STATE FILE #	SOCIAL SECURITY NO:	DATE OF INJURY:

FORM SD1

Revised 12-07 Page 1 of 3

WORKERS' COMPENSATION STATISTICAL DATA FORM

Fraud Warning. 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.

This area for Department use only.

THIS FORM MUST BE FILED WITH THE CLERK OF THE COURT THIS FORM MUST BE FILED WITH THE CLERK OF THE COURT CONTEMPORANEOUSLY WITH THE FINAL ORDER IN ALL WORKERS' COMPENSATION CASES IN WHICH THE COURT This area for Court use only.

EITHER TRIES THE CASE OR APPROVES A SETTLEMENT. FOR SETTLEMENTS SUBMITTED TO THE DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT FOR APPROVAL, SUBMIT THIS FORM WITH THE APPROVAL REQUEST. NEITHER THE ORDER OF THE COURT NOR THE DEPARTMENT'S APPROVAL IS FINAL UNTIL THIS FORM IS FULLY COMPLETED AND FILED WITH THE APPROPRIATE ENTITY. [STATUTORY AUTHORITY: TCA 50-6-244(b), (d)]							
I. EMPLOYEE INFORMATIO	N						
1. State File #:	2. SOCIAL SEC	CURITY NO:		3. DATE OF IN	NJURY:		
4. FIRST NAME:	1	5. MIDDLE IN	NITIAL:	6. LAST NAME:			
7. ADDRESS:		8. CITY:			10. ZIP:		
11. COUNTY & STATE OF RESIDENCE AT CO	ONCLUSION OF C	CASE	12. COUNTY & ST	ATE OF RESIDE	ENCE AT T	IME OF IN.	JURY:
COUNTY:	STATE:		COUNTY:			STAT	E:
13. Insurer File #:	1	4. DATE OF BIRT	ГН:		15. D	ATE OF HII	RE:
16. EDUCATION LEVEL: SOME COLLEGE/ASSOC DEGREE		ESS THAN 9TH	SOME HIGH SCHO		GED [HIG	GH SCHOOL DIPLOMA
17. ABLE TO RETURN TO PRIOR EMPLOYME			18. REASONABLY		LE JOB SK	ILLS? YES	□ NO □
19. READ & WRITE AT 8TH GRADE LEVEL?	YES NO						
II. CLAIM/INJURY INFORMA	ATION						
20. INJURY OCCURRED: IN TN OUT OF S		21.TN COUN		GE WEEKLY	23. WEEL	KLY COMF	PRATE
24. NATURE OF PRIMARY INJURY/ILLNESS:		OF INJURY:	WAGE:				
25. BODY PART:							
			: STATUTE OF LIMIT	ATIONS [], NO	TICE ,	NOT WORI	K RELATED □,
YES NO SURGERY PERFORMED? INTOXICATED/POSITIVE DRUG TEST OTHER, SPECIFY, 28. WAS SURGERY PERFORMED? 29. WAS PSYCHOLOGICAL INJURY CLAIMED? 30. WAS PSYCHOLOGICAL INJURY SOLE CLAIM?							
YES NO YES NO YES NO NO							
YES NO 33. DATE OF FIRST TTD PAYMENT: 34. FIRST DATE OUT OF WORK:			35. FINAL RETURN TO WORK DATE: 36. TOTAL NUMBER OF D				AL NUMBER OF DAYS
37. MMI DATE: 38. DATE RETURNED TO WORK BY PHYSICIA							
40. IS EMPLOYEE CURRENTLY RECEIVING SOCIAL SECURITY DISABILITY? YES NO							
41. DID INJURY RESULT IN DEATH? YES NO IF YES, THEN LIST DATE OF BIRTH, AND RELATIONSHIP OF ALL DEPENDENTS:							
42. CLAIMS ADMINISTRATOR OR TPA FIRM NAME: (If Different From Insurance Carrier) 43. CLAIMS ADM/TPA FEIN:						TPA FEIN:	
44. ADDRESS: 45. CITY: 46. STATE: 47. ZIP:						7. ZIP:	
48. NAME OF CASE MGMT PROVIDER:							
III. EMPLOYER INFORMATION							
49. EMPLOYER NAME: (not parent co., DBA where injured employee works) 50. FEIN:							
51. ADDRESS:	52. CITY:		53. STAT	E: 5	4. ZIP:		
55. DID EMPLOYER HAVE A CERTIFIED DRUG FREE WORKPLACE PROGRAM? YES NO							
56. IF SELF INSURED, NAME OF SELF INSUR	RED PROGRAM				57. SELF	INSURED	PROGRAM FEIN

