

303 N. Church Street
Murfreesboro, TN 37130

RUTHERFORD COUNTY GOVERNMENT "ON-THE-JOB INJURY" CLAIM REPORT

Phone (615) 898-7715
Fax (615) 867-4602

Claim # _____ Date of Injury: _____ Time of Injury: _____ AM
(Office Use Only) Date of Report: _____ PM

As is allowed by T.C.A. 50-6-106, Rutherford County (RC) has opted to withdraw from the Tennessee Workers' Compensation Act, and instead has chosen to implement an On-The-Job Injury Program administered by the Rutherford County Insurance Department.

Employee Name _____ Gender F M Date of Birth _____
 Address _____ Date of Hire _____
 City _____ State _____ Zip _____ Social Security No _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Work Location _____
 Injury Location _____
 Time employee began work on the date of injury: _____ AM PM

Affected area (please "X" all appropriate areas). (If multiple areas are affected, please "X" all areas that apply).

<input type="checkbox"/> Ankle	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Elbow	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Groin	<input type="checkbox"/> Mouth	<input type="checkbox"/> Stomach	<input type="checkbox"/> rt	<input type="checkbox"/> lft
<input type="checkbox"/> Arm	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Eye	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Hand	<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulder	<input type="checkbox"/> rt	<input type="checkbox"/> lft
<input type="checkbox"/> Back	<input type="checkbox"/> up	<input type="checkbox"/> wfr	<input type="checkbox"/> Face	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Head	<input type="checkbox"/> Nose	<input type="checkbox"/> Wrist	<input type="checkbox"/> rt	<input type="checkbox"/> lft
<input type="checkbox"/> Buttock	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Finger	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Hip	<input type="checkbox"/> Nibs	<input type="checkbox"/> Toe	<input type="checkbox"/> rt	<input type="checkbox"/> lft
<input type="checkbox"/> Cheek	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Foot	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Jaw	<input type="checkbox"/> Teeth	<input type="checkbox"/> Throat	<input type="checkbox"/> rt	<input type="checkbox"/> lft
<input type="checkbox"/> Chest	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Forehead	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Knee	<input type="checkbox"/> Skin			
<input type="checkbox"/> Ear	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Genital			<input type="checkbox"/> Leg	<input type="checkbox"/> rt	<input type="checkbox"/> lft		

Injury Type (please X)

Burn Chemical Cut Lifting Human Bite Insect Bite Animal Bite Machine Injury Slip/Fall Student Assault Vehicle Other _____

Describe - please enter details of events causing injury. (Please be sure to enter what employee was doing just before the injury occurred.)

I hereby understand that all OJI Claims are investigated by the Rutherford County (RC) Insurance Department. Completion of an OJI Claim Report and/or an Employee Injury Statement or attempting to file a claim does not guarantee acceptance of the individual claim. Therefore, after a full investigation of my claim, my claim may be non-compensable although I may have already seen an OJI Physician with OJI office approval. If that occurs, bills prior to the investigation will be paid in full by the Insurance Department and I understand that I will be responsible for any further treatment or medication. I also understand that any unauthorized treatment or failure to seek medical treatment within 7 days of the injury will terminate my OJI benefits. I also hereby authorize the release of my protected health information from any and all health care providers, their employees, and agents and direct them to release or disclose to RC Insurance Department (address above) my complete medical record regardless of stated areas of injury. I waive my right to confidentiality of these records for the purpose of an on-the-job injury. These records may be used by the RC Insurance Department in making a determination as to my eligibility for benefits under the On-The-Job Injury Program. Unless otherwise stated, this authorization expires 365 days from the date of execution. Making a false or fraudulent claim is immediate grounds for termination from RC Government. I also understand the Safety Coordinator or their representative has the right to attend all visits with me and my physician. A physician must be selected from the list below.

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Concentra
1203 A Memorial Blvd
Murfreesboro, TN 37129
Phone 895-4855 | <input type="checkbox"/> Physicians Medical
1525 South Church St.
Murfreesboro, TN 37130
Phone 217-7236 | <input type="checkbox"/> Tennessee Urgent Care Associates
1332 Hazelwood Drive
Smyrna, TN 37167
Phone 355-1338 | <input type="checkbox"/> Tennessee Urgent Care Associates
2553 Murfreesboro Road
Antioch, TN 37217
Phone 399-6898 |
|--|--|---|--|

Please note: Before scheduling any doctor's appointment, you **MUST** make immediate contact with the RC Insurance Department for approval. (615-898-7715)

Schedule Drs. Appointment: Yes No If so, Appt. Date: _____ Time: _____ AM PM

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

OJI CLAIM REPORT