



**Workers' Compensation  
Benefits and Procedures  
Handbook  
Roane County Government**

Workers' Compensation Representative

Jennifer Suter

865-717-4109 Office

865-376-5671 Fax

865-399-1472 Cell

Alternative Contact Amber Cofer

865-717-4103

## **Roane County Government**

- Roane County Government's most valuable asset is its employees; We strive to provide you a safe and comfortable environment in which you can carry out the county's business.
- Your responsibility is to perform your job with skill and care, following the rules of safety associated with each task on your job.
- Should you have an on-the-job injury, we want to assist you in receiving all of the benefits due and to provide support to enable you to return to your job as quickly as possible.
- Your responsibility in case of an injury is to follow the steps for reporting your injury as outlined in this handbook. We have provided you with a panel of medical facilities which have guaranteed to help us help you.

## **On The Job Injuries**

- It is the responsibility of the employee to report any and all on the job injuries to their supervisor.
- It is the responsibility of the employee to complete the C20 form (Tennessee Department of Labor and Workforce Development Employee's First Report of Work Injury or Illness).
- The forms are to be submitted to Jennifer Suter in the Accounting Office at the Roane County Courthouse.
- The First Report of Injury form, C-42G, and C-31 is included in this booklet. Your supervisor will also have copies of these forms if you do not have one with you at the time of the injury.

- Your supervisor will be available to help fill out the forms. Please fill them out entirely. This enables an efficient filing of the accident or injury.

### **County Responsibilities**

- Provide a safe working environment
- Provide the proper equipment for the job
- Provide training for all operations
- Provide medical care in the event of an injury on the job

### **Employee Responsibilities**

- Follow all safety rules when performing tasks and operating vehicles and equipment
- Advise supervisor to any safety hazards in the work place
- Follow all reporting procedures in the event of an on-the-job injury
- Seek medical care from the designated medical provider's panel

### **Steps for when an injury occurs:**

1. The employee turns in completed C20, C31, and C-42 to his or her supervisor or supervisor's designee.
2. The supervisor or the designee check the forms to make sure they are complete and accurate.
3. The forms are emailed or faxed to Jennifer Suter, Workers Comp Representative.
4. The supervisor or designee will call Jennifer to verify receipt.
5. Jennifer will make the employee an appointment with the physician chosen from the panel.
6. The supervisor or designee will be given the time and date of the appointment and relay that information to the employee if the employee is not contacted directly.
7. It is the responsibility of the employee to ensure all forms and documents received from the treating physician are provided to Jennifer for the work comp file.

\*If immediate care is required call 911 or seek emergency treatment and then follow steps 1-4

\*If an incident occurs after hours complete steps 1-4 using Jennifer's cell phone number to verify receipt of forms.

Jennifer Suter  
Office: 865-717-4109  
Fax: 865-376-5671  
Cell: 865-399-1472  
Email: [jennifer.suter@roanecountytn.gov](mailto:jennifer.suter@roanecountytn.gov)

Alternative Contact:  
Amber Cofer  
Office: 865-717-4103  
Email: [amber.cofer@roanecountytn.org](mailto:amber.cofer@roanecountytn.org)

**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 <input type="checkbox"/> MED ONLY <input type="checkbox"/> INDEMNITY <input type="checkbox"/> BECAME LOST TIME <input type="checkbox"/> BECAME MED ONLY <input type="checkbox"/> NOTIFY ONLY <input type="checkbox"/> TRANSFER		<p>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.</p> <p>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.</p> <p>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).</p>		
	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)		CITY			STATE	ZIP
	CLAIMS ADJUSTER NAME		CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2				
	CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2						
EMPLOYER	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		
POLICY	INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)		POLICY NUMBER		EFF DATE	EMPLOYMENT STATUS CODE <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		
EMPLOYEE	EMPLOYEE LAST NAME		PHONE INCL AREA CODE		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	OCCUPATION DESCRIPTION	
	FIRST	MI	DEPARTMENT REGULARLY WORKED		MARITAL STATUS <input type="checkbox"/> UNMARRIED, SINGLE, DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN		
	ADDRESS LINE 1 & 2		CITY		STATE		ZIP
	SSN		DATE OF BIRTH	DATE OF HIRE	NCCI CLASS CODE		
	WAGE \$		PERIOD <input type="checkbox"/> HOURLY <input type="checkbox"/> DAILY	<input type="checkbox"/> WEEKLY <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
ACCIDENT/INJURY	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 <input type="checkbox"/> WIDOW <input type="checkbox"/> FATHER <input type="checkbox"/> SISTER <input type="checkbox"/> WIDOWER <input type="checkbox"/> DAUGHTER <input type="checkbox"/> BROTHER <input type="checkbox"/> MOTHER <input type="checkbox"/> SON <input type="checkbox"/> HANDICAPPED CHILD				
	DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		TOTAL # DEPENDENTS				
ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)						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 <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		
OTHER	DATE PREPARED	PREPARER'S NAME & TITLE		PREPARER'S COMPANY NAME	PHONE NUMBER		

