AmTrust North America
An AmTrust Financial Company

Tennessee
Worker's Compensation
Claim Kit

(p) 888.239.3909 • (f) 678.258.8399 • www.amtrustfinancial.com

AmTrust North America
An AmTrust Financial Company

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EASY ONLINE CLAIMS REPORTING INSTRUCTIONS

By logging into AmTrust's web portal, policyholders can access a wide variety of account information including the ability to report injuries online. The following instructions will help get you started.

First Time Portal Access:

1. Go to www.amtrustnorthamerica.com
2. In the upper right corner of the home page, click "LOGIN"
3. In the subsequent AmTrust *Online* drop-down box, click the word "**Register**"
4. On the following screen, enter your policy number, zip code and the security code that appears on that screen and click "**Enter**" at the bottom right of the screen
5. Enter your email address, user name and password to complete the registration process
6. After completing the registration process, go back to www.amtrustnorthamerica.com and log in

Reporting of New Injuries:

1. Go to www.amtrustnorthamerica.com
2. Log in to "AmTrust ***Online***"
3. Click the "**Claims**" icon in the upper middle of your screen to view the screen that lists your policies
4. Click "**View**" next to the policy for which you wish to enter a claim. This brings you to the policy detail screen
5. Click on "**First Reports**" in the upper left corner
6. On the next screen, click "**Add**" to view the "**New First Report of Injury**" screen
7. Click "**Use WebForm**." This brings you to the screen where you will enter all of the detailed information about the injury/injured worker
8. When finished entering all of the data, click "**Submit**" and this report will channel into our intake center to be set up and assigned to a claims adjuster
9. Return to the "**First Reports"** screen and you will see the claim number for the report entered
10. When finished, click on "**Return to Listing**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

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Helpful Hints:

- "**Time Employee Began Work**" and "**Time of Occurrence**" must be entered in military time
- Enter the hours in the first box and the minutes in the second box
- All dates must be entered as two-digit day, two-digit month and four-digit year, i.e.: XX/XX/XXXX
- For PEOs, in the "**Location Address**" box, please include the PEO client name and address of the applicable PEO client location. If there is a location code/number, specify in the "**Location #**" box
- If during the entry of a claim you must exit the application, first click on "S**ave as Draft**" and you may return to it later by going back into the "**First Reports"** screen and clicking on "**In Progress**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

Thank you for your attention to this matter.

Sincerely,

AmTrust North
America Claims
Department

800 Superior Avenue E • 21st Floor • Cleveland, OH 44114
(p) 866.203.3037 • (f) 800.487.9654 • www.amtrustnorthamerica.com

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

CLAIMS ADM/CARRIER

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

CARRIER FEIN

CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER) AmTrust North America

FEIN OF CLMS ADM

CLAIMS ADJUSTER NAME

CLMS ADJ PHONE # 888-239-3909

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).

CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2 P.O. Box 94405

CITY Cleveland | STATE OH | ZIP 44101

EMPLOYER

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

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
- ☐ 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

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
- ☐ 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

STATE OF TENNESSEE
BUREAU OF WORKERS' COMPENSATION
220 FRENCH LANDING DRIVE NASHVILLE, TENNESSEE 37243-1002
(615) 741-2395 (800) 332-2667

NOTICE OF REPORTED INJURY

The Tennessee Bureau of Workers' Compensation has been notified you were injured on the job. **This notice does not mean that your claim has been accepted** or that you are eligible to receive benefits. This only confirms that **your claim has been reported** by your employer to its insurance company and to the Bureau.

Your employer should help you obtain all needed medical care related to your injury, at no cost to you, from a doctor you select from their approved list. The doctor selected becomes your authorized treating physician.

Your employer will also help you contact their workers' compensation insurance adjuster who will administer your claim and help you with your recovery. The adjuster's name and contact information are on a separate letter enclosed with this notice.

The adjuster has fifteen (15) calendar days (from the date you provided notice of your injury to your employer) to conduct an investigation and to either accept or deny your claim.

If your claim is accepted, you may be eligible to receive medical treatment including prescriptions, mileage reimbursement for attending appointments with your authorized treating physician and partial wage replacement benefits (also known as temporary disability benefits) as described in the enclosed "Beginner's Guide to Tennessee Workers' Compensation".

- If you are eligible for temporary total disability benefits, the first payment must be sent to you within fifteen (15) calendar days of when your disability begins (the date you are taken off work by your authorized treating physician) and then every subsequent payment must be made within the following fifteen (15) calendar days until you are allowed to return to work.
- If you are eligible for temporary partial disability benefits because your authorized treating physician allows you to continue to work but restrictions reduce the amount of money you earn, the payments must be sent as near as possible to the same schedule as your normal paychecks are paid.

If your claim is denied, the adjuster assigned to your claim will send you a Notice of Denial that provides the reason for the denial.

Most employers and adjusters provide all required benefits for an accepted claim, also known as "compensable" claim, without assistance from the Bureau. If you have questions about your claim, you should contact your employer and your adjuster first. If, after contacting your employer and your adjuster, you have questions or are not getting the benefits you are due, you can request assistance from the Bureau by calling (800) 332-2667. The Bureau will work with you, your employer, and your adjuster to help resolve any issues. The Bureau's role is to ensure workers' compensation claims are handled in a fair and professional manner and is available to assist you, if needed.

ESTADO DE TENNESSEE
OFICINA DE COMPENSACIÓN A TRABAJADORES
220 FRENCH LANDING DRIVE NASHVILLE, TENNESSEE 37243-1002
(615) 741-2395 (800) 332-2667

AVISO DE LESIÓN INFORMADA

Se ha informado a la Oficinal de Compensación a Trabajadores Tennessee de que usted sufrió una lesión en el trabajo. **Este aviso no significa que su reclamación ha sido aceptada** o que usted es elegible para recibir beneficios. Esto es solo una confirmación de que **su reclamación ha sido notificada** por su empleador a su empresa de seguros y a la Oficina.

Su empleador debe ayudarle a obtener toda la atención médica que necesite relacionada con su lesión, sin costo alguno para usted, proporcionada por un médico que usted seleccione de la lista de médicos autorizados. El médico que usted seleccione se convierte en su médico tratante autorizado.

Su empleador también le ayudará a comunicarse con el tasador del seguro de indemnización laboral quien administrará su reclamación y le ayudará en su recuperación. El nombre del tasador y su información de contacto se encuentran en una carta adjunta a este aviso.

El tasador dispone de quince (15) días calendario (a partir de la fecha en que notifique de su lesión a su empleador) para llevar a cabo una investigación y para aceptar o denegar su reclamación.

Si su reclamación es aceptada, podría ser elegible para recibir tratamiento médico, así como medicamentos recetados, reembolso de millaje para asistir a las citas con su médico tratante autorizado y beneficios de reemplazo parcial de su salario (también conocido como beneficios de discapacidad temporal), tal y como se describe en el folleto adjunto "Guía Informativa de Compensación a Trabajadores de Tennessee."

- Si usted es elegible para beneficios de discapacidad absoluta temporal, el primer pago tiene que enviársele en un plazo de quince (15) días calendario a partir del comienzo de su discapacidad (la fecha en que su médico tratante le indica una licencia) y luego cada uno de los pagos subsiguientes debe realizarse cada quince (15) días calendario hasta que se le permita volver a trabajar.
- Si es elegible para beneficios de discapacidad parcial temporal porque su médico tratante autorizado le permite continuar trabajando, pero le indicó restricciones que limitan sus ingresos, los pagos tienen que ser enviados lo más cercano posible al mismo esquema en que se paga su sueldo normal.

Si su solicitud es denegada, el tasador asignado a su reclamación le enviará una Notificación de denegación que indica el motivo de la denegación.

La mayoría de los empleadores y tasadores proporcionan todos los beneficios requeridos para una reclamación aceptada, también conocida como reclamación "indemnizable", sin asistencia de la Agencia. Si tiene alguna pregunta respecto a su reclamación, comuníquese con su empleador y su tasador primero. Si tras comunicarse con su empleador y su tasador, tiene alguna pregunta o no está recibiendo los beneficios que debiera recibir, puede solicitar asistencia a la Oficina llamando al (800) 332-2667. La Oficina colaborará con usted, su empleador y su tasador para ayudar a resolver cualquier problema. La función de la Oficina es asegurarse de que las reclamaciones de indemnización laboral sean atendidas de manera justa y profesional y está a su disposición para ayudarle, si fuera necesario.

테네시주 산재 보상국
220 FRENCH LANDING DRIVE NASHVILLE, TENNESSEE 37243-1002
(615) 741-2395 (800) 332-2667

보고된 산재 통지

테네시주 산재 보상국에서 귀하가 업무상 상해를 입었다는 통지를 받았습니다. **본 통지를 받았다고 해서, 귀하의 청구가 수락되었거나 귀하가 혜택을 받을 자격이 있음을 의미하지는 않습니다. 본 통지는 고용주가 보험사와 산재 보상국에 귀하의 청구를 보고했음을 확인하기 위한 목적으로만 제공됩니다.**

귀하의 고용주는 승인된 목록에서 선택한 의사로부터 귀하의 상해와 관련하여 필요한 모든 의료 서비스를 무료로 받을 수 있도록 도와야 합니다. 선택한 의사가 귀하의 승인받은 주치의가 됩니다.

또한, 귀하의 고용주가 귀하의 청구를 처리하고 귀하의 회복을 도와줄 산재 보상 보험 조정인에게 연락하는 데 도움을 드릴 것입니다.

