SUMNER COUNTY OCCUPATIONAL INJURY REPORT

SUMNER COUNTY GOVERNMENT RISKMANAGEMENT OFFICE
355 N. BELVEDERE DR., ROOM 304
GALLATIN, TENNESSEE 37066
PHONE # (615) 451-6023 FAX # (615) 451-6052 AFTER HOURS # (615) 308-6977
employeeinjury@sumnercountytn.gov

SUMNER COUNTY DOES NOT FOLLOW THE PROCEDURES OF THE STATE OF TENNESSEE WORKERS' COMPENSATION PLAN
PLEASE SEE SUMNER COUNTY GOVERNMENT EMPLOYEE RIGHTS WITH REGARDS TO COMPENSATION FOR YOUR INJURY OR EXPOSURELOCATED AT THE BOTTOM OF THIS FORM
THIS FORM MUST BE COMPLETED WITHIN 24 HOURS OF INJURY OR INCIDENT AND PROVIDED TO THE OFFICE OF RISK MANAGEMENT WITHIN SEVEN (7) DAYS OR COVERAGE WILL BE DENIED

EMPLOYER

NAME:_____ FEDERAL EMPLOYEE ID # _____

ADDRESS:_____ CITY:_____ STATE: TN ZIP CODE: _____

DEPARTMENT/SCHOOL: _____ PHONE: _____

DATE REPORT WRITIEN:__/__/__ WRITIEN BY: TITLE/POSITION:_____

INJURED EMPLOYEE

NAME: _____ SOCIAL SECURITY NO. _____

ADDRESS:_____ CITY:_____ STATE:___ ZIP CODE:_____

PHONE:_____ OCCUPATION:_____ AGE:_____ DOB:_____

SEX: MALE___ FEMALE_____ MARITAL STATUS: SINGLE___ MARRIED___ DIVORCED____ WIDOWED: _____

NUMBER OF HOURS WORKED: PER DAY: _____ PER WEEK:_____ NUMBER OF DAYS PER WEEK:_____

WAGES: PER HOURS: $_____ PER DAY: $_____ EXTRA WAGES: $_____

DESCRIPTION OF INJURY OR EVENT

DID THE INJURY OR EXPOSURE OCCUR ON THE EMPLOYER'S PREMISES? YES: _____ NO: _____

DATE OF INJURY: ___/___/___ TIME OF INJURY: _____ A.M./P.M.

DATE OF NOTICE OF INJURY OR EXPOSURE: ___/ ____ / ____

ADDRESS OF WHERE INJURY OR EXPOSURE OCCURRED: _____

DESCRIBE WHAT EMPLOYEE WAS DOING WHEN THE INJURY OR EXPOSURE OCCURRED, LIST TOOLS, EQUIPMENT OR MATERIALS INVOLVED: _____

_____

DESCRIBE FULLY WHEN AND HOW THE INJURY OR EXPOSURE OCCURRED IN DETAIL, GIVING ALL BODY PART(S) AFFECTED: _____

_____

WAS THE EMPLOYEE PAID IN FULL FOR THE DATE OF INJURY OR EXPOSURE: YES: _____ NO: _____

HAS THE EMPLOYEE MISSED WORK BECAUSE OF THE INJURY OR EXPOSURE ON ANY DAY AFTER THE DATE IT OCCURRED, INCLUDING WEEKEND OR REGULSCHEDULED DAYS OFF? YES: ____ NO: _____

IF YES, GIVE DATE LAST WORKED: ___/___/___

HAS THE EMPLOYEE RETUREND TO WORK? YES: _____ NO: _____ IF YES, GIVE DATE: ___/___/___

DID THE INJURY/EXPOSURE RESULTIN DEATH? YES: ____ NO: _____ IF YES, GIVE DATE: ___/___/____

ALL MEDICAL ATTENTION MUST BE AUTHORIZED THROUGH RISK MANAGEMENT

NAME/ADDRESS OF NEAREST RELATIVE: _____

NAME/ADDRESS OF PHYSICIAN: _____

IF HOSPITALIZED, NAME/ADDRESS OF HOSPITAL: _____

I CERTIFYTHATTHE INFORMATION GIVEN IN THIS FORM IS TRUE,AND COMPLETE TO THE BESTOF MY KNOWLEDGE. I understand that it is a crime to knowingly provide false, incomplete or misleading information regarding this injury for the purpose of receiving benefits.

SIGNATURE OF INJURED EMPLOYEE: _____

IF EMPLOYEE IS UNABLE OR REFUSESTO SIGN, STATEREASON: _____

SUMNER COUNTY GOVERNMENT EMPLOYEE RIGHTS

1. As an employee of the Sumner County Government, it is your obligation to fill out the Sumner County Occupational Injury Report.

2. Before accepting any benefits or receiving treatment for any injury and/or exposure, you have the right to speak, at your own expense, with an attorney.

3. Sumner County has adopted the Occupational Compensation Plan of Sumner County (the "Plan"). The Plan is based upon a no-fault system of compensation and under the terms of the Plan, injured employees receive payment from the Sumner County Government of medical expenses as well as a percentage of your salary should a doctor determine you are unable to work. Any and all benefits paid to you under the Plan are paid pursuant to the terms and conditions described in the Plan.

4. As an employee, you have a choice. **If you accept the benefits and treatment offered under the Plan, the Plan shall act as your exclusive remedy. By accepting the benefits and treatment under the Plan, you hereby waive any and all rights to bring a lawsuit against the Sumner County Government for your injuries and/or exposure.**

5. If you decide to not accept the benefits offered under the Plan, you, or your insurance provider if you have one, will be responsible for payment of any and all medical treatment you receive with regards to your injury and/or exposure.

6. The Entire Plan can be seen on the Sumner County website at www.sumnercountytn.gov then go to the Risk Management page.

****As stated in the Occupational Compensation Plan, an injured employee has 6 months from the date an injury report is filed or 6 months from the last date of treatment to seek additional treatment for any injury. If no treatment is sought during this period, the claim will automatically close.**