



## Claims Reporting

## Policy and Procedures

## Tennessee

Fax or email all completed forms **WITHIN 4 HOURS** of notification of an injury to:

239-415-1114

Or

[claim@continuumhr.com](mailto:claim@continuumhr.com)

March 2018

# OSHA –REPORTING REQUIREMENTS

OSHA requires the reporting of severe work-related injuries and illnesses that all covered employers must adhere. All fatalities must be reported within 8 hours and all inpatient hospitalizations, amputations and loss of an eye within 24 hours to OSHA.

## How to report fatalities, severe work-related injuries, and illnesses to OSHA?

You can report to OSHA by:

- Calling OSHA's free and confidential number at 1-800-321-OSHA (6742)
- Calling your closest OSHA Area Office during normal business hours
- Using the new OSHA online form found at:  
<https://www.osha.gov/pls/ser/serform.html>

## Information Required When Filing a Report

- Establishment name
- Location of the incident
- Time of the incident
- Type of reportable event
- Number of employees injured / deceased
- Names of injured / deceased
- Your contact person and phone number
- Description of incident

Only fatalities occurring within 30 days of the work-related incident must be reported to OSHA. Further, for an inpatient hospitalization, amputation or loss of an eye, these incidents must be reported to OSHA only if they occur within 24 hours of the work-related incident.

Because of the time restraints, **YOU**, the on-site employer should notify OSHA of all reportable events using one of the methods described above. If however, you notify CHR in time and with **ALL** of the required information, we would be happy to assist you by notifying OSHA on your behalf. When calling CHR for assistance in this matter, please be clear in stating that you wish CHR to contact OSHA to report the accident.

Should you have any questions, please feel free to contact the office @239-415-1110 or [claim@ContinuumHR.com](mailto:claim@ContinuumHR.com).



## Post Accident Drug Testing

Post accident drug testing is a requirement of your insurance carrier. **In ALL CASES where an employee receives initial medical treatment for a workplace accident, a post accident drug test is REQUIRED.** Drug testing should be performed the same day of treatment or prior to reporting to work the following day. In almost all cases, a drug test is required within **4 hours, but no later than 24 hours** of the initial incident or of the employee reporting the incident.

We have made this process easier for you by establishing accounts at Labcorp and Quest Diagnostics. By taking the applicable Chain of Custody (COC) form to the location, the employee can be tested and returned to work as quickly as possible and at no cost to you or the employee.

In addition, some Walk-In Clinics perform post accident testing at their facility. If possible, check with the facility prior to sending the employee and see if they use either Labcorp or Quest for testing. If they do, when the employee goes for initial treatment, make sure they bring the appropriate COC. That way, the employee can receive the initial treatment and submit the drug test in the same visit.

**It is of the utmost importance that the employee be drug tested within 4 hours, but no later than 24 hours.**

While we ask when possible to use a Labcorp or Quest for post accident testing, as long as an accredited lab conducts the test, it will meet your obligation to the carrier.

If your clinic does not use Labcorp or Quest, you can find your nearest lab locations by using the links below. Pay special attention to the times drug testing is offered at each location as it may differ from lab to lab.

### LabCorp

<https://www.labcorp.com/wps/portal/findalab>

### Quest

<https://secure.questdiagnostics.com/hcp/psc/jsp/SearchLocation.do?newSearch=FindLocation>

If you have not received your Chain Of Custody forms or need more, please call our office at 239-415-1110 and we will order more for you.

Please note; the COC's you receive are ONLY to be used for post accident testing. All other types of drug tests (pre-hire, random, etc.) are coordinated using the Global HR online system. Please contact our HR Department for further information regarding that process.



## Claims Reporting Forms and Procedures

All forms and medical paperwork are to be faxed or emailed to the Claims Center at 239-415-1114 or [claim@continuumhr.com](mailto:claim@continuumhr.com)