조정인의 이름과 연락처 정보는 본 통지에 동봉된 별도의 서신에 포함되어 있습니다.

조정인은 (귀하가 고용주에게 상해에 대한 통지를 제공한 날짜로부터) 15일 이내에 조사를 수행하고 청구를 수락하거나 거부할 수 있습니다.

귀하의 청구가 수락되는 경우, 동봉된 "테네시주 산재 보상에 대한 초보자 안내서"에 설명된 대로 처방, 승인받은 주치의로부터 받는 진료에 대한 교통비 환급 및 부분 임금 대체 급여(임시 장애 급여라고도 함)을 포함한 진료를 받을 자격이 있을 수 있습니다.

- 귀하가 임시 총 장애 급여를 받을 자격이 있는 경우, 장애가 시작된 날(귀하의 승인받은 주치의가 지시한 휴가 시작 날짜)로부터 15일 이내에 첫 번째 지급금을 귀하에게 보내야 하며 이후의 모든 지급금은 귀하가 업무에 복귀할 수 있을 때까지 역일 기준으로 다음 15일 이내에 제공되어야 합니다.
- 승인받은 주치의가 계속 업무를 수행할 수 있도록 허용했지만 제한 사항으로 인해 수입이 감소하여 임시 부분 장애 급여를 받을 자격이 있는 경우, 해당 급여는 정상 급여가 지급되는 일정과 최대한 비슷한 일정으로 제공되어야 합니다.

귀하의 청구가 거부되는 경우, 귀하의 청구에 배정된 조정인이 귀하에게 거부 사유를 제공하는 거부 통지를 보내드릴 것입니다.

대부분의 고용주와 조정인은 승인된 청구(“보상 가능” 청구라고도 함)에 대해 산재 보상국의 도움 없이 필요한 모든 혜택을 제공합니다. 청구에 대해 궁금한 점이 있는 경우, 먼저 고용주와 조정인에게 문의해야 합니다. 고용주와 조정인에게 문의한 후에도 궁금한 점이 있거나 마땅히 받아야 할 혜택을 받지 못하는 경우, 산재 보상국에 (800) 332-2667번으로 전화하여 도움을 요청할 수 있습니다. 산재 보상국은 귀하, 고용주, 조정인과 협력하여 문제를 해결할 수 있도록 도울 것입니다. 산재 보상국의 역할은 산재 보상 청구가 공정하고 전문적으로 처리되고 필요 시 귀하를 지원하는 것입니다.

Tennessee Department of Labor and Workforce Development;
Authorization number 337586, July 2022. This document was promulgated for electronic use only.

OPTUM®

AmTrust North America
An AmTrust Financial Company

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM®

AmTrust North America
An AmTrust Financial Company

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
CARRIER/TPA

EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER

DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-1614-109-FFWG

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AMTRUST NORTH AMERICA
PORTADORA — EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL — FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1614-109-FFWG

RETURN-TO-WORK; A **GREAT** IDEA

We at the AmTrust Group, are convinced that an employer who provides light, or restricted work for injured employees, enjoys numerous benefits. This is not just an opinion, it's something we see day in and day out. Consider:

- Unless an injured worker returns to the workplace within 60 days, chances of him/her ever returning drop dramatically. (resulting in a very expensive permanent disability situation.)
- After 6 months away from the workplace, only 50% chance of return.
- After 12 months, only a 10% chance of return.

Some Return-to Work Benefits Include:

- "Test" of malingering potential. Injured employees who refuse light duty are more prone to being malingerers.
- Opportunity for employer to demonstrate true concern for workers' well-being.
- Promotion of rehabilitation and recovery.
- Lower medical and rehabilitation costs.
- Productivity.
- Morale improvement for the injured worker.
- Ability for the employer to monitor the injured employee's recovery progress.
- Decrease of WC claims costs, with resultant downstream WC premium savings.

(Notice we're not just talking about 'feel-good' issues, but also hard dollars !)

Some common misconceptions (and truths) about Return-to-Work / Light Duty:

Misconception: *We've already got too many "programs" around here, and don't need any more paper*.

Truth: While it is true a written, planned program works best, in many cases a Light Duty "program" can be nothing more than a management understanding of the benefits and principles of Return-to-Work, how it works, and the commitment to 'just do it', when light-duty recommendations are made by WC physicians.

Misconception: *It will get me into an Americans With Disabilities (ADA) "situation".*

Truth: Light-duty and ADA "reasonable accommodation" are two entirely separate issues. Generally, light duty is a temporary assignment, for a relatively short period. ADA accommodations are made for serious, permanent disabilities that impair major life activities.

Misconception*: I'll have to devise a whole new job each time an employee needs light duty.*

Truth: The vast majority of light-duty restrictions require accommodating only one or two factors, such as "no lifting over 10 pounds", or the like. In many cases, if you break the jobs down into individual **tasks**, you'll see that only one or two tasks within the employee's normal job are affected, and can be handled in some other way.

Misconception: *Once an employee gets into a "cushy" light-duty job, s/he'll never leave it, and I'll be stuck with it.*

Truth: Light duty is always defined by, and monitored by the attending physician. An employee on light duty is periodically monitored by the physician for improvement, and is released for full-duty as soon as medically indicated.

Misconception: *We're a union company. Our union won't allow us to pay lower rates, or move employees between classifications, or between bargaining groups.*

Truth: Any Local that objects to a Return-to-Work program should be referred to its national body for guidance. Return to Work is universally recognized as a very positive influence on an injured worker (as well as benefiting the employer). Labor unions, whose major purpose for existence is the benefit of the workers they represent, should not only "tolerate" Return-to-Work programs, but enthusiastically promote, and assist in such programs' implementation and operation. It is strongly suggested that management approach labor representatives to solicit their input, and assistance in making Return to Work a positive force in your workplace.

Misconception: *I might be willing to place a worker in a light-duty position, but I can't afford pay them their full pay, for the decreased productivity.*

Truth: Talk to your WC insuror's claims professional. In many cases, states' WC plans provide for "make-up" pay to replace some, or all of the injured employees' decreased earnings. The goal of getting them back to the workplace, and doing some productive work is that important!

TENNESSEE WORKERS' COMPENSATION INSURANCE

POSTING NOTICE

How to Report Work-Related Injuries

What should be done if injured at work?

Employee

1. Immediately **report the injury** to the employer representative named below.
2. **Select a treating physician** from a panel provided by your employer.
3. If you have questions or problems, contact the employer representative or the Bureau of Workers' Compensation.

Employer

1. Complete your company's internal "Workplace Injury form" and **notify your workers' compensation insurance company** immediately, even if you have concerns about the validity of the claim.
2. **Offer a panel of physicians** to the employee via Form C-42 available on the Bureau's website. *In cases of emergency, call an ambulance and provide this form as soon as the injured employee has stabilized.*

_____

*Printed **name and title** of the employer representative to be notified in the event of a work-related injury*

_____

*Printed name of an **alternative employer representative** to be notified in the event of a work-related injury*

_____

***Telephone number** of employer representative to notify in event of a work-related injury*

_____

***Address** of employer representative to notify in event of a work-related injury*

The Tennessee Bureau of Workers' Compensation is available to help both employees and employers.

BWC Bureau of WORKERS' COMPENSATION

220 French Landing Dr. 1-B
Nashville, TN 37243-2667

800-332-2667

615-532-4812 *TTD: 800-332-2257*

tn.gov/workerscomp

Workers' Compensation law requires this notice to be posted in a conspicuous place at the work site at all times.

(REV. 4/18) Authorization No. 337545 RDA 10183

SEGURO DE COMPENSACIÓN A TRABAJADORES DE TENNESSEE

PUBLICACIÓN DE AVISO

Cómo informar de lesiones laborales

¿Qué se debe hacer en caso de lesión laboral?

Empleado

1. **Informe** inmediatamente de **la lesión** al representante del empleador indicado aquí abajo.
2. **Seleccione un médico tratante** del panel provisto por su empleador.
3. Si tiene alguna pregunta o problema, comuníquese con el representante de empleadores de la Oficina de Compensación a Trabajadores.

Empleador

1. Complete el formulario interno de su empresa de "Lesión laboral" y **notifique a su aseguradora de compensación a trabajadores** inmediatamente, incluso aunque tenga dudas acerca de la validez de la reclamación.
2. **Ofrezca un panel de médicos** al empleado a través del Formulario C-42, disponible en el sitio web de la Agencia. *En casos de emergencia, llame a una ambulancia y proporcione este formulario en cuanto el empleado lesionado se haya estabilizado.*

_____

Nombre en letra de molde y título *del representante del empleador a ser notificado en caso de una lesión laboral*

_____

Nombre en letra de molde del ***representante del empleador alterno*** *a ser notificado en caso de una lesión laboral*

_____

Número de teléfono *del representante del empleador a ser notificado en caso de una lesión laboral*

_____

Dirección *del representante del empleador a ser notificado en caso de una lesión laboral*

La Oficina de Compensación a Trabajadores de Tennessee está disponible para ayudar a empleados y empleadores.

BWC Bureau of WORKERS' COMPENSATION

220 French Landing Dr. 1-B
Nashville, TN 37243-2667
800-332-2667
615-532-4812 *TTD: 800-332-2257*
tn.gov/workerscomp

La ley de Compensación a Trabajadores exige que se publique este aviso en un lugar visible en el centro de trabajo en todo momento.

