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 ☐ MED ONLY ☐ INDEMNITY ☐ BECAME LOST TIME ☐ BECAME MED ONLY ☐ NOTIFY ONLY ☐ TRANSFER
CLAIMS ADM CLAIM # (INSURER CLAIM #)	
OSHA LOG CASE #	
NAME OF INSURANCE CARRIER: Public Entity Partners	CARRIER FEIN: 62-1074045
CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)	FEIN OF CLMS ADM: 59-2863407
CLAIMS ADJUSTER NAME: FAX 877-469-7611	CLMS ADJ PHONE #: 615-370-4180
CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2: 5100 Maryland Way	CITY: Brentwood · STATE: TN · ZIP: 37027

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

EMPLOYER NAME: Highland Rim Economic Corporation	EMPLOYER FEIN: 62-0757461
EMPLOYER ADDRESS LINE 1 AND LINE 2: PO Box 208	SIC CODE · PHONE NUMBER
CITY: Erin · STATE: TN · ZIP: 37061	NATURE OF BUSINESS: Community Action Agency
	INSURED REPORT # · EMPLOYER LOCATION

POLICY

INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)	POLICY NUMBER · SELF INSURED? ☐ YES ☐ NO
	EFF DATE: 7/01/2021 · EXP DATE: 06/30/2022

EMPLOYEE

EMPLOYEE LAST NAME	PHONE INCL AREA CODE
FIRST · MI	DEPARTMENT REGULARLY WORKED
ADRRESS LINE 1 & 2	
CITY · STATE · ZIP	
SSN · DATE OF BIRTH · DATE OF HIRE	

GENDER: ☐ MALE ☐ FEMALE ☐ UNKNOWN

EMPLOYMENT STATUS CODE: ☐ FULL TIME/REGULAR ☐ PART TIME ☐ PIECE WORKER ☐ SEASONAL ☐ VOLUNTEER ☐ APPRENTICE FULL TIME ☐ APPRENTICE PART TIME

OCCUPATION DESCRIPTION

MARITAL STATUS: ☐ UNMARRIED, SINGLE, DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN

NCCI CLASS CODE

WAGE

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

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: N/A · NATURE OF INJURY CODE: N/A · CAUSE OF INJURY CODE: N/A
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 ☐ WIDOW ☐ WIDOWER ☐ MOTHER ☐ FATHER ____ DAUGHTER ____ SON ____ SISTER ____ BROTHER ____ HANDICAPPED CHILD · TOTAL # DEPENDENTS
DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ 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 ☐ 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

C20