<p style="text-align: center;"><b><u>First Report of Injury (FROI)</u></b></p>	<p>Complete this form IMMEDIATELY. Do not wait until other forms are completed. Submit to the Continuum HR Claims Center via email or fax <b><u>within 4 hours</u></b> of the accident. A sample form has been included as a reference. If an employee requires medical treatment, <b><u>YOU are required</u></b> to contact the clinic and arrange the first visit.</p>
<p style="text-align: center;"><b>AR-1</b> Employee Injury/Illness Accident Report</p>	<p>Form needs to be completed by the injured worker <b><u>ASAP</u></b> following an accident and basic first aid or medical treatment.</p>
<p style="text-align: center;"><b>AR-2</b> Supervisor's Accident Investigation Report</p>	<p>Form needs to be completed every time an employee is involved in a work related injury or accident. This form is also to be used for "Report Only" incidents that do not require medical attention. Form should be completed and submitted with the FROI within 4 hours of the accident. This form will assist the supervisor with conducting a thorough investigation</p>
<p style="text-align: center;"><b>AR-3</b> Witness Statement Form</p>	<p>Form needs to be completed whenever there is a witness to an accident. Have all witnesses complete this form immediately following the incident, while facts are clear. Once completed, the form should be signed and returned to the Claims Center via email or fax.</p>
<p style="text-align: center;"><b><u>Chain of Custody</u></b> Drug Test Form</p>	<p><b><u>Post Accident drug tests are mandatory and must be performed within 24 hours of the incident.</u></b> Send or escort the employee to the nearest Labcorp facility with the Labcorp Chain of Custody form. Labcorp locations can be found at <a href="https://www.labcorp.com/wps/portal/findalab">https://www.labcorp.com/wps/portal/findalab</a> CHR can schedule this appointment for you. Please call 239-415-1110 for assistance.</p>
<p style="text-align: center;"><b>AR-4</b> Consent for Release of Medical Information</p>	<p>Form needs to be completed and sent to CHR <b><u>if/when the employee seeks medical treatment.</u></b> This completed form proves our ability (CHR / the carrier) to request and receive medical documents relating to the claim directly from the treating facility.</p>
<p style="text-align: center;"><b>AR-5</b> Medical Authorization for Initial Treatment</p>	<p>Form should be sent with the injured employee to the medical provider. Fill in the employee's name and Social Security Number before employee seeks treatment.</p>
<p style="text-align: center;"><b>AR-6</b> Refusal of Medical Treatment</p>	<p>If an employee reports an incident but <b><u>refuses medical treatment</u></b>, have them complete this form <b><u>immediately.</u></b> This is not a waiver for all medical treatment. The employee may choose at a later date to seek medical treatment if necessary, however, they <b><u>MUST follow the state mandated guidelines</u></b> for Workers Compensation injuries. They <b><u>cannot</u></b> go to their personal physician or an ER without prior authorization from the Claims Center. A post accident drug screen <b><u>may/may not be required</u></b> when an employee signs this form. Please call CHR for guidance.</p>
<p style="text-align: center;"><b><u>Medical Treatment and Paperwork</u></b></p>	<p>After any and all medical treatment(s), employees are required to supply the employer with all paperwork provided by the treating physician(s). This paperwork must be faxed immediately to the claims center. The injured employee must <b><u>keep to all appointments...</u></b> even if they are feeling better.</p>



## **Workers Compensation FAQ**

**Should I send my injured employee to the Emergency Room?** Only use ER's for sever/traumatic injury cases, if it is after normal business hours and clinics are closed, OR, if a walk in clinic is not located within a reasonable distance of the employee. Treatment is typically slower in an ER and can cost as much as 5 times more than a clinic for most common workplace injuries.

**Should someone go to the clinic with my injured employee the first time?** If at all possible you should send a company representative to the clinic with the employee. This shows the employee that you care and ensures that you are aware of any developments or complications with the treatment.

**When an employee is injured, should I call the clinic?** YES! Contact the nearest clinic and let them know you have an employee on the way, the nature of the injury, and that it is a work comp claim. This is a requirement in some states and is always a good practice. Ensure that the clinic has the "Medical Authorization For Initial Treatment" (AR-5) form.

**Why do I have to forward the medical paperwork? Doesn't it come to your and the carrier anyway?** Eventually the paperwork may find its way to us and the carrier, however, it may be days or weeks after the treatment. By not forwarding your copies of the paperwork, you could possibly delay necessary treatments, specialist referrals, diagnostics, and increase the overall cost of the claim.

**What is "Light Duty"?** Light duty refers to tasks the employee has been medically approved to perform while they heal from their injury. Often times the treating physician does not allow the injured employee to perform his/her regular duties based on the physical demands of their original position. The doctor then states on a form what physical activities are allowed during the employees' recovery. The restriction may change after additional medical treatments so always refer to the most recent medical paperwork returned with the employee.

**If I have an employee that is taken out of work by the treating doctor, what should I do.** Notify us immediately and forward all medical paperwork. Sometimes doctors will make a determination without all the facts about the employees' work responsibilities. We will work with you, the carrier, and the medical provider to ensure that the employee returns to work as quickly as possible.

**The employee went to the doctor. They claim to be fine but didn't bring back any paperwork. What should I do?** If the employee receives treatment from a medical facility and he/she returns to work "full-duty" with no restrictions, a release from the treating physician must be obtained before the employee may begin work. Call the clinic and have them email/fax the paperwork or send the employee back to obtain the release. You cannot allow them to work without a written release from the treating facility.