(REV. 4/18) Autorización No. 337545 RDA 10183

Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002

FORM C-41

WAGE STATEMENT

EMPLOYEE: _____ SSN: _____ STATE FILE #:_____

Employer _____ Ins Claim # _____ Date of Injury: _____

Please list the wages earned by the employee named above during each of the 52 weeks prior to date of injury, if applicable.

WEEK	WEEK ENDING	GROSS WAGES	WEEK	WEEK ENDING	GROSS WAGES
1			27		
2			28		
3			29		
4			30		
5			31		
6			32		
7			33		
8			34		
9			35		
10			36		
11			37		
12			38		
13			39		
14			40		
15			41		
16			42		
17			43		
18			44		
19			45		
20			46		
21			47		
22			48		
23			49		
24			50		
25			51		
26			52		
				TOTAL PAID	$0.00

Date: _____ Name of Preparer and Title _____

FORM C-33

TENNESSEE BUREAU OF WORKERS' COMPENSATION
220 French Landing Dr., 1B
Nashville, Tennessee 37243-1002
tn.gov/workerscomp

CASE MANAGEMENT NOTIFICATION

EMPLOYEE INFORMATION

State File # _____ Date of Injury _____ Social Security # _____
Claimant _____

EMPLOYER INFORMATION

FEIN: _____ Employer: _____
Street: _____ City: _____ State: _____ Zip: _____

INSURER INFORMATION

Insurer: _____
Insurer Address: _____
Insurer Claim #: _____ Policy Number: _____

CASE MANAGEMENT ELECTION

☐ Proof of notification has been provided to employee that employer has elected to use Case Management.

PROVIDER INFORMATION

Case Management Provider _____ I.D. # _____
Case Management Provider Address _____
_____
_____

CASE MANAGER INFORMATION

Case Management Provider Phone # _____
Date Case Manager received referral _____
Date Face to Face Meeting took place between CM and Employee
_____
Case Manager _____ TN CM Registration # _____
Comments _____
_____

Tennessee Bureau of Workers' Compensation
220 French Landing Drive, 1-B
Nashville, TN 37243-1002
Phone: 615-532-1321 **Fax: 615-253-5265** **Email:** DFW.Program@tn.gov

tn.gov/workforce/injuries-at-work/employers/employers/drug-free-workplace-program.html

DRUG FREE WORKPLACE PROGRAM APPLICATION

1. This application must be **complete**, legible, and signed or it will be RETURNED.
2. This application must be resubmitted anytime a participating employer **purchases or renews** their workers' comp policy.
3. This form must be submitted to the Bureau by email, fax, or mail. If mailed, **please include** the completed original copy of this form, plus one photocopy, a copy of PROOF OF COVERAGE and two pre-addressed, stamped envelopes:
   a. One addressed to your Workers' Compensation Insurance Carrier and
   b. One addressed to the employer named below.
4. THIS APPLICATION MUST BE RENEWED **ANNUALLY**.

Check One: **New application** ☐ **Renewal application** ☐ **Changed Insurance Carrier** ☐

Company Name _____ FEIN: _____

Mailing Address _____ City _____ State & Zip _____

Business Address _____ City _____ State & Zip_____

Primary Contact (Name and Title) _____/_____

Phone #_____ Fax #_____ Email _____

Nature of Business _____ Total # of FT & PT employees_____

Workers' Compensation Insurance Carrier _____

Lab Certification (circle one): **SAMHSA** **CAP-FUDTAP** **Other** _____

Name of Testing Laboratory _____City _____State_____ ZIP _____

Name of Medical Review Officer (MRO)_____ Phone # _____

Have all employees hired prior to the date of this application been provided at least one hour of substance abuse training? Yes ☐ No ☐

Have all employees hired prior to the date of this application been informed of your company's drug free program policies? Yes ☐ No ☐

Effective date of your program _____

Renewal applicants only:

Number of tests performed in past 12 months for each of the following:

Job Applicants: Total_____ Positive _____ Routine Fitness for Duty: Total_____ Positive _____

Post work accident: Total _____ Positive _____ EAP Follow-up: Total _____ Positive _____

Random (optional): Total _____ Positive _____ Reasonable Suspicion Total _____ Positive _____

Have all employees that have undergone substance abuse training acknowledged, in writing, their attendance at that training and the existence of your company's drug free program policies? Yes No

I hereby certify that all provisions and requirements of the Tennessee Drug-Free Workplace Program as established by T.C.A. have been met and implemented. (To be signed by all applicants)

_____

Owner/Officer's Signature and title Printed name Date

_____

Bureau of Workers' Compensation Representative Signature Title Accepted Date

Oficina de Compensacion a Trabajadores de Tennessee
Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002
Teléfono (Phone): 615-532-1321 FAX (FAX): 615-253-5265 Correo Electrónico (Email) DFW.Program@tn.gov
https://www.tn.gov/workforce/injuries-at-work/employers/employers/drug-free-workplace-program.html

SOLICITUD DEL PROGRAMA PARA AMBIENTE LABORAL LIBRE DE DROGAS
DRUG FREE WORKPLACE PROGRAM APPLICATION

1. Esta solicitud tiene que ser completa, legible, y firmada o será DEVUELTA.
2. Esta solicitud tiene que ser presentada de nuevo cada vez que el empleador cambie compañías de seguro.
3. Este formulario tiene que ser presentado a la Oficina. Por favor incluya la copia original completada de este formulario más una fotocopia, una copia de COMPROBANTE DE COBERTURA, y dos sobres franqueados y con dirección:
a. Uno con la dirección de su Compañía de Seguro de Compensación a Trabajadores y
b. Uno con la dirección del empleador nombrado abajo.
4. ESTA SOLICITUD TIENE QUE SER REVISADA ANUALMENTE.

1. **This application must be complete, legible and signed or it will be RETURNED.**
2. **This application must be resubmitted anytime the employer changes insurance carriers.**
3. **This form must be submitted to the Bureau. Please include the completed original copy of this form plus one photocopy, a copy of PROOF OF COVERAGE and two pre-addressed, stamped envelopes:**
   a. **One addressed to your Workers' Compensation Insurance Carrier and**
   b. **One addressed to the employer named below.**
4. **THIS APPLICATION MUST BE RENEWED ANNUALLY.**

Marque uno(Circle one): ☐ **Nueva solicitud (new application)** ☐ **Solicitud de renovación (Renewal application)**

☐ **Cambio de Compañía de Seguro (Changed Insurance Carrier)**

Nombre de la Compañía (Company Name) _____ FEIN: _____

Dirección de Correo (Mailing Address) _____ Ciudad (City) _____
Estado y Código Postal(State & Zip) _____

Dirección de Empresa (Business Address) _____ (Ciudad)City _____
Estado y Código Postal (State & Zip)_____

Número de Teléfono (Phone #)_____Número de Fax (Fax #)_____
Correo Electrónico (Email) _____

Nombre del Administrador del Programa de Abuso a Sustancias (Name of Substance Abuse Program Administrator)_____

Tipo de Empresa (Nature of Business) _____ Número total de empleados de tiempo completo y tiempo parcial (Total # of FT & PT employees)_____

Compañía de Seguro de Compensación a Trabajadores (Workers' Compensation Insurance Carrier)_____

Certificación del Laboratorio, marque uno (Lab Certification, circle one): ☐ **SAMHSA** ☐ **CAP-FUDTAP** ☐ **Otro (Other)**

_____

Nombre de Laboratorio de Pruebas (Name of Testing Laboratory) _____Ciudad (City)_____
Estado (State)_____ Código Postal (ZIP) _____

Nombre del Oficial de Revisión Médica (Name of Medical Review Officer) (MRO)_____

Número de Teléfono (Phone #) _____

Fecha que condujo o piensa conducir entrenamiento de Conocimiento de Abuso a Sustancias en el Ambiente Laboral para personel de supervisión (Date you conducted or plan to conduct an annual minimum two-hour of Workplace Substance Abuse Recognition training for supervisory personnel.)_____

Fecha que condujo o piensa conducir entrenamiento de Conocimiento de Abuso a Sustancias en el Ambiente Laboral para todos sus empleados. (Date you conducted or plan to conduct an annual minimum one-hour of Workplace Substance Education and Awareness Program for all your Employees)._____

Solo para nuevos solicitantes(New applicants only):
Fecha en que la declaración de política por escrito fue proporcionada a los empleados (Date written policy statement was provided to employees) _____ Fecha de vigencia de su programa (Effective date of your program) _____

Solo para solicitantes de Renovación (Renewal applicants only:)

Número de pruebas realizadas en los ultimos 12 meses para cada uno de los siguientes
Number of tests performed in past 12 months for each of the following:

Solitantes de Empleo (Job Applicants): Total(Total) _____ Positivo(Positive) _____
Rutina del estado físico para el trabjado(Routine Fitness for Duty:) Total(Total) _____ Positivo(Positive) _____
Post-accidente de trabajo (Post work accident:) Total(Total) _____ Positivo(Positive) _____
Seguimiento de EAP(EAP Follow-up:) Total(Total) _____ Positivo(Positive) _____
Aleatorio (Random) opcional (optional): Total(Total) _____ Positivo(Positive) _____
Sospecha Razonable (Reasonable Suspicion) Total(Total) _____ Positivo(Positive) _____

Por medio del presento yo certifico que se ha cumplido e implementado todos los requisitos y provisiones del Programa para Ambiente Laboral Libre de Drogas como lo establecido por el T.C.A.

I hereby certify that all provisions and requirements of the Tennessee Drug-Free Workplace Program as established by T.C.A. have been met and implemented.

