TNRMT
TENNESSEE RISK MANAGEMENT TRUST
101 Tamaras Way, Hendersonville, TN 37075
888-743-4336 | Fax: 615-953-6292
wcclaims@tnrmt.com

SEC | SAFETY ENGINEERING & CLAIMS MANAGEMENT
111 Hazel Path, Hendersonville, TN 37075
615-826-4274 | Fax 615-826-6378
wcclaims@sectn.com

EMPLOYEE ACCIDENT REPORT

Employee Name: _____

Address: _____

Phone: _____ **Email Address:** _____

DOB: _____ **SS #:** _____ **Date of Hire:** _____

Job Title: _____ **School:** _____

Date of Injury: _____ **Time of Injury:** _____ **Shift Start Time:** _____

Location of Accident: _____

Body Parts Injured:
Please specify whether right or left side for each body part. (example: right hand, left knee, low back)
Specific Fingers/Toes: Index/First, Middle/Second, Ring/Third, Pinky/Fourth, Thumb/Great Toe

_____

_____

_____

Describe Exactly What Happened: _____

_____

_____

Medical Treatment:
None at this time ____ **Minor by Employer** ____ **Hospital** ____ **Minor by Doctor/Clinic** ____

Name of Supervisor _____ **Was the injury reported to your supervisor?** _____

When was the injury reported? _____ **To whom was the injury reported?** _____

What did your supervisor do? _____

List All Witnesses _____

_____

Employee Signature _____ **Date** _____

Please submit all paperwork via fax or email after reporting claim online.

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ACCIDENT WITNESS REPORT

Witness Name: _____

Work Number: _____ Alternate Number: _____

Witness Email Address: _____

Job Title: _____ Shift Start Time: _____

Date of Accident: _____ Time of Accident: _____

Location of Accident: _____

Identify the Employee Involved in the Accident: _____

Did you see the accident happen? Yes _____ No _____

If no, explain what you were told. _____

_____

_____

If yes, describe exactly what you saw. _____

_____

_____

List Any Other Witnesses: _____

_____

Witness Signature _____ Date _____

Please submit all paperwork via fax or email after reporting claim online.

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SUPERVISOR ACCIDENT INVESTIGATION REPORT

Supervisor Name: _____

Work Number: _____ Alternate Number: _____

Job Title: _____ Department: _____

Identify the Employee Involved in the Accident: _____

Date of Accident: _____ Time of Accident: _____

Location of Accident: _____

Did the employee report the accident to you? Yes _____ No _____

If no, who reported the accident to you? _____

When did the employee report the accident to you? _____

What was reported to you about the accident? _____

_____

_____

Did the injured employee receive first aid? Yes _____ No _____

Was injury report or first aid delayed? Yes _____ No _____

If yes, why? _____

Was the employee referred for outside medical treatment? Yes _____ No _____

If so, where? _____

Was the employee provided a workers' comp panel? Yes _____ No _____

List Any Witnesses: _____

_____

Was corrective action required? Yes _____ No _____

If yes, what correction action was taken? _____

Supervisor Signature _____ Date _____

Please submit all paperwork via fax or email after reporting claim online.

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MEDICAL AUTHORIZATION

RE: Name: _____

DOB: _____

SSN: _____

1. In accordance with the provisions of the Privacy Rule for the Health Insurance Portability and Accountability Act, I,_____, do hereby expressly authorize any and all hospitals, physicians, clinics, chiropractors, pharmacists, therapists, and any and all other medical personnel and health care providers, to provide my medical records and/or medical information to my Employer, Insurer, Tennessee Risk Management Trust, its Third Party Administrator, Safety Engineering Consultants, Inc., and/or nurse case manager; said records including, but not limited to, all reports, records, clinical notes, diagnostic tests, operative notes, billing, and all other documentation or information produced by the aforesaid providers and pertaining to my medical care; and said aforesaid providers are hereby authorized and ordered to release said records to my Employer, Insurer, Tennessee Risk Management Trust, its Third Party Administrator, Safety Engineering Consultants, Inc., and/or nurse case manager for inspection and use, and any records obtained pursuant to this Authorization shall not be used or released to any third party not connected with my workers' compensation claim. This authorization specifically authorizes the aforementioned hospitals, physicians, clinics, chiropractors, pharmacists, therapists, and any and all other medical personnel and health care providers, to have communications, either in person, via telephone, or in writing, with my Employer, Insurer, Tennessee Risk Management Trust, its Third Party Administrator, Safety Engineering Consultants, Inc., and/or nurse case manager, regarding any aspect of my medical condition, including but not limited to diagnosis, etiology, medical restrictions, medical impairment, and prognosis.

2. A photocopy of this Medical Authorization shall be deemed as effective and valid as the original.

3. I understand that this Medical Authorization allows the disclosure of reports, records, clinical notes, diagnostic tests, operative notes, and other documentation or information pertaining to psychotherapy treatment.

4. I understand that I have the right to revoke this authorization at any time. I understand that if I do revoke this authorization, I must do so in writing and present my written revocation to My Employer, Insurer, Tennessee Risk Management Trust, its Third Party Administrator, Safety Engineering Consultants, Inc., and/or nurse case manager. Said revocation will be effective only when a covered entity which had previously been authorized to make disclosure receives the written notification of revocation. A revocation will not be effective to the extent that a covered entity has already taken action in reliance thereon.

5. Unless otherwise revoked, this Authorization will be effective during the pendency of my workers' compensation claim.

Please submit with First Report of Injury Form within 24 hours

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6. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

7. I understand that treatment, payment, enrollment, or eligibility for benefits is not conditioned on my signing this Medical Authorization.

8. My Employer, Insurer, Tennessee Risk Management Trust, its Third Party Administrator, Safety Engineering Consultants, Inc., and/or nurse case manager, are hereby released from any and all liability or responsibility which could or might result because of the disclosure of any information pursuant to this authorization including, but not limited to, liability resulting from any breach of an implied covenant of confidentiality.

9. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

_____ _____

Signature of Employee Date