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

C20

CLAIMS ADM/CARRIER

JURISDICTION CLAIM # (STATE FILE #)	**CLAIM TYPE CODE** ☐ MED ONLY ☐ INDEMNITY ☐ BECAME LOST TIME ☐ BECAME MED ONLY ☐ NOTIFY ONLY ☐ TRANSFER
CLAMS ADM CLAIM # (INSURER CLAIM #)	
OSHA LOG CASE #	

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).

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

EMPLOYER

EMPLOYER NAME	EMPLOYER FEIN	SIC CODE	PHONE NUMBER
EMPLOYER ADDRESS LINE 1 AND LINE 2		NATURE OF BUSINESS	
CITY	STATE / ZIP	INSURED REPORT NUMBER	EMPLOYER LOCATION #

POLICY

INSURED NAME (parent co. if different than employer)	POLICY NUMBER	EFF DATE	**EMPLOYMENT STATUS CODE** ☐ FULL TIME/REGULAR ☐ PART TIME ☐ PIECE WORKER
	SELF INSURED? ☐ YES ☐ NO	EXP DATE	

EMPLOYEE

EMPLOYEE LAST NAME	PHONE INCL AREA CODE	**GENDER** ☐ MALE ☐ FEMALE ☐ UNKNOWN	☐ SEASONAL ☐ VOLUNTEER ☐ APPRENTICE FULL TIME ☐ APPRENTICE PART TIME
FIRST / MI	DEPARTMENT REGULARLY WORKED		
ADRRESS LINE 1 & 2		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 ☐ WEEKLY ☐ HOURLY ☐ BI-WEEKLY ☐ DAILY ☐ 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