**Can the employee go anywhere they want for treatment, like to their personal doctor?** Absolutely NOT. The employee must go to an approved facility and all visits after the initial care MUST be authorized by the carrier.

**How many witnesses need to fill out the Witness Statement Form?** If possible, have ALL of the witnesses fill out the form. Often times you will get different accounts that can help in the investigation. Also, should the employee get a lawyer, witness statements help in the defense of the lawsuit.

**How do I report a claim that happens after normal business hours?** You can call the CHR corporate headquarters like you would call during regular business hours and leave a message. You can send an email or fax. If you need to speak with someone immediately, you may contact Phil Herron on his cell at 678-988-8544. If he does not answer please leave a message and he will get back to you ASAP. The office phone number is 239-415-1110 and the fax number is 239-592-9800. At any time, to email information about a claim please send it to [claim@continuumhr.com](mailto:claim@continuumhr.com).

**If an employee is involved in auto accident while working, do I need to report it to workers' compensation? If so why?** If an employee is injured while performing a job function for the company (even if that function involves driving or riding in a vehicle), it is a workers' compensation claim. The work comp carrier can then try to recoup some of the costs of the claim from the responsible parties auto carrier.

**What information is helpful during an investigation of an injury?** Pictures, documentation, and witness statements. Take pictures of the equipment and area the employee was working in when the injury happened? Use an item to show scale if possible. Have a person stand in the picture to point out the specific area, part, or location where or how the injury occurred. Document everything; claims forms, name and type of equipment involved (model and SN if applicable), and witness statements.

**When an employee has filed a claim and has returned to work on light duty, can they come and go as they please?** No. The light duty restrictions will detail if a reduction of hours is necessary for the proper healing of the injury. Other than for medical treatments and/or evaluations, the employee should be expected to maintain a normal work schedule.

**Can I fire an employee that has filed a claim?** NO! There are very few circumstances that allow for terminating an injured employee without severe penalties to you and your business. In addition, you/we lose complete control of making sure the injured employee follows the medical orders, goes to appointments and treatments, and inevitably the cost of the claim soars. **CALL US** and we will discuss the situation and assist you with getting the immediate problem corrected.

**Can I fire an employee after their claim has been closed?** It is against the law to terminate an employee for being injured at work whether the claim is open or closed. However, you can terminate the employee for cause for misconduct or performance reasons with proper written documentation showing a disciplinary process has been followed. **CALL US FIRST to review the circumstances and to receive guidance.**

**If an employee tells me they had an accident on the job, but they don't want to go to the doctor, do we report this?** YES! The employee must fill out the refusal form (AR-6) and it must be sent to us immediately. There are many times where an employee initially refuses treatment and then later decides to go. Late reporting causes a number of problems including having to remember forgotten details and possible fines from the state.

**Why must the employee take a drug test immediately after being injured?** The carrier requires that a drug test be performed. In addition, some states require the test to be performed within hours of the incident. To be accepted as part of the claims process, the test has to be timely in relation to the accident. Also, should an employee test positive for drugs or alcohol, by law the compensation benefits can be reduced or the claim can be denied outright. This has the potential of saving YOU money.

**Can we reduce the wages of an injured employee working light duty work?** The employee should be paid as close to their normal wages as possible based on the restrictions and work that is available. An employee returning to work but unable to perform their normal duties can be assigned other duties that meet the light duty restrictions. The employee only has to be paid what the interim job is worth, but it SHOULD be at least 80% of their current pay. If the employee meets the requirements, a percentage of the difference between the two wages will be made up by the workers' compensation carrier. **If you choose to pay a lower than current wage, please call CHR and let us know so that we file the correct paperwork to ensure that the employee is paid what they are owed.**

**Must we work an injured employee their normal work hours/shift?** It is always better for the overall cost of the claim to have the employee work a normal schedule if the restrictions allow it. If you do not have enough light duty work to support a regular shift, you do not have to create work to keep the employee busy. If you are having difficulty providing hours to an injured employee, please contact CHR and we discuss the situation with you.