Firma y título del Propietario/Oficial Owner/Officer's Signature and title	Nombre en letra de molde Printed name	Fecha Date

Firma del Representante de la Oficina de Compensación a Trabajadores Bureau of Workers' Compensation Representative Signature	Título Title	Fecha Aceptada Accepted Date

Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002
http://www.tn.gov/workforce/section/injuries-at-work

REQUEST FOR MEDICATION

(For injuries prior to 7/1/2014 only)
This form replaces the Request for Assistance (C40A), the Request for Benefit Review Conference (C40B) and the Certificate of Readiness (C40R).

This request is for:

☐ Lost Wage Benefits ☐ Medical Benefits ☐ Discovery
☐ Penalty (For Late or Non-Payment of wages) ☐ Lifetime Medical Coverage

OR

☐ A Benefit Review Conference:

☐ To keep the statute of limitations from running or,

☐ For mediation--I am ready to proceed to mediation in a Benefit Review Conference.

Date of MMI _____ Impairment Rating Assigned _____

If applicable, the Subsequent Injury Fund Attorney is _____ & he/she has been notified.

The parties have discussed possible dates for conducting the mediation and <u>all parties or their representatives have agreed upon the three dates and times listed below.</u> Please provide dates and circle the desired time slots.

_____	_____	_____	_____	_____
9:00am or 1:00 pm	9:00am or 1:00 pm	9:00am or 1:00 pm	Signature of Requesting Party	Signature of Opposing Party

Please give a brief description of the disputed issues: _____

_____

Date of Injury _____ TN County of Injury (Name state if injury not in TN)_____

Employee Name _____ SSN _____ Date of Birth _____

Mailing Address _____

City _____ State _____ ZIP _____ County _____

Phone _____ Email _____

Employee Attorney _____BPR # _____

Phone _____ Fax _____ Email _____

Office Contact Person_____ Email _____

Employer _____ Phone _____

Mailing Address _____

City _____ State _____ ZIP _____ County _____

Employer Contact Person_____ Email _____

Employer Attorney _____ BPR # _____

Phone _____ Fax _____ Email _____

Office Contact Person_____ Email _____

Insurance Company or TPA: _____

Ins. Adjuster Name _____Email _____

Mailing Address _____ City _____ State _____ ZIP _____

Phone _____ Fax _____ Email _____

REQUESTING PARTY

I hereby request the Tennessee Bureau of Workers' Compensation to assist in any disputed workers' compensation issues related to the above-detailed injury. I also authorize the Bureau to contact any person who has information regarding that injury.

_____ _____ _____

Printed name **Signature** **Date**

Please return the completed form to the office below that is closest to the Employee's home address or
@ email:**WC.Ombudsman@tn.gov**

Chattanooga
Tennessee Bureau of Workers' Compensation
1301 Riverfront Pkwy., Ste. 202
Chattanooga, Tennessee 37402
Fax: 423-634-3115

Cookeville
Tennessee Bureau of Workers' Compensation
P.O. Box 678
Cookeville, Tennessee 38503-0678
Fax: 931-520-4316

Gray
Tennessee Bureau of Workers' Compensation
5788 Bobby Hicks Hwy.
Gray, TN 37615
Fax: 423-239-7844

Jackson
Tennessee Bureau of Workers' Compensation
225 Dr. Martin L. King Jr. Dr.
1st Floor, Suite 120, Box 16
Jackson, TN 38301-6920
Fax: 731-265-7022

Knoxville
Tennessee Bureau of Workers' Compensation
520 Summit Hill, Ste. 103
Knoxville, TN 37902
Fax: 865-594-5172

Memphis
Tennessee Bureau of Workers' Compensation
One Commerce Square
40 South Main St., Ste. 500
Memphis, TN 38103-1820
Fax: 901-543-6039

Murfreesboro
Tennessee Bureau of Workers' Compensation
845 Esther Lane
Murfreesboro, TN 37129-5537
Fax: 615-217-9378

Nashville
Tennessee Bureau of Workers' Compensation
220 French Landing Drive, 1-B
Nashville, Tennessee 37243-1002
Fax: 615-253-1223

Oficina de Compensación a Trabajadores
Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002
http://www.tn.gov/workforce/section/injuries-at-work

SOLICITUD PARA MEDIACIÓN
REQUEST FOR MEDIATION

(Solamente para lesiones antes del 1 de julio de 2014)
(For injuries prior to 7/1/2014 only)
Este formulario reemplaza la Petición para Asistencia (C40A), la Petición para Conferencia de Revisión de Beneficios(C40B) y el Certificado de Preparación (C40R)
This form replaces the Request for Assistance (C40A), the Request for Benefit Review Conference (C40B) and the Certificate of Readiness (C40R).

Esta petición es para
This request is for:

☐ Beneficios de Sueldos Perdidos (Lost Wage Benefits) ☐ Beneficios Médicos (Medical Benefits)
☐ Descubrimiento (Discovery) ☐ Aprobación de Asentamiento(Settlement Approval)
☐ Multa por sueldos no pagados o pagados tarde (Penalty For Late or Non-Payment of wages)
☐ Cobertura Médica Vitalicia (Lifetime Medical Coverage) ☐ Beneficios de Muerte (Death Benefits)

O
OR

☐ Una Conferencia de Revisión de Beneficios (A Benefit Review Conference:)
☐ Para prevenir que el estatuo llegue a límite o
(To keep the statute of limitations from running or,)

☐ Para mediación – Estoy listo para proceder a mediación en una Conferencia de Revisión de Beneficios (For mediation--I am ready to proceed to mediation in a Benefit Review Conference.)

Fecha de MMI Calificación de Discapacidad Asignada
Date of MMI _____ Impairment Rating Assigned _____

Si corresponde, el Abogado del Fondo de Seguna Lesión es _____ y él/ella ha sido notificado (If applicable, the Subsequent Injury Fund Attorney is _____ & he/she has been notified.)

Las partes han discutido fechas posibles para conducir la mediación y <u>todas las partes o sus representantes están de acuerdo con las tres fechas y horas que aparecen en lista más abajo.</u> Por favor marque el tiempo deseado.
The parties have discussed possible dates for conducting the mediation and <u>all parties or their representatives have agreed upon the three dates and times listed below.</u> Please circle desired time slot.

_____	_____	_____	_____	_____
9:00am o	9:00am o	9:00am o	Firma de la Parte Solicitante Signature of Requesting Party	Firma de la Parte Opuesta Signature of Opposing Party
1:00 pm	1:00 pm	1:00 pm		

Por favor, dé una descripción breve de la lesion (Please give a brief description of the injury:)

_____

_____

Fecha de Lesión (Date of Injury) _____

Condado de TN donde ocurrió la lesión (Nombre del estado si lesión no fue en TN) TN County of Injury (Name state if injury not in TN) _____

Nombre del Empleado (Employee Name)_____ NSS(SSN) _____ Fecha de Nacimiento (Date of Birth) _____

Dirección de Correo (Mailing Address)

_____

Ciudad (City) _____ Estado(State) _____ Código Postal (ZIP)_____

Condado (County) _____

Teléfono (Phone) _____ Correo Electrónico (Email)_____

Abogado del Empleado (Employee Attorney)_____Núm. de BPR(BPR #) _____

Teléfono (Phone) _____Fax(Fax)_____ Correo electrónico (Email) _____

Persona de Contacto de la Oficina (Office Contact Person)_____

Correo Electrónico (Email) _____

Empleador(Employer) _____Teléfono(Phone) _____

Dirección de Correo (Mailing Address)

_____

Ciudad (City) _____ Estado(State) _____ Código Postal (ZIP)_____

Condado (County) _____

Persona de Contacto del Empleador (Employer Contact Person)_____

Correo Electrónico (Email) _____

Abogado del Empleador(Employer Attorney)_____ Núm. de BPR(BPR #) _____

Teléfono (Phone)_____ Fax(Fax) _____

Correo Electrónico (Email) _____

Persona de Contacto de la Oficina (Office Contact Person)_____

Correo Electrónico (Email) _____

Compañía de Seguro o TPA (Insurance Company or TPA:)_____

Nombre del Ajustador de Seguro (Ins. Adjuster Name) _____

Correo Electrónico (Email) _____

Dirección de Correo (Mailing Address) _____ Ciudad (City) _____

Estado (State) _____ Código Postal (ZIP) _____

Teléfono (Phone) _____ Fax(Fax) _____

PARTE SOLICITANTE

REQUESTING PARTY

Por el presente pido a la Oficina de Compensación a Trabajadores que asista en cualquier asunto que se cuestione de compensación a trabajadores con relación a la lesión detallada arriba. También autorizo a la Oficina para que contacte a culaquier persona que tenga información acerca de esa lesión.

I hereby request the Tennessee Bureau of Workers' Compensation to assist in any disputed workers' compensation issues related to the above-detailed injury. I also authorize the Bureau to contact any person who has information regarding that injury.

_____	_____	_____
Nombre en letra de molde **Printed name**	**Firma** **Signature**	**Fecha** **Date**

Por favor devuelva el formulario completado a la oficina abajo que esté más cerca de la dirección residencial del Empleado.