49. EMPLOYER NAME: (not parent co., DBA where injured employee works)			50. FEIN:		
51. ADDRESS:	52. CITY:	53.	STATE:	54. ZIP:	
55. DID EMPLOYER HAVE A CERTIFIED DRUG FREE WORKPLACE PROGRAM? YES NO					
56. IF SELF INSURED, NAME OF SELF INSURED PROGRAM			57. SELF INSURED PROGRAM FEIN		

15 NAME OF INSURANCE CARRIER:	STATE FILE # SOCIAL SECURITY NO:					Υ:				
59, PSURANCE CARRIER FEIN: 60, ZPF.	FO	RM SD1					ļ.			
NAMES OF TREATING PHYSICIANS 64. (C) LAST NAME:							59. IN	SURANCE	CARRIER FEIN:	
NAMES OF TREATING PHYSICIANS 64. (C) LAST NAME:										
NAMES OF TREATING PHYSICIANS 64. (a) LAST NAME:	60. ADDRESS:			61. CITY:	61. CITY:			ATE:	63. ZIP:	
NAMES OF TREATING PHYSICIANS 64. (a) LAST NAME:	IV	MEDICAL AND VOC	ATIONAL FX	PERTS						
(P) IMPARRIENT RATING (%)				LKI						
(G) IDBODY OR SPECIFIC (B) SCHIDLLED MEMBER LOCATION MEMBER: (A) LAST NAME: (B) FIRST (C) MI: (D) TITLE: (M) D D D D D D D D D D D D D D D D D D D	64.	(A) LAST NAME:			(C) M	I: (D)		1	(E) LICENSE NUMBER:	
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(G) MPARMENT RATING (%) (G) TO BODY OR SPECIFIC (H) SCHEDILED MEMBER LOCATION MEMBER: LEFT RIGHT RIGHT		(A) LAST NAME:		(B) FIRST	(C) M		TITLE:	1	(E) LICENSE NUMBER:	
65. (a) LAST NAME: (B) FIRST (C) MI: (b) TITLE: (E) VOCATIONAL DISABILITY (E) VOCATIONAL DIS		(F) IMPAIRMENT RATING (%)		(G) TO BODY	OR SPECIF	FIC (H)	SCHEDULED MEMBE		ON	
S. A. LAST NAME				MEMBER.			LEF1 RIGH1			
Comparison Com				(B) FIRST	(c) M	I· (D)	Fitle:		(E) LICENSE NUMBER	
EMPLOYER'S IME(S) 66. (A) LAST NAME:	00.			NAME:			MD DO DC DC]		
(B) FIRST NAME: (B) FIRST (C) MI: (D) TITLE: (B) FLOOD OF (C) (E) LICENSE NUMBER: NAME: (D) DO OF (C) (D) DO OF (C) (D) DO OF (C) IN AMEDICAL PROPERT RATING (%) (C) TO BODY OR SPECIFIC (H) SCHEDULED MEMBER LOCATION LEFT (RIGHT (C) MEMBER: (D) FIRST (D) MEMBER: (D) TITLE: (E) SCHEDULED MEMBER LOCATION LEFT (RIGHT (C) MEMBER: (D) FIRST (D) TITLE: (E) VOCATIONAL DISABILITY NAME: (E) FIRST (C) MI: (D) TITLE: (E) VOCATIONAL DISABILITY NAME: (E) FIRST (C) MI: (D) TITLE: (E) VOCATIONAL DISABILITY PHD (D) MA (D) THE (E) VOCATIONAL DISABILITY NAME: (E) FIRST (C) MI: (D) TITLE: (E) VOCATIONAL DISABILITY NAME: (E) FIRST (C) MI: (D) TITLE: (E) VOCATIONAL DISABILITY NAME: (E) FIRST (C) MI: (D) TITLE: (E) VOCATIONAL DISABILITY NAME: (E) FIRST (C) MI: (D) TITLE: (E) VOCATIONAL DISABILITY NAME: (E) FIRST (C) MI: (D) TITLE: (E) VOCATIONAL DISABILITY NAME: (E) FIRST (C) MI: (D) TITLE: (E) VOCATIONAL DISABILITY NAME: (E) FIRST (C) MI: (D) TITLE: (E) VOCATIONAL DISABILITY NAME: (E) FIRST (C) MI: (D) TITLE: (E) VOCATIONAL DISABILITY NAME: (E) FIRST (C) MI: (D) TITLE: (E) VOCATIONAL DISABILITY NAME: (E) FIRST (C) MI: (D) TITLE: (E) VOCATIONAL DISABILITY NAME: (E) FIRST (C) MI: (D) TITLE: (E) VOCATIONAL DISABILITY NAME: (E) FIRST (C) MI: (D) TITLE: (E) VOCATIONAL DISABILITY (E) VOCATIONAL DISABILITY (E) VISITS? CHIROPRACTIC TREATMENT? YES (D) NO (D) FIRST (D) TITLE: (E) VOCATIONAL DISABILITY (E) VISITS? (C) MI: (D) TITLE: (E) VOCATIONAL DISABILITY (E) VISITS? (E) PHO (D) MA (D) TITLE: (E) VOCATIONAL DISABILITY (E) VISITS? (E) PHO (D) MA (D) TITLE: (E) VISITS? (E) MI (D) TI		(F) IMPAIRMENT RATING (%)		` ′	OR SPECIF	TC (H)	LEFT RIGHT	R LOCATIO	ON	
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EMPLOYEE'S VOCATIONAL EXPERT 67. (a) LAST NAME: (B) FIRST (C) MI: (D) TITLE: (E) VOCATIONAL DISABILITY NAME: (B) FIRST (C) MI: (D) TITLE: (E) VOCATIONAL DISABILITY NAME: (B) FIRST (C) MI: (D) TITLE: (E) VOCATIONAL DISABILITY NAME: (B) FIRST (C) MI: (D) TITLE: (E) VOCATIONAL DISABILITY NAME: (B) FIRST (C) MI: (D) TITLE: (E) VOCATIONAL DISABILITY NAME: (B) FIRST (C) MI: (D) TITLE: (E) VOCATIONAL DISABILITY NAME: (D) MI: (D) TITLE: (E) VOCATIONAL DISABILITY NAME: (E) VOCATIONAL DISABILITY NAME: (D) MI: (D) TITLE: (E) VOCATIONAL DISABILITY NAME: (D) MI: (D) TITLE: (D) MI: (D) TITLE: (D) MI: (D) MI:		(F) IMPAIRMENT RATING (%)		(G) TO BODY	OR SPECIF	FIC (H)	SCHEDULED MEMBE		ON	
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68. (A) LAST NAME:				NAME:			PHD MA OTH	ER 🗌	RATING:	
CHIROPRACTIC/PHYSICAL THERAPY 69. CHIROPRACTIC (TREATMENT) YES			XPERT	(p) Finer	(c) M	I: (D)	Гит Б.		(E) VOCATIONAL DISABILITY	