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



<b>CLAIMS ADM/CARRIER</b>	JURISDICTION CLAIM # (STATE FILE #)		CLAIM TYPE CODE MED <input type="checkbox"/> ONLY INDEMNITY <input type="checkbox"/> BECAME <input type="checkbox"/> LOST TIME BECAME <input type="checkbox"/> MED ONLY NOTIFY <input type="checkbox"/> ONLY TRANSFER <input type="checkbox"/>		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).					
	CLAIMS ADM CLAIM # (INSURER CLAIM #)		CARRIER FEIN							
	OSHA LOG CASE #		FEIN OF CLMS ADM							
	NAME OF INSURANCE CARRIER		CLMS ADJ PHONE #							
	CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)		CLM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2					CITY	STATE	ZIP
	CLAIMS ADJUSTER NAME									
<b>E. EMPLOYER</b>	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			
<b>POLICY</b>	INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)		POLICY NUMBER		EFF DATE		<b>EMPLOYMENT STATUS CODE</b> <input type="checkbox"/> FULL TIME/REGULAR <input type="checkbox"/> PART TIME <input type="checkbox"/> PIECE WORKER <input type="checkbox"/> SEASONAL <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> APPRENTICE FULL TIME <input type="checkbox"/> APPRENTICE PART TIME			
			SELF INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO		EXP DATE					
<b>EMPLOYEE</b>	EMPLOYEE LAST NAME		PHONE INCL AREA CODE		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN					
	FIRST	MI	DEPARTMENT REGULARLY WORKED		OCCUPATION DESCRIPTION					
	ADDRESS LINE 1 & 2									
	CITY		STATE	ZIP	MARITAL STATUS <input type="checkbox"/> UNMARRIED, SINGLE, DIVORCED		<input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN	NCCI CLASS CODE		
	SSN		DATE OF BIRTH	DATE OF HIRE						
<b>WAGE</b>	WAGE \$	PERIOD <input type="checkbox"/> WEEKLY <input type="checkbox"/> HOURLY <input type="checkbox"/> DAILY	<input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> MONTHLY		NUMBER OF DAYS WORKED PER WEEK		SALARY CONTINUED IN LIEU OF COMPENSATION <input type="checkbox"/> YES <input type="checkbox"/> NO			
							FULL WAGES PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO			
<b>ACCIDENT/INJURY</b>	DATE OF INJURY		TIME OF INJURY <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> COULD NOT BE DETERMINED		TIME EMPLOYEE BEGAN WORK ON INJURY DATE <input type="checkbox"/> AM <input type="checkbox"/> 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							
	DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> WIDOW	<input type="checkbox"/> FATHER	___ SISTER	TOTAL # DEPENDENTS				
		<input type="checkbox"/> WIDOWER	___ DAUGHTER	___ BROTHER						
		<input type="checkbox"/> MOTHER	___ SON	___ HANDICAPPED CHILD						
ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)						COUNTY OF INJURY				
CITY						STATE	ZIP			
<b>TREATMENT</b>	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 <input type="checkbox"/> NO MEDICAL TREATMENT		<input type="checkbox"/> MINOR BY EMPLOYER <input type="checkbox"/> MINOR BY CLINIC/HOSPITAL		<input type="checkbox"/> HOSPITALIZED > 24 HRS <input type="checkbox"/> EMERGENCY CARE		<input type="checkbox"/> FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED			
<b>OTHER</b>	DATE PREPARED		PREPARER'S NAME & TITLE		PREPARER'S COMPANY NAME		PHONE NUMBER			

# TENNESSEE WORKERS' COMPENSATION INSURANCE POSTING NOTICE



*Employers: The law requires this notice to be conspicuously posted at the employer's place of business so all employees have access to it.*

## WHO IS REQUIRED TO HAVE WORKERS' COMPENSATION INSURANCE?

All employers with five (5) or more full or part-time employees, except as indicated below.

All employers engaged in the mining and production of coal with one (1) or more employees.

All workers in the construction industry unless they are specifically exempted.

To confirm if an employer is subject to the workers' compensation law and, if so, to obtain the name of the workers' compensation insurance company contact:

\_\_\_\_\_  
Name of employer representative authorized to provide information on workers' compensation

\_\_\_\_\_  
Telephone number of employer representative to provide information on workers' compensation

\_\_\_\_\_  
Address of employer representative to provide information on workers' compensation

## WHAT SHOULD AN EMPLOYEE DO IF INJURED AT WORK?

1. Report the injury to the employer immediately. Employer notification is required;  
AND,
2. Select a treating physician from a panel provided by the employer. To report an injury contact:

\_\_\_\_\_  
Name of employer representative to notify in 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

## WHAT SHOULD AN EMPLOYER DO WHEN AN INJURY IS REPORTED?

1. Immediately complete a First Report of Work Injury form and send it to the workers' compensation insurance company or the third party administrator to be filed with the Tennessee Division of Workers' Compensation;  
AND,
2. Offer a panel of physicians.  
The employer shall designate a panel of three (3) or more independent reputable physicians, surgeons, chiropractors or specialty practice groups if available in the injured employee's community or, if not so available, within a 100-mile radius of the employee's community. The names shall be provided on a state-developed form, AGREEMENT BETWEEN EMPLOYER/EMPLOYEE CHOICE OF PHYSICIAN —Form C-42. Additional instructions are available on the form. The employee shall select a treating physician from the employer's panel.