(Please return the completed form to the office below that is closest to the Employee's home address or @ email: WC.Ombudsman@tn.gov)

Chattanooga
Tennessee Bureau of Workers' Compensation
1301 Riverfront Pkwy., Ste. 202
Chattanooga, Tennessee 37402
Fax: 423-634-3115

Cookeville
Tennessee Bureau of Workers' Compensation
P.O. Box 678
Cookeville, Tennessee 38503-0678
Fax: 931-520-4316

Gray
Tennessee Bureau of Workers' Compensation
5788 Bobby Hicks Hwy.
Gray, TN 37615
Fax: 423-239-7844

Jackson
Tennessee Bureau of Workers' Compensation
225 Dr. Martin L. King Jr. Dr.
1st Floor, Suite 120, Box 16
Jackson, TN 38301 6920
Fax: 731-265-7022

Knoxville
Tennessee Bureau of Workers' Compensation
520 Summit Hill, Ste. 103
Knoxville, TN 37902
Fax: 865-594-5172

Memphis
Tennessee Bureau of Workers' Compensation
One Commerce Square
40 South Main St., Ste. 500
Memphis, TN 38103-1820
Fax: 901-543-6039

Murfreesboro
Tennessee Bureau of Workers' Compensation
845 Esther Lane
Murfreesboro, TN 37129-5537
Fax: 615-217-9378

Nashville
Tennessee Bureau of Workers' Compensation
220 French Landing Drive, 1-B
Nashville, Tennessee 37243-1002
Fax: 615-253-1223

Filed Date Stamp Here

SOLICITUD PARA DETERMINACIÓN DE BENEFICIOS (PBD)
Agencia de Compensación a Trabajadores de Tennessee
Tribunal de Reclamaciones de Compensación a Trabajadores
PETITION FOR BENEFIT DETERMINATION
Tennessee Bureau of Workers' Compensation
Court of Workers' Compensation Claims
PBD.CourtClerk@tn.gov
800-332-2667

For BWC Use Only

Docket No._____
State File No._____
RFA No. _____
Date of Injury_____
Prior PBD Filed: ☐ Yes ☐ No
Assigned Judge_____

Se aplica a las lesiones en o después del 1º de julio de 2014
(Para las lesiones de antes del 1 de julio de 2014, presente una Solicitud de Mediación)

Applies to injuries on or after July 1, 2014
(For injuries before July 1, 2014, please use a Request for Mediation)

Información General (General Information)

La Solicitud para Determinación de Beneficios (PDB, por sus siglas en inglés) es el formulario que se presenta a la Agencia de Compensación a Trabajadores para comenzar el proceso de resolución de conflictos. El proceso legal para las reclamaciones de indemnización laboral comienza con esta presentación. (The Petition for Benefit Determination (PBD) is the form to file with the Bureau of Workers' Compensation to begin the dispute resolution process. The legal process for a workers' compensation claim begins with this filing.)

Consulte Información y consejos útiles en la página 7 antes de completar este formulario. Llame al: 800-332-2667 o haga clic aquí para obtener ayuda adicional. La información sobre los beneficios, las leyes y los procedimientos está disponible en www.tn.gov/workerscomp. (Please see page 7 Helpful Tips and Information before completing this form. Call: 800-332-2667 or click here for additional help. Information about benefits, laws, and procedures is available at www.tn.gov/workerscomp.)

De no presentar oportunamente este formulario ante el Secretario del Tribunal, se le pudieran denegar los beneficios. Este formulario tiene que ser presentado en un plazo de un año después del accidente que ocasionara la lesión; un año del último tratamiento médico autorizado; o un año del último pago de compensación del empleador o en nombre del empleado, lo que sea posterior.

(If you fail to timely file this form with the Court Clerk, you may be denied benefits. This form must be filed within one year after the accident resulting in injury; one year from the last authorized medical treatment; or one year from the employer's last compensation payment to or on behalf of the employee, whichever is later.)

Sección A: Identifique las personas y las empresas involucradas. (Identify the people and the companies involved.)

Nombre del empleado _____ Fecha de la lesión_____
Employee Name Date of Injury

NSS _____ Fecha de nacimiento _____
SSN Date of Birth

Dirección postal _____
Mailing Address

Ciudad _____ Estado _____ Código postal_____ Condado_____
City State ZIP Country

Teléfono _____ Correo electrónico _____
Phone Email

¿El empleado requiere un intérprete? ☐ SÍ ☐ NO Si la respuesta es "Sí", idioma _____ dialecto _____
Does employee require an interpreter? If "Yes," language dialect

Abogado del empleado _____ BPR # _____
Employee Attorney

Dirección _____ Ciudad _____ Estado___ Código postal _____
Address City State ZIP

Teléfono _____ Fax _____ Correo electrónico _____
Phone Email

Persona de oficina a contactar _____ Correo electrónico _____
Office Contact Person Email

Empleador(es) _____ Teléfono _____
Employer(s) Phone

Dirección postal _____
Address

Ciudad _____ Estado _____ Código postal_____ Condado _____
City State ZIP Country

Personal del empleador a contactar_____ Correo electrónico _____
Office Contact Person Email

Abogado del empleador _____ BPR # _____
Employer Attorney

Dirección _____ Ciudad _____ Estado____ Código postal _____
Address City State ZIP

Teléfono _____ Fax _____ Correo electrónico _____
Telephone Email

Persona de oficina a contactar_____ Correo electrónico _____
Office Contact Person Email

Empresa de seguro: _____
Insurance Company

Administrador de terceros: _____
Third Party Administrator

Nombre del tasador de la aseguradora _____Correo electrónico _____
Ins. Adjuster Name Email

Dirección postal _____ Ciudad _____ Estado _____ Código postal _____
Mailing Address City State ZIP

Teléfono_____ Fax _____ No. de reclamación del seguro_____
Telephone Ins. Claim #

El Fondo secundario para lesiones (SIF, por sus siglas en inglés) puede proporcionar beneficios a los empleados elegibles con una discapacidad física permanente previa y que se vuelven discapacitados total y permanentemente por una lesión laboral posterior. Para conservar una reclamación ante el SIF, el empleado tiene que enviar este formulario por fax al 615-741-4169, por correo electrónico a WC.SIFLegal@tn.gov o por correspondencia a: SIF Director, Legal Section, 220 French Landing Drive, 3B, Nashville, TN 37243.

The Subsequent Injury Fund (SIF) may provide benefits to qualified employees who have a prior permanent physical disability and who become permanently and totally disabled by a later work injury. To preserve a claim against the SIF, Employee must submit this form via fax to 615-741-4169, email to WC.SIFLegal@tn.gov or mail to: SIF Director, Legal Section, 220 French Landing Drive, 3B, Nashville, TN 37243.

¿El empleado desea solicitar resarcimiento del Fondo secundario para lesiones? ☐ SÍ (Yes) ☐ NO
Is the Employee seeking recovery from the Subsequent Injury Fund?

Nombre del abogado del SIF (si se conoce): _____
SIF Attorney Name (If known)

Sección B: Proporcione detalles acerca de la lesión laboral. (Adjuntar hojas adicionales de ser necesario.)
Provide details about the work injury. (Attach additional sheets if necessary.)

La fecha de la lesión es: _____
The date of injury is

La(s) parte(s) del cuerpo lesionada(s) es (son): _____
The injured body part(s) is (are)

El lugar donde ocurrió la lesión es: _____.
The place where the injury happened is

Los testigos de la lesión son: _____
The witnesses to the injury are

La lesión ocurrió mientras el empleado se encontraba realizando las siguientes actividades laborales:
The injury occurred while the employee was performing the following work activities

_____

_____

_____

_____

La lesión fue causada por: _____
The injury was caused by

_____

_____

El empleado informó de la lesión a_____ el _____.
Employee reported the injury to
Ingresar el nombre. (Insert Name)
Ingresar la fecha. (Insert Date)

Sección C: Identificar el problema que tiene con la reclamación de compensación a trabajadores.

Yo(I), _____, tengo el siguiente problema: (Adjuntar hojas adicionales de ser necesario.)
Ingresar el nombre. (Insert Name) have the following problem: (Attach additional sheets if necessary.)

_____

_____

_____

_____

Sección D: Identificar los problemas de compensación a trabajadores aplicables a la reclamación. (Seleccione todo lo que corresponda). Identify the workers' compensation issues that apply to the claim. (Select all that apply.)

Beneficios médicos
Medical Benefits

Incluir los registros médicos que muestran el tratamiento recibido por la lesión laboral.
Please include medical records showing the treatment received for the work injury.

☐ El empleado recibió una lista de 3 médicos en _____ y seleccionó _____.
Employee received a list of 3 doctors on Fecha (Date) Nombre del doctor o clínica (Doctor or Clinic Name)

☐ El empleado no ha recibido la lista de 3 médicos.
Employee has not received a list of 3 doctors.

☐ El empleado no ha recibido atención médica del empleador o de la empresa aseguradora.
Employee has not received medical care from Employer or the insurance company.

☐ El empleado no ha recibido la atención médica requerida por una orden judicial. (Proporcionar la orden judicial). Employee has not received medical care as required by a court order. (Provide court order.)

☐ Se le negó atención médica al empleado después de haberla recibido.
Employee was denied medical care after receiving it.

☐ El empleado no ha recibido la atención médica indicada por el médico.
Employee has not received medical care ordered by the doctor.

☐ El empleado buscó atención médica de un médico que no figuraba en la lista proporcionada por el empleador. Employee sought medical care from a physician who was not on the list provided by employer.

Beneficios por discapacidad temporal
Temporary Disability Benefits

Incluir registros de los salarios y las órdenes del médico que indican que no puede trabajar o las restricciones de trabajo asignadas.
Please include wage records and doctor notes taking you off work or assigned work restrictions.

