### TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

**EMPLOYER’S FIRST REPORT OF WORK INJURY OR ILLNESS**

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).

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### Claims Admin/Carrier

- JURISDICTION CLAIM # (STATE FILE #)
- CLAIMS ADM CLAIM # (INSURER CLAIM #)
- OSHA LOG CASE #
- NAME OF INSURANCE CARRIER
- CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)
- CLMS ADJ PHONE #

### Employer

- EMPLOYER NAME
- EMPLOYER FEIN
- WC NUMBER
- EMPLOYER LOCATION
- INSURED REPORT #
- NATURE OF BUSINESS
- SIC CODE
- PHONE NUMBER

### Insured Name (Parent Co. If Different Than Employer)

- INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)
- POLICY NUMBER
- EFF DATE
- EXP DATE
- SELF INSURED?
- YES
- NO

### Employee

- EMPLOYEE LAST NAME
- FIRST NAME
- MI
- MARITAL STATUS
- MARRIED
- UNMARRIED, SINGLE,
- SEPARATED
- DIVORCED
- UNKNOWN
- DEPARTMENT REGULARLY WORKED
- OCCUPATION DESCRIPTION
- GENDER
- MALE
- FEMALE
- UNKNOWN
- DEPARTMENT REGULARLY WORKED
- EMPLOYMENT STATUS CODE
- FULL TIME/REGULAR
- PART TIME
- PIECE WORKER
- SEASONAL
- VOLUNTEER
- APPRENTICE FULL TIME
- APPRENTICE PART TIME

### Wage

- WAGE
- PERIOD
- NUMBER OF DAYS WORKED PER WEEK
- TIME OF INJURY
- AM
- PM
- DATE EMPLOYER NOTIFIED OF INJURY
- BODY PART AFFECTED CODE
- NATURE OF INJURY CODE
- CAUSE OF INJURY CODE

### Accident/Injury

- DATE OF INJURY
- DATE CLAIM ADM NOTIFIED OF INJURY
- DATE LAST DAY WORKED
- DATE DISABILITY BEGAN

### Return to Work Date (If Applicable)

- DATE OF DEATH (IF APPLICABLE)
- TOTAL # DEPENDENTS
- IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP
- FATHER
- SISTER
- DAUGHTER
- BROTHER
- MOTHER
- SON
- HANDICAPPED CHILD

### 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

### Date Prepared

- PREPARER’S NAME & TITLE
- PREPARER’S COMPANY NAME
- PHONE NUMBER

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**RDA 10183**

**LB-0021 (REV. 12/07)**