The Tennessee Division of Workers' Compensation has staff available to help both employees and employers. For more information contact:

TENNESSEE DIVISION OF WORKERS' COMPENSATION  
220 FRENCH LANDING DRIVE  
NASHVILLE, TENNESSEE 37243-1002  
615-532-4812 OR TOLL FREE 1-800-332-2667  
1-800-332-2257 (TDD)  
[www.tn.gov/labor-wfd/wcomp.html](http://www.tn.gov/labor-wfd/wcomp.html)

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

Division of Workers' Compensation

220 French Landing Dr.  
Nashville, Tennessee 37243-1002



**AGREEMENT BETWEEN EMPLOYER/EMPLOYEE CHOICE OF PHYSICIAN**

*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.*

In compliance with The Tennessee Workers' Compensation Law, T.C.A. Section 50-6-204

The injured employee shall accept the medical benefits afforded hereunder; provided, the employer shall designate a group of three (3) or more reputable physicians or surgeons not associated together in practice, if available in that community, from which the injured employee shall have the privilege of selecting the operating surgeon and the attending physician. If the injury is a back injury, the statutory panel must be expanded to 4, one of whom must be a chiropractor with treatment limited to 12 chiropractic visits. Further, if the injury or illness requires the treatment of a physician or surgeon who practices orthopedic or neuroscience medicine, the employer **may** appoint a panel practicing orthopedic or neuroscience medicine consisting of 5 physicians, with no more than 4 physicians affiliated in practice. If the employer provides this panel, the injured employee shall be entitled to have a second opinion on the issue of surgery, impairment, and a diagnosis from that same panel.

1.	_____	_____	_____	_____
	PHYSICIAN'S NAME		PHONE	
	_____	_____	_____	_____
	OFFICE ADDRESS	CITY	STATE	ZIP
2.	_____	_____	_____	_____
	PHYSICIAN'S NAME		PHONE	
	_____	_____	_____	_____
	OFFICE ADDRESS	CITY	STATE	ZIP
3.	_____	_____	_____	_____
	PHYSICIAN'S NAME		PHONE	
	_____	_____	_____	_____
	OFFICE ADDRESS	CITY	STATE	ZIP
4.	_____	_____	_____	_____
	PHYSICIAN'S or CHIROPRACTOR'S NAME		PHONE	
	_____	_____	_____	_____
	OFFICE ADDRESS	CITY	STATE	ZIP
5.	_____	_____	_____	_____
	PHYSICIAN'S NAME		PHONE	
	_____	_____	_____	_____
	OFFICE ADDRESS	CITY	STATE	ZIP

(d)(1) "The injured employee must submit to examination by the employer's physician at all reasonable times if requested to do so by the employer, but the employee shall have the right to have the employee's own physician present at such examination, in which case the employee shall be liable to such physician for such physician's services."

(7) "If the injured employee refuses to comply with any reasonable request for examination or to accept the medical or specialized medical services which the employer is required to furnish under the provisions of this law, such injured employee's right to compensation shall be suspended and no compensation shall be due and payable while such injured employee continues such refusal."

**According to the provisions of this agreement, I hereby have selected the following physician from the list provided to me by my employer.**

Physician chosen: \_\_\_\_\_

Date of injury: \_\_\_\_\_

Date of selection: \_\_\_\_\_

Date of appointment: \_\_\_\_\_

\_\_\_\_\_  
Employer's Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Employer's Signature

\_\_\_\_\_  
Employee's Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Employee's SSN

\_\_\_\_\_  
State File Number

**CLEAR FORM**



**State of Tennessee**  
**Department of Labor and Workforce Development**  
**Division of Workers' Compensation**  
**220 French Landing Drive**  
**Nashville, Tennessee 37243-0661**  
**1-800-332-2667**  
**Fax: (615) 741-9916**

## **FORM C-41 WAGE STATEMENT**

Pursuant to T.C.A. Section 50-6-201 (c), an insurance carrier, employer or self-insured employer shall file a wage statement on a Form C-41, Wage Statement, a form prescribed by the Tennessee Department of Labor & Workforce Development, Workers' Compensation Division. The Form C-41 must be properly completed and filed with the Division within thirty (30) calendar days of the notice of the injury if one of the following occur:

- If the injured worker suffers a work-related injury that results in the employee not returning to work within seven (7) days after the accident
- If the work-related injury results in death
- If the work-related injury results in permanent impairment

The wage statement will detail the injured worker's wages for the 52 weeks prior to the injury. However, if the employee did not work 52 weeks prior to the injury with the employer, the wage statement must reflect all wages earned and the applicable number of weeks that the employee worked for the employer. In addition, those particular claims require that the specific fields, RATE PER DAY, PER HOUR and AVERAGE PER WEEK be completed accurately.