☐ El Doctor _____ ordenó al empleado no trabajar y/o asignó restricciones de trabajo de:
Nombre
Doctor _____ took employee off work and/or assigned restrictions of:
Insert Name

☐ El empleado faltó al trabajo los siguientes días debido a la lesión:
_____
Employee has missed the following days from work due to the injury:

☐ El empleado no ha recibido pago por los días que faltó al trabajo y/o cree que se le debe más de lo recibido.
Employee has not been paid for missing work and/or believes he/she is owed more than received.

☐ Se ha pagado al empleado mientras faltó al trabajo a una tasa de $_____ por semana.
Employee has been paid while missing work at the rate of $_____ per week.

☐ Las partes no están de acuerdo en cuanto al monto de los beneficios de discapacidad temporal.
Parties do not agree on the amount of the temporary disability benefit.

Presentación de pruebas
presentación de pruebas.
Discovery

Si ya se ha presentado una PBD, no es necesario presentar otra PBD para la
If a PBD is already on file, it is not necessary to file another PBD for discovery.

☐ Es necesario un citatorio. (Incluir el citatorio completado).
A subpoena is needed. (Include completed subpoena.)

☐ Otro_____
Other

☐ Las respuestas a las peticiones de presentación de pruebas no han sido entregadas. (Incluir copias).
Written discovery responses have not been returned. (Include copies.)

Beneficios por fallecimiento
Death Benefits

Favor de completar y adjunte el Apéndice Únicamente para la Petición de Determinación de Beneficios para Reclamos por Fallecimiento.
Please complete and attach the Addendum to Petition for Benefit Determination for Death Claims Only.

☐ La reclamación ha sido aceptada.
The claim has been accepted.

☐ La reclamación fue denegada.
The claim was denied.

☐ Existe un cónyuge dependiente.
There is a dependent spouse.

☐ Hay otros dependientes aparte de los hijos y el cónyuge.
There are dependents other than children & spouse.

☐ Hay _____ hijos dependientes.
Número
There are _____ dependent children.

☐ Es necesario nombrar a un defensor de menores.
A child advocate needs to be appointed.

Beneficios por discapacidad permanente
Permanent Disability Benefits

Proporcione el Último Informe Médico (C30A) o el más reciente Informe del Médico.
Please provide the Final Medical Report (C30A) or most recent Physician's Report.

Existe un conflicto acerca de:
A dispute exists regarding

☐ Importe del Beneficio por Discapacidad Permanente,
Amount of Permanent Disability Benefit

☐ Resarcimiento original,
Original Award

☐ Resarcimiento resultante y/o aumento de beneficios,
Resulting Award and/or Increased Benefits

☐ Amparo extraordinario,
Extraordinary Relief

☐ Beneficios por Discapacidad Total Permanente, y/o
Permanent Total Disability Benefits, and/or

☐ Otro _____
Other

☐ El empleado alcanzó el máximo de mejora médica el_____.
Employee reached maximum medical improvement on

☐ El Dr. _____ asignó una clasificación de impedimento de _____% del cuerpo como un todo.
Doctor assigned an impairment rating of % to the body as a whole

☐ El Dr. _____ asignó una clasificación de impedimento de _____% del cuerpo como un todo.
Doctor assigned an impairment rating of % to the body as a whole

☐ El Dr. _____ asignó restricciones permanentes de: _____
Doctor assigned permanent restrictions of
_____

Sección E: Indicar su disponibilidad para la Mediación:
Indicate Your Availability for Mediation

Antes de que un juez pueda tomar una decisión en un conflicto acerca de una discapacidad o de los beneficios médicos, las partes deben participar en una mediación. Un mediador que trabaja para el estado, sin intereses en el asunto, ayudará a las partes a llegar voluntariamente a un acuerdo. La mayoría de los conflictos se resuelven sin tener que presentarse ante un juez. (Before a judge can decide a dispute about disability or medical benefits, the parties must participate in mediation. A mediator working for the state, without a stake in the outcome, will help the parties reach an agreement voluntarily. Most disputes are resolved without going before a judge.)

Las mediaciones se tienen que programar de mutuo acuerdo entre las partes. Comuníquese con todas las partes e indique a continuación las tres (3) diferentes fechas y horarios convenidos. Marque con un círculo el horario deseado. Si no cuenta con un abogado, puede llamar al 800-332-2667 para obtener ayuda en la selección de las fechas de la mediación. (Mediations must be scheduled by agreement between the parties. Please contact all parties and indicate the three (3) different agreed upon dates and times below. Please circle the desired time slot. If you do not have an attorney, you can call 800-332-2667 for help with selecting mediation dates.)

_____	_____	_____
9:00 am o 1:00 pm	9:00 am o 1:00 pm	9:00 am o 1:00 pm

*La parte que hace la presentación debe marcar una de las siguientes opciones:
*The filing party must check one of the following

☐ Las fechas y los horarios anteriores han sido acordados por todas las partes.
The above dates and times have been agreed upon by all parties.

☐ No pude coordinar las fechas con la otra parte; las fechas anteriores solo muestran mi disponibilidad.
I am unable to coordinate dates with the other party; the dates above only show my availability.

Sección F: Aviso
Section F: Notice

Usted puede perder su caso de no proporcionarse este formulario a todas las partes o a sus abogados. Indique cómo les envió una copia de este formulario. Haga clic aquí para ver un ejemplo. A case can be lost because this form is not provided to the parties or their attorneys. Please indicate how you sent them a copy of this form. Click here for an example.

"Notificación enviada a": Se refiere a la dirección, el número de fax o la dirección de correo electrónico utilizados para enviar el formulario a la otra parte.
"Service sent to:" means the address, fax number, or email address used to send the form to the other party.

☐ **Empleado**_____
Employee
Vía de notificación (Service Sent to): ☐ En persona (By Hand)
☐ Por correo (Mail) ☐ Fax ☐ Correo electrónico (Email)
Notificación enviada a: _____
(Service Sent to)

☐ **Empleador(es)**_____
Employer(s)
Vía de notificación (Service Sent to): ☐ En persona (By Hand)
☐ Por correo (Mail) ☐ Fax ☐ Correo electrónico (Email)
Notificación enviada a: _____
(Service Sent to)

☐ **Abogado del Empleado**_____
Employee's Atty
Vía de notificación (Service Sent to): ☐ En persona (By Hand)
☐ Por correo (Mail) ☐ Fax ☐ Correo electrónico (Email)
Notificación enviada a: _____
(Service Sent to)

☐ **Abogado(s) del/de los empleador(es)** _____
Employer's Atty(s)
Vía de notificación: (Service Sent to) ☐ En persona (By Hand)
☐ Por correo (Mail) ☐ Fax ☐ Correo electrónico (Email)
Notificación enviada a: _____
(Service Sent to)

☐ **Aseguradora(s)**_____
Carrier(s)
Vía de notificación: ☐ En persona (By Hand) ☐ Por correo (Mail)
☐ Fax ☐ Correo electrónico (Email)
Notificación enviada a: _____
(Service Sent to)

☐ **Abogado del SIF** _____
SIF's Atty
Vía de notificación: (Service Sent to) ☐ En persona (By Hand)
☐ Por correo (Email) ☐ Fax ☐ Correo electrónico (Email)
Notificación enviada a: _____
(Service Sent to)

Sección G: Certifique que la información contenida en la Solicitud para determinación de beneficios es la correcta. Certify the information contained in the Petition for Benefit Determination is correct.

Yo, _____, declaro que toda la información proporcionada en esta Solicitud para Determinación de Beneficios es fiel y exacta a mi mejor conocimiento, información y entender. Además, certifico que una copia de la Solicitud para determinación de beneficios **ha sido enviada a las partes tal y como se ha descrito anteriormente.** (I, _____, state that the information provided in this Petition for Benefit Determination is true and accurate to the best of my knowledge, information, and belief. Further, I certify a copy of the Petition for Benefit Determination **has been sent to the parties as described above.)**

_____ _____ _____
Nombre en letra de imprenta **Firma** **Fecha**
Print Name **Signature** **Date**

Información y consejos útiles

1. La mejor manera de enviar el formulario es por correo electrónico a PBD.CourtClerk@tn.gov. Asegúrese de que sea legible. The best way to send in the form is by email to PBD.CourtClerk@tn.gov. Please make sure it is legible.

2. La Agencia enviará una copia sellada del formulario como prueba de que el formulario fue recibido en un plazo de cinco días siguientes a su recepción. Si no recibe una copia sellada, comuníquese con la oficina asignada según la ubicación del empleado tal y como se indica en la página 6. The Bureau will return a stamped copy of this form as proof the form was received within five days of receipt. If you do not receive a stamped copy, please contact the office designated for the employee's location listed on page 6.

3. Complete este formulario en su totalidad. Si falta alguna información ello hará que nos atrasemos en ayudarle. Puede obtener ayuda para completar el formulario llamando al 1-800-332-2667. Please fully complete this form. Missing information slows our ability to help you. You can get help to complete the form by calling 1-800-332-2667.

4. Intente comunicarse con la otra parte para completar la sección E. Esto hace que podamos ayudarle más pronto. Please try to contact the other party to complete Section E. This speeds up our ability to help you.

5. Un mediador ayuda a las partes a entender el problema y a encontrar soluciones que sean factibles para todos. El mediador no trabaja para ninguna de las partes y no es sustituto para un abogado. A mediator helps the parties understand the problem and find solutions that work for everyone. The mediator does not work for the injured worker and is not a replacement for an attorney.