**FORM C-42**

TENNESSEE  
BUREAU OF WORKERS' COMPENSATION



**EMPLOYEE'S  
CHOICE OF PHYSICIAN**  
Medical Panel

**Employer**

- List at least three physicians and provide this panel to employee upon the report of a workplace injury.
- Keep the completed original form on file and send a copy to the employee for their records.
  - Do *not* send this form to the State unless requested.

**Employee**

- Fill out the bottom portion of this form to indicate which physician you choose.
  - If you refuse to accept medical services from the chosen physician, your rights to benefits may be delayed.
  - Traveling more than 15 miles (one way) to (or from) medical treatment? Employees may seek reimbursement of their travel expenses from the insurance carrier.
- **Send** completed form **back to your employer**.

TO BE COMPLETED BY THE **EMPLOYER**:

Employee Name \_\_\_\_\_ Date Panel Provided \_\_\_\_\_

Employer Roane County Government/Schools Date of Injury \_\_\_\_\_

Employer Contact Jennifer Suter Phone 865-717-4109 Email jennifer.suter@roanecountytn.org

Physician 1	Physician 2	Physician 3
Name <u>Dr. Denton RC Family Practice</u>	Name <u>Dr. Vora Summit Medical</u>	Name <u>Dr. Hine MMC Healthworks</u>
Phone <u>865-376-6272</u>	Phone <u>865-882-0105</u>	Phone <u>865-835-4320</u>
Address <u>7855 Tanner Way, Ste 200</u>	Address <u>933 West Race St</u>	Address <u>988 Oak Ridge Physicians Plaza, Ste L-50</u>
City <u>Harriman</u>	City <u>Kingston</u>	City <u>Oak Ridge</u>
State <u>TN</u> Zip <u>37748</u>	State <u>TN</u> Zip <u>37763</u>	State <u>TN</u> Zip <u>37830</u>
Is Telehealth available with Physician #1? Yes ___ No ___	Is Telehealth available with Physician #2? Yes ___ No ___	Is Telehealth available with Physician #3? Yes ___ No ___
If yes, web address _____	If yes, web address _____	If yes, web address _____
(Optional) Telehealth-Only <b>Physician 4</b> Name _____ Phone _____		
Telehealth Provider email address _____ Web address _____		

TO BE COMPLETED BY THE **EMPLOYEE**:

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

Physician Name \_\_\_\_\_ Appt Date/Time \_\_\_\_\_

I select: In-person treatment \_\_\_ **or** Treatment by Telehealth \_\_\_ Were you offered in-person treatment? Yes \_\_\_ No \_\_\_

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



**Tennessee Bureau of Workers' Compensation  
220 French Landing Drive, I-B  
Nashville, TN 37243-1002  
800-332-2667**

**FORM C-31**

**MEDICAL WAIVER AND CONSENT**

**This form is not required for injuries occurring on or after July 1, 2014**

THIS MEDICAL AUTHORIZATION FORM ONLY PERMITS THE EMPLOYER OR THE BUREAU 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  
(Printed Patient Name)

\_\_\_\_\_ to furnish to my employer or my employer's  
(Name of Medical Provider)

representative, and/or the Bureau of Workers' Compensation any information or written material reasonably related to my work-related injury of \_\_\_\_\_ for which I am claiming compensation. I further authorize the release of  
(Date of Injury)

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.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of Birth