Effective July 1, 2007, the Workers' Compensation Division will no longer accept printouts, adding machine tapes or any other attachments to the Form C-41 Wage Statement. It is most important that the **Employee's name, Social Security number, State File number, Insurer Claim number and Date of injury** fields be filled out accordingly on each wage statement submitted to the Division. The itemized weekly gross wages should be totaled and the resulting Average per week computed.

Incomplete Form C-41 wage statements will not be accepted by the Division and will be returned to the insurance carrier, employer or self-insured. The latest version of the Form C-41 wage statement is available online at the Workers' Compensation homepage, at <http://www.state.tn.us/labor-wfd/forms/c41.pdf>

Upon approval by the Division, the C-41 can be replicated with other software which would allow for the form to be computer generated. It is important that the location/positions of the data fields are not modified or deleted. For approval, send the form to [Bonnie.Hudgens@state.tn.us](mailto:Bonnie.Hudgens@state.tn.us) or fax the form to (615) 532-1942.

SAH/bjh  
March 2007

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

Division of Workers' Compensation

220 French Landing Dr.  
Nashville, Tennessee 37243-1002



WAGE STATEMENT

*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.*

Employee: \_\_\_\_\_ SSN: \_\_\_\_\_ State File # \_\_\_\_\_

Insurer Claim #: \_\_\_\_\_ Date of Injury \_\_\_\_\_

In order to determine the correct rate of compensation to be paid to the above injured party, please fill in the schedule below and return it promptly. This information is required by law and no agreement for payment of compensation can be made until it has been received. Please complete 52 weeks prior to date of accident.

Please describe allowances of any character made in lieu of wages that must be deemed a part of employee's earnings: \_\_\_\_\_

If the average weekly wage is not based on fifty-two weeks of earnings proceeding the date of injury, please show your computation below: \_\_\_\_\_

WEEK	NO. DAYS	WEEK ENDING	GROSS WAGES	WEEK	NO. DAYS	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			
						<b>TOTAL PAID</b>	

Rate per Day \_\_\_\_\_ Rate per Hour \_\_\_\_\_ Average per Week \_\_\_\_\_

I hereby certify that the above is a true and correct account, as taken from our time books or payroll records, of the wages paid to the above-named injured employee for the periods indicated.

Date \_\_\_\_\_ 20\_\_\_\_ Employer \_\_\_\_\_

Name of Preparer & Title \_\_\_\_\_

Phone, Fax, Email \_\_\_\_\_

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT  
Division of Workers' Compensation



**MEDICAL WAIVER AND CONSENT**

*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 MEDICAL AUTHORIZATION FORM ONLY PERMITS THE EMPLOYER OR THE DIVISION OF WORKERS' COMPENSATION TO OBTAIN MEDICAL INFORMATION THROUGH ORAL OR WRITTEN COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, CHARTS, FILES, RECORDS, AND REPORTS IN THE POSSESSION OF A MEDICAL PROVIDER AUTHORIZED BY THE EMPLOYER PURSUANT TO T.C.A. § 50-6-204 AND A MEDICAL PROVIDER THAT IS REIMBURSED BY THE EMPLOYER FOR THE EMPLOYEE'S TREATMENT.

I, \_\_\_\_\_, having filed a claim for workers' compensation benefits, do hereby authorize

\_\_\_\_\_  
(Name of Medical Provider)

to furnish to my employer or my employer's representative, and/or the Division of Workers' Compensation any information or written material reasonably related to my work-related injury for which I am claiming compensation.

I further authorize the release of the same information to me or my attorney.

The authorization includes, but is not restricted to, a right to review and obtain copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

A photocopy of the authorization may be accepted in lieu of the original.

Dated: \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Social Security last four numbers

\_\_\_\_\_  
Witness

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.





