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 Amanda Lloyd, 865-717-4107

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 compete the C20 form (Tennessee Department of Labor and Workforce Development Employee's First Report of Work Injury of 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 entirety. 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.org

Alternative Contact:
Amanda Lloyd
Office: 865-717-4107
Email:
amanda.lloyd@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 #)

CLAIMS ADM CLAIM # (INSURER CLAIM #)

OSHA LOG CASE #

CLAIM TYPE CODE
- ☐ MED ONLY
- ☐ INDEMNITY
- ☐ BECAME LOST TIME
- ☐ BECAME MED ONLY
- ☐ NOTIFY ONLY
- ☐ TRANSFER

NAME OF INSURANCE CARRIER

CARRIER FEIN

CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)

FEIN OF CLMS ADM

CLAIMS ADJUSTER NAME

CLMS ADJ PHONE #

CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2

CITY | STATE | ZIP

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).

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

SELF INSURED? ☐ YES ☐ NO

EFF DATE

EXP DATE

EMPLOYMENT STATUS CODE
- ☐ FULL TIME/REGULAR
- ☐ PART TIME
- ☐ PIECE WORKER
- ☐ SEASONAL
- ☐ VOLUNTEER
- ☐ APPRENTICE FULL TIME
- ☐ APPRENTICE PART TIME

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

DATE LAST DAY WORKED

DATE DISABILITY BEGAN

RETURN TO WORK DATE (IF APPLICABLE)

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 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

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 Dr. Denton RC Family Practice	Name Dr. Vora Summit Medical	Name Dr. Alday, MMC Healthworks
Phone 865-376-6272	Phone 865-882-0105	Phone 865-835-4320
Address 7855 Tanner Way, Ste 200	Address 933 West Race St	Address 988 Oak Ridge Physicians
_____	_____	Plaza, Ste L-50
City Harriman	City Kingston	City Oak Ridge
State TN Zip 37748	State TN Zip 37763	State TN Zip 37830
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 **Physician 4** 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