MURFREESBORO CITY SCHOOLS
ADMINISTRATIVE DIRECTIVES

Descriptor Term:	Descriptor No:	Effective Date:
Accidents/Injuries to Employees On School Property	**AD STU12**	**10/92**
	Revised: **3/99; 1/07; 10/08; 2/14; 7/14; 8/15; 7/19**	

When an accident or injury occurs, the supervisor shall report the accident to the Murfreesboro City Schools' Human Resource Department. The MCS HR Department will then report said accident/injury to Tennessee Risk Management Trust within twenty-four (24) hours of being notified.

All reports of accidents involving injury to a MCS employee shall be recorded on the State of Tennessee C20 form: Tennessee Department of Labor and Workforce Development Employer's First Report of Work Injury or Illness. (Copy attached.) There are two additional reports required by Tennessee Risk Management Trust. These additional documents: Medical Authorization and C42 Employee's Choice of Physician shall be completed and signed by the injured employee then forwarded to Tennessee Risk Management Trust via MCS Human Resource Department as timely as possible, preferably within 72 hours. (See attached.) **These documents must be completed regardless of whether or not employee seeks medical treatment.**

A report of the accident should be immediately reported to TNRMT whenever there is a fatality, an accident involving more than three (3) employees, an accident involving unconsciousness or an accident involving broken bones or a severed member.

If the MCS employee requires or requests medical treatment, contact the MCS HR Department. In turn, the MCS HR Department will notify Tennessee Risk Management Trust.

If the accident/injury is life threatening, the employee shall immediately be taken to St. Thomas Rutherford Hospital. Should an ambulance be required, please proceed with emergency protocol by calling 911. **The injured employee (or the MCS employee accompanying the injured employee) should not give any medical facility their personal insurance information.** Should the medical facility staff need insurance information or verification, they should contact either the MCS HR Department or Tennessee Risk Management Trust (Dawn Wiles at 888-743-4336 ext. 396)

A report to the MCS HR Department should be made within twenty-four (24) hours of the accident. All forms are to be completed regardless of whether medical treatment is received.

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

CLAIMS ADM/CARRIER

JURISDICTION CLAIM # (STATE FILE #)	CLAIM TYPE CODE ☐ MED ONLY ☐ INDEMNITY ☐ BECAME LOST TIME ☐ BECAME MED ONLY ☐ NOTIFY ONLY ☐ TRANSFER
CLAIMS ADM CLAIM # (INSURER CLAIM #)	
OSHA LOG CASE #	
NAME OF INSURANCE CARRIER: TN RISK MANAGEMENT TRUST	CARRIER FEIN
CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)	FEIN OF CLMS ADM
CLAIMS ADJUSTER NAME: TN RISK MANAGEMENT TRUST	CLMS ADJ PHONE #

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).

CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2: 404 BNA DRIVE SUITE 208	CITY: NASHVILLE	STATE: TN	ZIP: 37217

EMPLOYER

EMPLOYER NAME: MURFREESBORO CITY SCHOOLS	EMPLOYER FEIN: 62-1823874	SIC CODE	PHONE NUMBER: 615-893-2313
EMPLOYER ADDRESS LINE 1 AND LINE 2: 2552 S. CHIURCH STREET		NATURE OF BUSINESS	
CITY: MURFREESBORO	STATE: TN	ZIP: 37127	INSURED REPORT # / EMPLOYER LOCATION

POLICY

INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)	POLICY NUMBER	EFF DATE	EMPLOYMENT STATUS CODE ☐ FULL TIME/REGULAR ☐ PART TIME ☐ PIECE WORKER ☐ SEASONAL ☐ VOLUNTEER ☐ APPRENTICE FULL TIME ☐ APPRENTICE PART TIME
	SELF INSURED? ☐ YES ☐ NO	EXP DATE	

EMPLOYEE

EMPLOYEE LAST NAME		PHONE INCL AREA CODE	GENDER ☐ MALE ☐ FEMALE ☐ UNKNOWN
FIRST	MI	DEPARTMENT REGULARLY WORKED	
ADRRESS LINE 1 & 2			OCCUPATION DESCRIPTION
CITY	STATE	ZIP	MARITAL STATUS ☐ UNMARRIED, SINGLE, DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN / NCCI CLASS CODE
SSN	DATE OF BIRTH	DATE OF HIRE	

WAGE

WAGE $	PERIOD ☐ HOURLY ☐ DAILY ☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY	NUMBER OF DAYS WORKED PER WEEK	SALARY CONTINUED IN LIEU OF COMPENSATION ☐ YES ☐ NO
			FULL WAGES PAID FOR DATE OF INJURY ☐ YES ☐ NO

ACCIDENT/INJURY

DATE OF INJURY	TIME OF INJURY ☐ AM ☐ PM ☐ COULD NOT BE DETERMINED	TIME EMPLOYEE BEGAN WORK ON INJURY DATE ☐ AM ☐ 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 ☐ WIDOW ☐ WIDOWER ☐ MOTHER ☐ FATHER ____ DAUGHTER ____ SON ____ SISTER ____ BROTHER ____ HANDICAPPED CHILD		TOTAL # DEPENDENTS
DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO			
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		ADDRESS LINE 1 AND 2	
CITY	STATE / ZIP	CITY	STATE / ZIP
INITIAL TREATMENT ☐ NO MEDICAL TREATMENT ☐ MINOR BY EMPLOYER ☐ MINOR BY CLINIC/HOSPITAL		☐ HOSPITALIZED > 24 HRS ☐ EMERGENCY CARE	☐ FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED

OTHER

DATE PREPARED	PREPARER'S NAME & TITLE	PREPARER'S COMPANY NAME	PHONE NUMBER

Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002

FORM C-42

EMPLOYEE'S CHOICE OF PHYSICIAN

An employer must provide a partially-completed form listing at least three physicians to an employee upon the report of a workplace injury. The employee must complete and then sign and date the section below that indicates the physician chosen. A copy of the fully-completed form should be provided to the employee with the original kept on file by the employer. If the employee refuses to accept medical services from the chosen physician, the employee's rights to benefits may be delayed. **NOTE**: Employees traveling more than 15 miles one way to or from medical treatment may seek reimbursement of their travel expenses from the insurance carrier.

TO BE COMPLETED BY THE EMPLOYER:

Employer Murfreesboro City Schools Date of Injury _____

Employer Contact Cindy Walker Phone 615-893-2313 Email Cindy.Walker@cityschools.net

Physician Name Concentra Medical Center/Dr. Frank Thomas Phone 615-895-4855

Address 1203-A Memorial Blvd. City Murfreesboro State TN Zip 37129

Physician Name Care Now/Dr. Paul Justice/Dr. Robert Cranfield Phone 615-410-4099/615-846-8585

Address 1340 NW Broad St./3031 Medical Center Pkwy City Murfreesboro State TN Zip 37129

Physician Name Hometown Family Medical & Urgent Care/Dr. Charles Tessier Phone 615-439-6165

Address 115 North Thompson Lane City Murfreesboro State TN Zip 37129

TO BE COMPLETED BY THE EMPLOYEE:

I have selected the following physician from the list provided to me by my employer:

Physician Name _____ Date Selected _____

Employee Name _____ Appt Date/Time _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Employee Signature _____ Date _____

TNRMT
TENNESSEE RISK MANAGEMENT TRUST

SEC | SAFETY ENGINEERING & CLAIMS MANAGEMENT

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

TNRMT
TENNESSEE RISK MANAGEMENT TRUST

SEC | SAFETY ENGINEERING & CLAIMS MANAGEMENT

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

Please submit with First Report of Injury Form within 24 hours