## SUPERVISOR'S ACCIDENT INVESTIGATION REPORT AR - 2

Client:	Employee:
Date of Injury:	Time of Accident: <span style="float: right;">AM/PM</span>
<b>Chain of Custody Number/ Drug Test Form #:</b>	Department:
Date the employee reported the accident to you:	

### Please Complete All Questions

Has the injured employee requested medical treatment?     Yes     No

(Have employee complete refusal of treatment "Form AR-6" – if applicable)

Job being performed: \_\_\_\_\_ Was this his/her regular job?  Yes     No

Place of Job (parking lot, garage, residential home): \_\_\_\_\_

Job Site Address (be specific) \_\_\_\_\_

How many hours was the employee on the job before the accident occurred? \_\_\_\_\_ Start Time: \_\_\_\_\_

Last full day worked before injury: \_\_\_\_\_ County of Injury: \_\_\_\_\_

Describe the Accident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What did employee do or fail to do that contributed to the accident? \_\_\_\_\_

\_\_\_\_\_

What body part was injured? \_\_\_\_\_ Any Witnesses:  Yes     No

Were you present at the accident location during the incident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you witness the incident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there issues or circumstances that make you question the employees' account of the incident or nature/severity of the injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Was a post-accident drug screen performed?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is light duty available for this injured employee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you believe the employee will lose time from work beyond medical treatments?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was the employee cited for the accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was employee paid for the rest of the day? If No, when was last hour paid thru? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did the employee willfully refuse to use a safety appliance or have prior knowledge and willfully refused to observe a safety standard or rule?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Where did the employee go for treatment (Name of clinic/hospital)?** \_\_\_\_\_

Clinic/ Hospital Address and phone #: \_\_\_\_\_

How were they transported to treatment (car, ambulance)? \_\_\_\_\_ Work Status: \_\_\_\_\_

Was the accident a result of  Unsafe Act or  Unsafe Condition?    First day of treatment? \_\_\_\_\_

Supervisor Print Name \_\_\_\_\_ Signature of Supervisor \_\_\_\_\_

**Direct Phone/Cell Line:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Fax or email to Claims Center at 239-415-1114 or [claim@continuumhr.com](mailto:claim@continuumhr.com)**





**AR - 4**

## **Consent For Release Of Medical Information**

I hereby authorize representatives of Continuum HR and / or Continuum HRs' Workers' Compensation Carrier to be permitted to obtain and review copies of all medical records related to my workers' compensation injury. This pertinent information will be discussed with other professionals involved in my medical treatment and any institution that, through the "Workers' Compensation Program" or otherwise is paying all or part of the cost associated with my medical care.

Employee Name	Social Security Number
Injury Date	Telephone Number
Name of Employer	
Signature of Employee	Date
Witness	Date

**A PHOTOCOPY OR FACSIMILE COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL**

**Fax or email to Claims Center at 239-415-1114 or [claim@continuumhr.com](mailto:claim@continuumhr.com)**



MEDICAL AUTHORIZATION FOR INITIAL TREATMENT **AR - 5**

To: Medical Treatment Facility,

Please **verify** the active status of the injured employee being treated by calling us at 239-415-1110. You are authorized to give a **ONE TIME INITIAL** treatment as necessary to our employee. **Please ensure all injured employees are drug tested or** told to go to the designated facility.\*

**\*If drug test collection is not performed at this location, please advise the Employee to go to the drug test location listed on the chain of custody form.**

Employee Name	Social Security Number

Authorized by:  
Continuum HR  
11691 Gateway Blvd Ste 104  
Ft. Myers, FL 33913  
(239) 415-1110

Send billings to:  
Continuum HR  
11691 Gateway Blvd Ste 104  
Ft. Myers, FL 33913  
(239) 415-1110

-----  
Please fax or email all treatment records including restrictions to Continuum HR following treatment.

*We require all physicians who provide treatment for a reported work related injury submit all relevant documents to the insurer and the employer immediately but no later than three (3) business days after the visit.*

**Please fax or email all medical paperwork to 239-415-1114, Attention Claims Center or [claim@continuumhr.com](mailto:claim@continuumhr.com)**

If possible, inform us of any follow up treatment and also of any **missed** appointment by calling our offices at 239-415-1110.

**Please Ensure All Injured Employees are Drug Tested.**

Note to **Client/ Employer**: Employee must carry a chain of custody form **AND** this authorization form to the assigned Medical Treatment Facility and/or pharmacy.



## REFUSAL OF TREATMENT FORM **AR - 6**

<b>Client:</b>	<b>Incident Date:</b>
<b>Employee:</b>	<b>Social Security:</b>
<b>Employee Phone:</b>	<b>Incident Location:</b>

I was involved in an incident on the above-mentioned date. I sustained no injuries. I was offered medical attention, but saw no need for medical treatment, because I sustained no injuries in the incident.

If my condition changes in the future, I agree to notify my supervisor and call the CHR Claims Center at 239-415-1110. I realize that medical treatment will be provided and I will receive authorization so that I might obtain medical attention, which, at this time, I have refused.

