Developmental Services of Dickson County
Employee First Report of Injury

Employee Information

Employee Name: _____ Job Title: _____

Home Address: _____ City, State, Zip: _____

Phone Number: _____ Social Security Number: _____

Date of Birth: _____ ☐ Male ☐ Female ☐ Married ☐ Single

Date of Hire: _____ Wages per hour: $_____ Scheduled hours per week:_____

Incident Information

Date of Incident: _____ Time of Incident: _____ ☐ am ☐ pm

Location where incident occurred: _____

Medical Treatment Required: ☐ None, report only ☐ Minor First Aid only ☐ Refused treatment
☐ Treatment was needed (explain in detail)

☐ Walk-in-Clinic (where, what doctor): _____
☐ ER (where): _____
☐ Hospitalization (where): _____

List all medications you had taken in the past 24 hours before the incident (prescription or over the counter)

_____
_____

Describe the activities prior to the incident: _____
_____
_____

Describe the incident:

_____
_____
_____
_____
_____
_____
_____

Name and phone number of all witnesses: _____

_____

_____

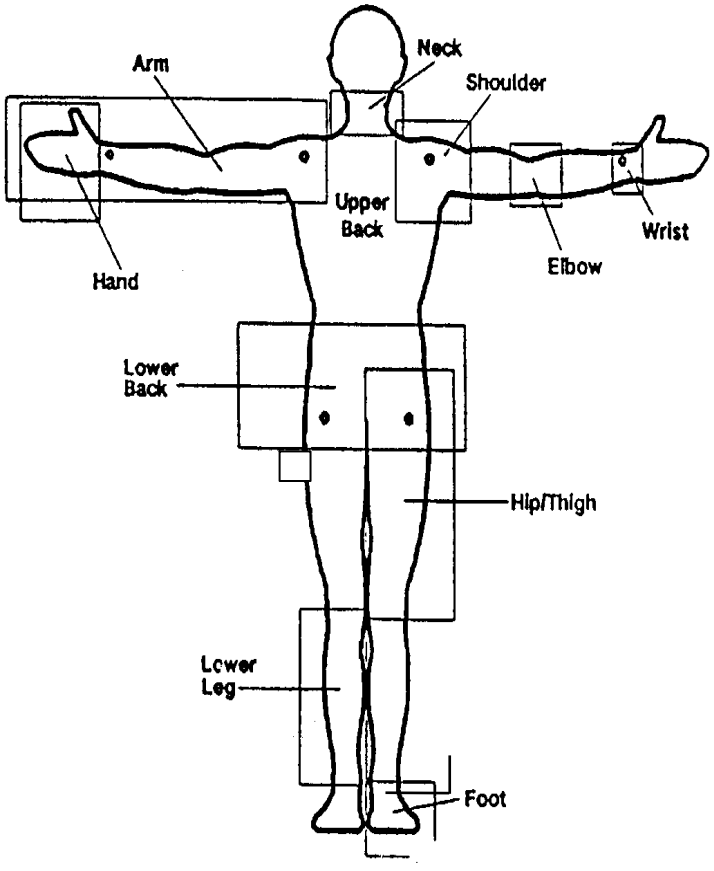
What part(s) of the body was injured? _____

Have you ever injured this part of your body before? ☐ Yes ☐ No

If Yes, when and how? _____

Check all injured body parts listed on the left side of this page and circle the injury(s) on the diagram.

Check the type of injury on the right side of the page.

Injured Area	Indicate Area of Injury	Type of Injury
1 ☐ Head 2 ☐ Eye: L / R 3 ☐ Shoulder L / R 4 ☐ Arm L / R 5 ☐ Elbow L / R 6 ☐ Wrist L / R 7 ☐ Hand L / R 8 ☐ Finger: Specify _____ 9 ☐ Back 10 ☐ Chest 11 ☐ Abdomen 12 ☐ Pelvis 13 ☐ Hip L / R 14 ☐ Leg L / R 15 ☐ Knee L / R 16 ☐ Ankle L / R 17 ☐ Foot L / R 18 ☐ Toe: Specify _____ 19 ☐ Other: _____ _____		1 ☐ Abrasion 2 ☐ Amputation 3 ☐ Bite: _____ 4 ☐ Bruise 5 ☐ Burn 6 ☐ Concussion 7 ☐ Cut / Laceration 8 ☐ Foreign Body 9 ☐ Fracture 10 ☐ Hearing Impaired 11 ☐ Infection 12 ☐ Pain: _____ _____ 13 ☐ Puncture 14 ☐ Rash/ Dermatitis 15 ☐ Respiratory 16 ☐ Strain/Sprain 17 ☐ Other: _____ _____

Employee Signature:_____ Date: _____

Administrative Use Only

Date Report Filed_____ Claim Number_____

Date Risk Management Reviewed Incident_____

Revised 10/1/2010

Consent For Release of Medical Information

I hereby authorize representatives of United Heartland 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: _____

Telephone Number of Employee: _____

Name of Employer: Developmental Services of Dickson County

Date of Injury: _____

Signature of Employee: _____

Date: _____

***NOTICE: A PHOTOCOPY OR FACSIMILE COPY OF THE AUTHORIZATION IS AS VALID AS THE ORIGINAL.**

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 _____ Date of Injury _____

Employer Contact _____ Phone _____ Email _____

Physician Name Walter Stephens of Covenanty Medical Group Phone (615) 441-6140

Address 200 Creekside Dr City Dickson State TN Zip 37055

Physician Name John Salyer of Dickson Medical Associates Phone (615) 446-5121

Address 127 Crestview Park Dr, Ste 114 City Dickson State TN Zip 37055

Physician Name Urgent Medical Phone (615) 441-6000

Address 1904 Hwy 46 South Ste 3 City Dickson State TN Zip 37055

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 _____ Phone _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Employee Signature _____ Date _____