIRCLE				NATURE OF BUSINESS HIGHER EDUCATION		
	CITY COLLEGEDALE		STATE TN	ZIP 37315		INSURED REPORT #	EMPLOYER LOCATION
POLICY	INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)		POLICY NUMBER KEY0137735		EFF DATE 07/01/2018	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 07/01/2019		
EMPLOYEE	EMPLOYEE LAST NAME		PHONE INCL AREA CODE		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN		
	FIRST	MI	DEPARTMENT REGULARLY WORKED		OCCUPATION DESCRIPTION		
	ADDRESS LINE 1 & 2		CITY		STATE	ZIP	MARITAL STATUS <input type="checkbox"/> UNMARRIED, SINGLE, DIVORCED
	CITY		STATE	ZIP	MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN		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		
	DATE CLAIM ADM NOTIFIED OF INJURY		CAUSE OF INJURY CODE				
	DATE LAST DAY WORKED		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 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 PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> WIDOW	<input type="checkbox"/> FATHER	____ SISTER	TOTAL # DEPENDENTS	
		<input type="checkbox"/> WIDOWER	____ DAUGHTER	____ BROTHER			
		<input type="checkbox"/> MOTHER	____ SON	____ HANDICAPPED CHILD			
ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)						COUNTY OF INJURY	
CITY						STATE	
ZIP							
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"/> HOSPITALIZED > 24 HRS	<input type="checkbox"/> FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED		
		<input type="checkbox"/> MINOR BY CLINIC/HOSPITAL	<input type="checkbox"/> EMERGENCY CARE				
OTHER	DATE PREPARED	PREPARER'S NAME & TITLE		PREPARER'S COMPANY NAME		PHONE NUMBER	