6. Envíe su información cuanto antes. Esto aumenta sus probabilidades de éxito. Los registros médicos a menudo son entregados demasiado tarde, lo cual retrasa los pagos por discapacidad y la atención médica. Please quickly submit your information. This increases your chance for success. Medical records are often provided too late, delaying disability payments and medical care.

7. Llame a su médico y obtenga sus registros médicos cuanto antes. Cuando solicite los registros médicos, entregue el Formulario de Certificación de Registro Médico al médico o proveedor de atención médica. Entregue la Certificación de Registro Médico completada junto con sus registros. Haga clic aquí para obtener el formulario. Talk to your doctor and obtain medical records as soon as possible.

8. Es obligatorio que entregue todos los registros médicos que posea a la parte contraria. Dispone de un plazo de 15 días a partir de la fecha de la presentación de este formulario. Esto se aplica a todos los registros médicos pertinentes a su reclamación. All medical records in your possession are required to be shared with the opposing party. This must be done within 15 days of submitting this form. This applies to all medical records that are relevant to your claim.

9. El empleado lesionado tiene que demostrar que él/ella tiene derecho a los beneficios solicitados. The injured worker has to prove he is owed the requested benefits.

10. Si se le debe dinero porque no puede trabajar, debe enviar los registros médicos. Los médicos documentan cuando un paciente no puede trabajar o no puede realizar ciertos trabajos durante períodos específicos. Envíe esos registros junto con este formulario. If you are owed money because you cannot work, you must submit medical records. Doctors document when a patient cannot work or cannot perform certain work during specific periods. Please submit those records with this form.

11. Si tiene facturas médicas impagas, sírvase proporcionar copias. Envíe también los registros médicos relacionados con las facturas. If you have unpaid medical bills, please provide copies of them. Also send the medical records related to the bills.

12. Si se le deben pagos por distancias recorridas, es necesario que incluya ciertos detalles. Indique la distancia recorrida, el día que viajó y el nombre del médico que fue a ver. Envíe también el registro médico de esa visita. If you are owed mileage, certain details are necessary. Please tell us how far you drove, the day you drove, and the name of the doctor you saw. Also send the medical record from that visit.

13. Tiene que proporcionar una copia de este formulario a cada una de las partes o a sus abogados. Es necesario completar la Sección F para comprobar que ha enviado una copia a todas las partes. Tiene que indicar el número de fax, la dirección postal o la dirección de correo electrónico que haya usado. A copy of this form must be sent to all parties or their attorneys. Section F is required to prove you sent a copy to all the parties. The fax number, mailing address, or email address you used must be listed.

14. Usted tiene que firmar y fechar este formulario. De no completarse la Sección G, le será devuelto el formulario y no se asignará su caso a mediación. You must sign and date this form. If Section G has not been completed, the form will be returned. Your case will not be assigned for mediation.

Para obtener más información sobre los beneficios de compensación a trabajadores o sobre cómo completar este formulario, visite nuestro sitio web en http://www.tn.gov/workerscomp o llame al 1-800-332-2667.

Envíe el formulario completado a la oficina que atiende la región del domicilio del empleado según el mapa aquí abajo. Please return the completed form to the office in the region of the Employee's home address per the map below.

Chattanooga
TN Bureau of Workers' Compensation
1301 Riverfront Pkwy., Ste. 202
Chattanooga, TN 37402
Fax: 423-634-3115
Correo electrónico:
PBD.CourtClerk@tn.gov

Cookeville
TN Bureau of Workers' Compensation
PO Box 678,
Cookeville, TN 38503
Fax: 931-520-4316
Correo electrónico:
PBD.CourtClerk@tn.gov

Jackson
TN Bureau of Workers' Compensation
225 Dr. Martin L. King Jr. Dr.
1st Floor, Suite 120, Box 16
Jackson, TN 38301-6985
Fax: 731-265-7022
Correo electrónico:
PBD.CourtClerk@tn.gov

Gray
TN Bureau of Workers' Compensation
5788 Bobby Hicks Highway
Gray, TN 37615-3190
Fax: 423-239-7844
Correo electrónico:
PBD.CourtClerk@tn.gov

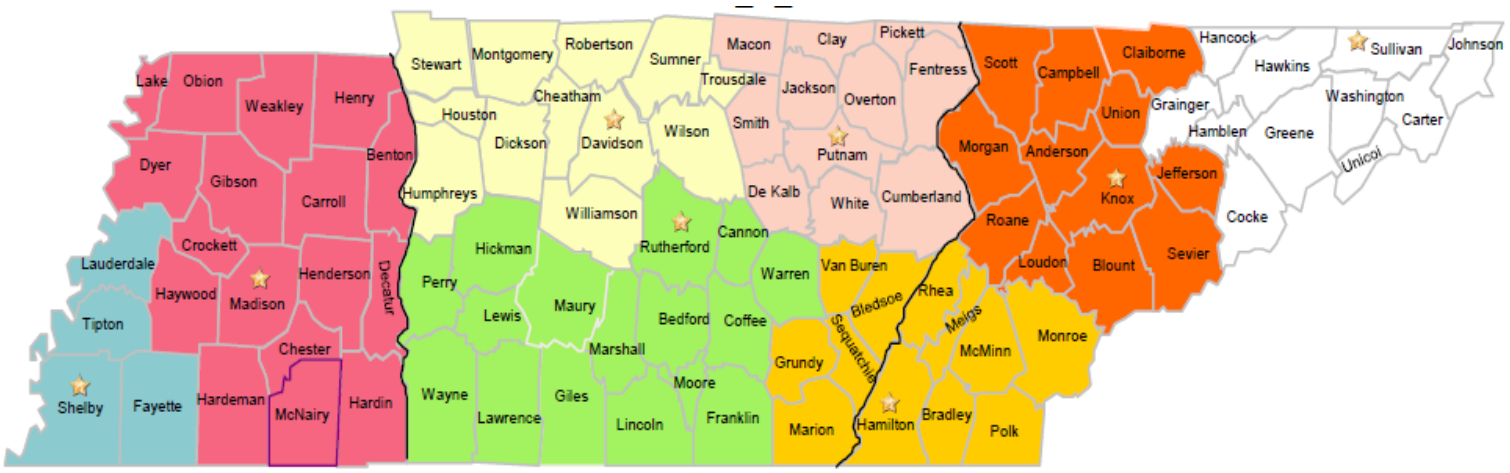
Knoxville
TN Bureau of Workers' Compensation
520 Summit Hill, Ste. 103
Knoxville, TN 37902
Fax: 865-594-5172
Correo electrónico:
PBD.CourtClerk@tn.gov

Memphis
TN Bureau of Workers' Compensation
One Commerce Square
40 South Main St., Ste. 500
Memphis, TN 38103-1820
Fax: 901-543-6039
Correo electrónico:
PBD.CourtClerk@tn.gov

Murfreesboro
TN Bureau of Workers' Compensation
845 Esther Lane
Murfreesboro, TN 37129-5537
Fax: 615-217-9378
Correo electrónico:
PBD.CourtClerk@tn.gov

Nashville
TN Bureau of Workers' Compensation
220 French Landing Drive, 1-B
Nashville, TN 37243-1002
Fax: 615-253-1223
Correo electrónico:
PBD.CourtClerk@tn.gov

Workers' Comp Court Clerk
TN Bureau of Workers' Compensation
220 French Landing, 1-B
Nashville, TN 37243-1002
Fax 615-253-2480
Correo electrónico:
PBD.CourtClerk@tn.gov



Filed Date Stamp Here

PETITION FOR BENEFIT DETERMINATION
Tennessee Bureau of Workers' Compensation
Court of Workers' Compensation Claims
PBD.CourtClerk@tn.gov
800-332-2667

Applies to injuries on or after July 1, 2014

(For injuries before July 1, 2014, please use a Request for Mediation)

For BWC Use Only

Docket No._____
State File No._____
RFA No._____
Date of Injury_____

Prior PBD Filed: ☐ Yes ☐ No
Assigned Judge_____

General Information

The Petition for Benefit Determination (PBD) is the form to file with the Bureau of Workers' Compensation to begin the dispute resolution process. The legal process for a workers' compensation claim begins with this filing.

Please see page 5 Helpful Tips and Information before completing this form. Call: 800-332-2667 or click here for additional help. Information about benefits, laws, and procedures is available at www.tn.gov/workerscomp.

If you fail to timely file this form with the Court Clerk, you may be denied benefits. This form must be filed within one year after the accident resulting in injury; one year from the last authorized medical treatment; or one year from the employer's last compensation payment to or on behalf of the employee, whichever is later.

Section A: Identify the people and the companies involved.

Employee Name _____ Date of Injury_____

SSN _____ Date of Birth _____

Mailing Address _____

City _____ State _____ ZIP _____ County _____

Phone _____ Email _____

Does employee require an interpreter? ☐ YES ☐ NO If "Yes," language _____ dialect _____

Employee Attorney _____BPR # _____

Address _____ City _____ State____ ZIP _____

Phone _____ Fax _____ Email _____

Office Contact Person_____ Email _____

Employer(s) _____ Phone _____

Mailing Address _____

City _____ State _____ ZIP _____ County _____

Employer Contact Person_____ Email _____

Employer Attorney _____ BPR # _____

Address _____ City _____ State____ ZIP _____

Phone _____ Fax _____ Email _____

Office Contact Person_____ Email _____

Insurance Company: _____

Third Party Administrator: _____

Ins. Adjuster Name _____Email _____

Mailing Address _____ City _____ State _____ ZIP _____

Phone _____ Fax _____ Ins. Claim#_____

The Subsequent Injury Fund (SIF) may provide benefits to qualified employees who have a prior permanent physical disability and who become permanently and totally disabled by a later work injury. To preserve a claim against the SIF, Employee must submit this form via fax to 615-741-4169, email to WC.SIFLegal@tn.gov or mail to: SIF Director, Legal Section, 220 French Landing Drive, 3B, Nashville, TN 37243.

