FORM C-42G

TENNESSEE DIVISION OF WORKERS' COMPENSATION

Nashville, Tennessee 37243-1002

Website: www.tn.gov/labor-wfd/wcomp.html

Telephone: 1-800-332-2667

EMPLOYEE'S CHOICE OF PHYSICIAN

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.

THIS FORM IS ONLY FOR USE BY GOVERNMENTAL ENTITIES ESTABLISHED BY TCA§29-20-401 AND SELF INSURED POOLS ESTABLISHED BY TCA§50-6-405(c)(1).

State File Number: _____ Date of Injury: _____

Employee: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: Union Co Board Of Education FEIN: 62-6000885

Address: P.O. Box 10 City: Maynardville State: TN Zip: 37807

PANEL OF PHYSICIANS

Tennessee Code Annotated §50-6-204 requires an employer to offer a panel of three physicians to the injured employee. The injured employee must select a physician from the panel.

Physicians Name: Caring Medical Center Phone: 865 992 2221

Address: 149 Durham Drive City: Maynardville State: TN Zip: 37807

Is Physician a Specialist? ☐ Yes ■ No If yes, give specialty: Ortho, Neuro, etc. _____

Physicians Name: Cherokee Medical Center Phone: 865 992 3849

Address: 4300 Maynardville Hwy City: Maynardville State: TN Zip: 37807

Is Physician a Specialist? ☐ Yes ■ No If yes, give specialty: Ortho, Neuro, etc. _____

Physicians Name: Halls Walk-In Medical Center Phone: 865 922 1400

Address: 7000 Maynardville Hwy City: Knoxville State: TN Zip: 37918

Is Physician a Specialist? ☐ Yes ■ No If yes, give specialty: Ortho, Neuro, etc. _____

Physicians Name: Rocky Top Family Practice Phone: 865 745 1160

Address: 598 John Deere Dr City: Maynardville State: TN Zip: 37807

Is Physician a Specialist? ☐ Yes ■ No If yes, give specialty: Ortho, Neuro, etc. _____

Physicians Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Is Physician a Specialist? ☐ Yes ☐ No If yes, give specialty: Ortho, Neuro, etc. _____

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

Physician Chosen: _____

Employee Signature: _____ Date Selected: _____

A copy of this form must be provided to the employee. The employer must keep the original form on file and upon request provide a copy to the Division of Workers' Compensation.

This form is required to be in compliance with Tennessee Code Annotated §50-6-204.

LB-0382 (rev. 8/14)

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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.

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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

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EMPLOYEE ACCIDENT REPORT

Employee Name: _____

Address: _____

Phone: _____

Job Title: _____ **Department:** _____

Date of Accident: _____ **Shift Start Time:** _____

Time of Accident: _____ **A.M. or P.M.:** _____

Supervisor: _____

Location of Accident: _____

Describe the Nature of the Injury: _____

_____

Describe Exactly What Happened: _____

_____

_____

_____

List Any Witnesses: _____

_____

To Whom Did You Report the Accident/Injury? _____

What did you tell your Supervisor? _____

_____

What did your Supervisor Do? _____

_____

_____ _____

Employee Signature **Date**

Please submit with First Report of Injury Form within 24 hours

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SUPERVISOR ACCIDENT INVESTIGATION REPORT

Employee Name: _____

Job Title: _____ **Department:** _____

Date of Accident: _____ **Shift Start Time:** _____

Time of Accident: _____

When Did You Learn of the Injury? _____

Did Injured Employee Receive First Aid? **Yes** _____ **No** _____

Was Injury Report or First Aid Delayed? **Yes** _____ **No** _____

If Yes, Why? _____

Was Employee Referred for Outside Medical Attention: **Yes** _____ **No** _____

If so, Where? _____

Location of Accident: _____

Describe the Nature of the Injury: _____

_____

Describe Exactly What Happened: _____

_____

_____

List Any Witnesses: _____

Recommended Corrective Action: _____

Corrective Action Taken? **Yes** _____ **No** _____

Work Order Written? **Yes** _____ **No** _____

_____ _____

Supervisor Signature **Date**

Please submit with First Report of Injury Form within 24 hours

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ACCIDENT WITNESS REPORT

Employee Name: _____

Employee Address: _____

Work Number: _____ **Alternate Number:** _____

Job Title: _____ **Department:** _____

Date of Accident: _____ **Shift Start Time:** _____

Time of Accident: _____ **A.M.** _____ **or P.M.** _____

Location of Accident: _____

Identify the Employee Involved in the Accident: _____

What were you doing when the accident occurred: _____

_____

Describe Exactly What Happened: _____

_____

_____

_____

List Any Other Witnesses: _____

_____

_____ _____

Witness Signature **Date**

Please submit with First Report of Injury Form within 24 hours