69. CHIROPRACTIC TREATMENT? YES \ NO \ 70. PHYSICIAL THERAPY? YES \ NO \ FYES, NUMBER OF VISITS? V. TYPE OF CONCLUSION AND COURT IDENTIFICATION INFORMATION TRIAL (Applicable only when the case has been TRIED by the court.) SETTLEMENT APPROVED BY COURT -COMPLAINT FILED (Applicable only when a lawsuit has been initiated by the filing of a complaint and summons.) SETTLEMENT APPROVED BY COURT -COMPLAINT NOT FILED. (Applicable only when a lawsuit has NOT been initiated by the filing of a complaint – term "joint petition" used to refer to this type of procedure for purposes of this form.) 71. STYLE OF CASE: 72. COURT DOCKET NO: 73. COUNTY: 74. COURT: 75. FULL NAME OF TRIAL JUDGE/CHANCELLOR: 79. DATE OF SETTLEMENT APPROVED BY DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT (Applicable only when the approval is by the Department.) 81. DATE OF SETTLEMENT APPROVED BY DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT (Applicable only when the approval is by the Department.) VI. BENEFIT REVIEW CONFERENCE 83. DATE OF CONFERENCE: 84. SETTLED? YES \ NO \ SET OF BODY OR SPECIALIST: VII. TRIAL RESULTS 86. PPDY% S8. DATE OF CONFERENCE: 88. DEATH CLAIM? YES \ NO \ SPECIALIST: VII. TRIAL RESULTS 87. PID? YES \ NO \ IF YES, NUMBER OF WEEKS? 89. JUDGMENT FOR EMPLOYER? YES \ NO \ NO \ IF YES, NUMBER OF WEEKS? 89. JUDGMENT FOR EMPLOYER? YES \ NO \ NO \ IF SELECT BASIS: STATUE OF LIMITATIONS \ NOTICE \ NOTICE \ NOTIONED \ NOTICE \ NOTICE \ NOTICE \ NOTICE \ NOTIVENE KRELATED \ IF SOTIONED \ NOTICE \ IF SOTIONED	08.	(A) LAST NAME:		` /	(C) M	I: (D)				
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83. DATE OF CONFERENCE: 84. SETTLED? YES NO SPECIALIST: YES NO IT PIECE SULTS 86. PPD% YES NO IF YES, NUMBER OF WEEKS? 87. PTD? YES NO IF YES, NUMBER OF WEEKS? 88. DEATH CLAIM? YES NO SPECIFIC MEMBER: 88. DEATH CLAIM? YES NO SPECIFIC MEMBER: 89. JUDGMENT FOR EMPLOYER? YES NO SELECT BASIS: STATUE OF LIMITATIONS; NOTICE ; NOT WORK RELATED ;			MEEDENGE							
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YES NO IF YES, NUMBER OF WEEKS? 87. PTD? YES NO IF YES, NUMBER OF WEEKS? 88. DEATH CLAIM? YES NO SELECT BASIS: STATUE OF LIMITATIONS; NOTICE ; NOT WORK RELATED;					то	BODY OR S	PECIFIC MEMBER		LEFT RIGHT	
YES NO IF YES, NUMBER OF WEEKS? 89. JUDGMENT FOR EMPLOYER? YES NO , SELECT BASIS: STATUE OF LIMITATIONS ; NOTICE ; NOT WORK RELATED ;	YES	☐ NO ☐ IF YES, NUMBER OF W	EEKS?					-0.v=- 🗖		
			EEKS?				88. DEATH CLAIM	1? YES 📙	NO 📙	
							OTICE :; NOT WORE	K RELATE	D □;	