Is the Employee seeking recovery from the Subsequent Injury Fund? ☐ YES ☐ NO

SIF Attorney Name (If known): _____

Section B: Provide details about the work injury. (Attach additional sheets if necessary.)

The date of injury is: _____.

The injured body part(s) is (are): _____.

The place where the injury happened is: _____.

The witnesses to the injury are: _____.

The injury occurred while the employee was performing the following work activities: _____

_____

_____

_____

The injury was caused by: _____

_____

_____

Employee reported the injury to_____ on _____.
Insert Name. Insert Date.

Section C: Identify the problem you are having with the workers' compensation claim.

I, _____, have the following problem: (Attach additional sheets if necessary.)
Insert name.

_____

_____

_____

_____

Section D: Identify the workers' compensation issues that apply to the claim. (Select all that apply.)

Medical Benefits Please include medical records showing the treatment received for the work injury.

- ☐ Employee received a list of 3 doctors on _____ (Date) and selected _____ (Insert Doctor or Clinic Name.).
- ☐ Employee has not received a list of 3 doctors.
- ☐ Employee has not received medical care from Employer or the insurance company.
- ☐ Employee has not received medical care as required by a court order. (Provide court order.)
- ☐ Employee was denied medical care after receiving it.
- ☐ Employee has not received medical care ordered by the doctor.
- ☐ Employee sought medical care from a physician who was not on the list provided by employer.

Temporary Disability Benefits Please include wage records and doctor notes taking you off work or assigned work restrictions.

- ☐ Doctor _____ (Insert Name) took employee off work and/or assigned restrictions of:

  _____
- ☐ Employee has missed the following days from work due to the injury:

  _____
- ☐ Employee has not been paid for missing work and/or believes he/she is owed more than received.
- ☐ Employee has been paid while missing work at the rate of $_____ per week.
- ☐ Parties do not agree on the amount of the temporary disability benefit.

Discovery If a PBD is already on file, it is not necessary to file another PBD for discovery.

- ☐ A subpoena is needed. (Include completed subpoena.) ☐ Other _____
- ☐ Written discovery responses have not been returned. (Include copies.)

Death Benefits Please complete and attach Addendum to Petition for Benefit Determination for Death Claims Only

- ☐ The claim has been accepted. ☐ The claim was denied.
- ☐ There is a dependent spouse. ☐ There are dependents other than children & spouse.
- ☐ There are _____ (Number) dependent children. ☐ A child advocate needs to be appointed.

Permanent Disability Benefits Please provide the Final Medical Report (C30A) or most recent Physician's Report.

- ☐ A dispute exists regarding: ☐ Amount of Permanent Disability Benefit, ☐ Original Award, ☐ Resulting Award and/or Increased Benefits, ☐ Extraordinary Relief, ☐ Permanent Total Disability Benefits, and/or ☐ Other _____
- ☐ Employee reached maximum medical improvement on_____.
- ☐ Dr. _____ assigned an impairment rating of _____% to the body as a whole.
- ☐ Dr. _____ assigned an impairment rating of _____% to the body as a whole.
- ☐ Dr. _____ assigned permanent restrictions of: _____

  _____

Section E: Indicate Your Availability for Mediation:

Before a judge can decide a dispute about disability or medical benefits, the parties must participate in mediation. A mediator working for the state, without a stake in the outcome, will help the parties reach an agreement voluntarily. Most disputes are resolved without going before a judge.

Mediations must be scheduled by agreement between the parties. Please contact all parties and indicate the three (3) <u>different</u> agreed upon dates and times below. Please <u>circle</u> the desired time slot. If you do not have an attorney, you can call 800-332-2667 for help with selecting mediation dates.

_____	_____	_____
9:00 am or 1:00 pm	9:00 am or 1:00 pm	9:00 am or 1:00 pm

*The filing party must check one of the following:

☐ The above dates and times have been agreed upon by all parties.
☐ I am unable to coordinate dates with the other party; the dates above only show my availability.

Section F: Notice

A case can be lost because this form is not provided to the parties or their attorneys. Please indicate how you sent them a copy of this form. Click here for an example.

"Service sent to:" means the address, fax number, or email address used to send the form to the other party.

☐ **Employee**_____
Service by: ☐ By Hand ☐ Mail ☐ Facsimile ☐ Email
Service Sent to: _____

☐ **Employer(s)**_____
Service by: ☐ By Hand ☐ Mail ☐ Facsimile ☐ Email
Service Sent to: _____

☐ **Employee's Atty**_____
Service by: ☐ By Hand ☐ Mail ☐ Facsimile ☐ Email
Service Sent to: _____

☐ **Employer(s)' Atty(s)**_____
Service by: ☐ By Hand ☐ Mail ☐ Facsimile ☐ Email
Service Sent to: _____

☐ **Carrier(s)**__ _____
Service by: ☐ By Hand ☐ Mail ☐ Facsimile ☐ Email
Service Sent to: _____

☐ **SIF's Atty** _____
Service by: ☐ By Hand ☐ Mail ☐ Facsimile ☐ Email
Service Sent to: _____

Section G: Certify the information contained in the Petition for Benefit Determination is correct.

I, _____, state that the information provided in this Petition for Benefit Determination is true and accurate to the best of my knowledge, information, and belief. Further, I certify a copy of the Petition for Benefit Determination **has been sent to the parties as described above.**

_____	_____	_____
Print Name	**Signature**	**Date**

Helpful Tips and Information

1. The best way to send in the form is by email to PBD.CourtClerk@tn.gov. Please make sure it is legible.

2. The Bureau will return a stamped copy of this form as proof the form was received within five days of receipt. If you do not receive a stamped copy, please contact the office designated for the employee's location listed on page 6.

3. Please fully complete this form. Missing information slows our ability to help you. You can get help to complete the form by calling 1-800-332-2667.

4. Please try to contact the other party to complete Section E. This speeds up our ability to help you.

5. A mediator helps the parties understand the problem and find solutions that work for everyone. The mediator does not work for the injured worker and is not a replacement for an attorney.

6. Please quickly submit your information. This increases your chance for success. Medical records are often provided too late, delaying disability payments and medical care.

7. Talk to your doctor and obtain medical records as soon as possible.

8. All medical records in your possession are required to be shared with the opposing party. This must be done within 15 days of submitting this form. This applies to all medical records that are relevant to your claim.

9. The injured worker has to prove he/she is owed the requested benefits.

10. If you are owed money because you cannot work, you must submit medical records. Doctors document when a patient cannot work or cannot perform certain work during specific periods. Please submit those records with this form.

11. If you have unpaid medical bills, please provide copies of them. Also send the medical records related to the bills.

12. If you are owed mileage, certain details are necessary. Please tell us how far you drove, the day you drove, and the name of the doctor you saw. Also send the medical record from that visit.

13. A copy of this form must be sent to all parties or their attorneys. Section F is required to prove you sent a copy to all the parties. The fax number, mailing address, or email address you used must be listed.

14. You must sign and date this form. If Section G has not been completed, the form will be returned. Your case will not be assigned for mediation.

For more information about workers' compensation benefits or how to complete this form, please visit our website at http://www.tn.gov/workforce/section/injuries-at-work or call 1-800-332-2667.

Please return the completed form to the office in the region of the Employee's home address per the map below.

Chattanooga
TN Bureau of Workers' Compensation
1301 Riverfront Pkwy., Ste. 202
Chattanooga, TN 37402
Fax: 423-634-3115
Email: PBD.CourtClerk@tn.gov

Cookeville
TN Bureau of Workers' Compensation
P.O. Box 678
Cookeville, TN 38503-0678
Fax: 931-520-4316
Email: PBD.CourtClerk@tn.gov

Jackson
TN Bureau of Workers' Compensation
225 Dr. Martin L. King Jr. Dr.
1st Floor, Suite 120, Box 16
Jackson, TN 38301-6985
Fax: 731-265-7022
Email: PBD.CourtClerk@tn.gov

Gray
TN Bureau of Workers' Compensation
5788 Bobby Hicks Highway
Gray, TN 37615-3190
Fax: 423-239-7844
Email: PBD.CourtClerk@tn.gov

Knoxville
TN Bureau of Workers' Compensation
520 Summit Hill, Ste. 103
Knoxville, TN 37902
Fax: 865-594-5172
Email: PBD.CourtClerk@tn.gov

Memphis
TN Bureau of Workers' Compensation
One Commerce Square
40 South Main St., Ste. 500
Memphis, TN 38103-1820
Fax: 901-543-6039
Email: PBD.CourtClerk@tn.gov

Murfreesboro
TN Bureau of Workers' Compensation
845 Esther Lane
Murfreesboro, TN 37129-5537
Fax: 615-217-9378
Email: PBD.CourtClerk@tn.gov

Nashville
TN Bureau of Workers' Compensation
220 French Landing Drive, 1-B
Nashville, TN 37243-1002
Fax: 615-253-1223
Email: PBD.CourtClerk@tn.gov

Workers' Comp Court Clerk
TN Bureau of Workers' Compensation
220 French Landing, 1-B
Nashville, TN 37243-1002
Fax 615-253-2480
Email: PBD.CourtClerk@tn.gov