TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

C20 EMPLOYER'S FIRST REPORT OF WORK INJURY OR ILLNESS

CLAIMS ADM/CARRIER

JURISDICTION CLAIM # (STATE FILE #)

CLAMS 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

CARRIER FEIN

CLAIMS ADMIN FIRM NAME (if different from carrier)

FEIN OF CLMS ADM

CLAIMS ADJUSTER NAME

CLMS ADJ PHONE #

CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2

CITY | STATE | ZIP

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

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

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

EMPLOYEE LAST NAME

PHONE INCL AREA CODE

FIRST | MI

DEPARTMENT REGULARLY WORKED

ADRRESS LINE 1 & 2

GENDER
☐ MALE
☐ FEMALE
☐ UNKNOWN

OCCUPATION DESCRIPTION

CITY | STATE | ZIP

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

NCCI CLASS CODE

SSN | DATE OF BIRTH | DATE OF HIRE

WAGE

WAGE $

PERIOD
☐ HOURLY ☐ WEEKLY
☐ DAILY ☐ 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

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
☐ WIDOW ☐ FATHER ____ SISTER
☐ WIDOWER ____ DAUGHTER ____ BROTHER
☐ MOTHER ____ SON ____ 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' NAME & TITLE | PREPARER'S COMPANY NAME | PHONE NUMBER