Please describe the incident in detail:
Please list specific body parts affected (i.e. Right thumb, Upper back, Left ankle, etc.):
The following people may have been a witness to the incident:

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Supervisor Signature Date

**Fax or email to Claims Center at 239-415-1114 or [claim@continuumhr.com](mailto:claim@continuumhr.com)**



# RETURN TO WORK

## Purpose

The purpose of a Return To Work program is to enable the employee to work and be productive during the period of the employees' recovery from an injury. This not only allows you to retain experienced staff, but also reduces the cost of the claim and increases employee morale.

CHR has established guidelines to return an injured employee to work following their injury as set forth in our contract. The employee will be placed on "light duty" (modified duty, transitional duty, limited service) as soon as he or she is able to do so prescribed by the treating medical provider. You are required to make light duty work available, as long as the restrictions are within reason, as soon as the employee is released to work by the treating physician. If you feel the restrictions are burdensome or if you have no work available, call us IMMEDIATELY and we will work with you, the doctor, the carrier, and the employee, so that YOU can keep your claims costs low and productivity high.



## **Lost Time / Return To Work FAQ**

**How often should I talk to an employee that has been placed out of work by the doctor?** You should require the employee to call or visit your establishment a minimum of once per week. If the employee has been to the doctor, require the employee to drop off or send in any medical paperwork they have received immediately. Ask the employee how they are doing, when their next treatment is, and when they expect to return to work. Report any new information to CHR.

**What do I need to do when an employee returns to work after missing time from an injury?** Verify that the employee has obtained a release from the doctor by either A) reviewing the medical release supplied by the employee from the doctor, or B) calling CHR and have us verify the release. Sometimes an overeager employee will say they have been released and it not be true.

**The employee has doctor restrictions and has returned to work. What do I need to do?** Sometimes an employee may be released from the doctor to return to work with physical restrictions. The supervisor and the employee must review these restrictions carefully and discuss what work the employee can do within the limitations set by the medical provider. Do not allow the employee to work beyond those restrictions or it may impede the healing process or possibly make the injury worse.

**What should I do if an employee has been released to work but doesn't show up for their shift?** Try to contact the employee and ask why they are not present. Report the "No-Show" and any findings to CHR. Even if you choose not to discipline the employee, document the absence and have the employee sign it upon their return. It is imperative that you notify and submit the documentation to CHR so that we can properly manage the claim and keep the costs to a minimum.

**Will an employee be paid if they miss time due to an injury?** Possibly. The first seven (7) days of lost time work is not payable by the workers' compensation system. In addition, if the doctor does not place the employee "off work" and/or if the employee *CHOOSES* to stay home, they will not be compensated. If you wish to pay the employee (by using vacation time, etc.), contact the Claims center at (239) 415-1110 for a discussion of the proper method. **Do not just put them on the payroll.** If, however, the treating physician places the employee off work for more than 7 days, they will be paid a portion of their average wages.

**How are lost time wages calculated?** – Depending on individual state statutes, loss wages are calculated based on average wages earned over a set period of time. Usually, an injured employee will receive sixty six and two thirds (66 and 2/3rds) of the calculated average wage. Example: Florida uses the 13 weeks leading up to the injury date to calculate the average pay. Example: Georgia uses the previous years' earnings to calculate the average pay. If there is not enough historical data to support the primary method for calculation, a "similar" employee (in position, duties, and pay) is selected and their time and earnings are used to establish an average wage for the injured employee.

**When can my employee expect to receive their benefit check(s) from the carrier?** – After the injured employee is eligible to receive benefits, the carrier then begins to process the benefit payment. Payments will be sent directly to the employee on a bi-weekly cycle.

**What if my company does not have light duty available?** Only in extreme cases are there no possibilities for making light duty available. Call CHR immediately and we will discuss with you the light duty restrictions and ways to get the employee back to work. Return To Work programs have been proven to reduce the costs of claims by 10% to 30%. We have access to several Return To Work options that you may not be aware of.

**How do I let an employee know I have light duty available? What should I do to protect our company when we offer an injured employee light duty work?** If the employee is present, sit down with them and the supervisor and discuss the light duty. Have the details put on paper and have the employee sign. Some states require that a formal light duty job offer be in writing and have a detailed job description that meets the restrictions. You must specify a date and time the employee is to report and exactly who the employee is to report to. The document must be sent to the employee certified mail, Fed Ex (signature required), or hand delivered to the employee with a receipt signature. The date the employee must report to work must allow for the time it takes to have the letter delivered (usually 5 days). The employee must be made to sign and date the document and return it for your files (copy to CHR). Even if this is not required in your state, it remains an excellent way to protect your business. **CHR has developed a document for this purpose and we will be happy to assist you on its completion.**