Pg 2 of 3

LB-0904 (REV. 12-07) RDA 10183

STATE FILE #		SOCIAL SECURITY NO:				DATE OF INJURY:			
FORM SD1									
VIII. SETTLEMEN	NT TERMS								
90. PPD% YES ☐ NO ☐ IF YES, NUM	BER OF WEEKS?			TO BOD	Y OR SI	PECIFIC M	EMBER:		LEFT RIGHT
91. PTD? YES ☐ NO ☐ IF YES, NUM	MDED OF WEEKS?			92. DEATH CLAIM? YES NO					
93. FUTURE MEDICAL EXPI		; OPEN FOR LIFE ; OR, O	PEN FOR	A SPECIFII	ED PERI	OD? 🔲			
94. WAS MONEY PAID TO C	LOSE FUTURE ME	EDICALS?	95. DATE MEDICALS WERE OR WILL BE CLOSED:						
96. WAS CASE SETTLED PU	RSUANT TO TCA	50-6-206(b)? YES 1	NO 🗌						
IX. SECOND INJU	RY FUND								
97. Is this a second inju			98. W	/AS JUDGN YES □ N	_	NTERED A	GAINST SEC	COND INJUR	Y FUND?
99. APPORTIONMENT:	(1) EMPLOYER:	;%;#WKS;	TOTAI	AMT.		ECOND IN	J FUND	_%; #WKS;	TOTAL AMT.
X. MONETARY A	MOUNTS P.	AID							
TYPE OF BENEFIT		PAID PRIOR TO TRIAL/ SETTLEMENT					PAID PURSU SETTLEMEN	TOTAL PAYMENTS	
100. TEMP TOTAL DISABIL	ITY	SETTLEMENT	KESO	LIS			SETTEEMEN	T TERMS	
101. TEMP PARTIAL DISAB	ILITY								
102. PERMANENT PARTIAL	DISABILITY								
103. PERMANENT TOTAL D	ISABILITY								
104. DEATH BENEFITS									
105. BURIAL EXPENSES									
106. MEDICAL EXPENSES T (includes medicine, PT, ch MD/DO costs, tests)									
107. CASE MANAGEMENT	COSTS								
108. DISCRETIONARY COSTS									
109. AMOUNT PAID TO CLOSE FUTURE MEDICAL EXPENSE									
110. LUMP SUM PAYMENT (not based on specific disability %)									
111 DATE LUMP SUM PAID (not based on specific disability %):									
112. TOTALS (ADD TOTALS FROM LINES 100 THRU 110)									
113. AMOUNT PAID IN LUMP SUM FROM LINES 100 THRU 105; (DO NOT ADD THIS AMOUNT TO TOTAL PAYMENTS. IT IS ALREADY INCLUDED IN THE TOTALS ABOVE.)						114. DATE LUMP SUM PAID FROM LINES 100 THRU 105			
XI. ATTORNEYS	FEES								
115. EMPLOYEE'S ATTORNEY FEE; AMOUNT OF AWARD % OF AWARD						116. WAS FEE APPROVED BY COURT ☐ OR TDLWD ☐			
117. EMPLOYER'S ATTORN	IEY FEE (SPECIFY		; \$1501	3000 □;	\$3000	\$10,000			
XII. CERTIFIC	CATION ANI	SIGNATURES							

By providing my BPR number and my signature, I hereby certify that I have read the contents of the form and the information provided is true and correct to the best of my knowledge. ATTORNEY MUST PROVIDE BPR#.

118. NAME OF EMPLOYEE'S ATTORNEY:	BPR#	119. NAME OF EMPLOYER'S ATTORNEY: BPR#
120. NAME OF EMPLOYEE:		121. NAME OF ADJUSTER/CARRIER/EMPLOYER REPRESENTATIVE:
SIGNATURE OF EMPLOYEE	DATE	SIGNATURE OF ADJUSTER/CARRIER/EMPLOYER REP DATE SIGNED

SIGNATURE OF EMPLOYEE'S ATTORNEY

DATE
SIGNATURE OF EMPLOYEE'S ATTORNEY

DATE
SIGNATURE OF EMPLOYEE'S ATTORNEY

DATE
SIGNATURE OF EMPLOYER'S ATTORNEY

DATE SIGNED

Pg 3 of 3