Gibson County Special School District
Workers Compensation Claims Reporting

To: Providers,
Administrative personnel should notify you that a staff member who is coming to your clinic as a worker compensation case.
Schools in the Gibson County Special School District (GCSSD) Include:

South Gibson Co. High School
South Gibson Co. Elementary School
South Gibson Co. Middle School
Spring Hill School
Kenton Elementary School
Gibson County High School
Dyer School
Rutherford School
Yorkville School

CLINICS- send all claims to Tennessee Risk Management Trust (TNRMT)

All claims and associated paperwork should be sent to
Tennessee Risk Management Trust
Contact information for TNRMT

Website: www.tnrmt.com

General email: wcclaims@tnrmt.com

Tennessee Risk Management Trust
101 Tamaras Way
Hendersonville, TN 37075

888-743-4336 Toll-Free Number
615-651-8625 Phone Number
615-953-6292 Fax Number

PHARMACIES- CALL TENNESSEE RISK MANAGEMENT TRUST FOR BILLING INFORMATION

GCSSD CENTRAL OFFICE CONTACT INFORMATION:
Rory Hinson
130 Trenton Highway, Dyer, TN 38330
Phone: 731-693-3803
Fax: 731-692-4375

GIBSON COUNTY SPECIAL SCHOOL DISTRICT

Creating Learning Communities

DATE PREPARED: _____

PREPARER'S NAME: _____

EMPLOYER'S FIRST REPORT OF INJURY

EMPLOYEE (Claimant)

Last Name: _____ **First Name:** _____ **MI:** _____ **Phone:** (____) -_____- _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Social Security #: _____-____-_____ **Date of Birth:** _____ **Gender:** ☐ **Male** ☐ **Female** ☐ **Unknown**

Martial Status: ☐ **Unmarried, Single, Divorced** ☐ **Married** ☐ **Separated** ☐ **Unknown**

Employee: ☐ **District Office** ☐ **DES** ☐ **GCHS** ☐ **KES** ☐ **RES** ☐ **SHS** ☐ **SGCES** ☐ **SGCMS** ☐ **SGCHS**

Date of Hire: _____ **Department Regularly Worked:** _____ **Occupation Description:** _____

Employment Status Code: ☐ **Full Time/Regular** ☐ **Part-Time** ☐ **Piece Worker** ☐ **Seasonal** ☐ **Volunteer**
☐ **Apprentice Full Time** ☐ **Apprentice Part Time**

Date of Injury: _____ **Time of Injury:** ___:_____ ☐ **AM** ☐ **PM** ☐ **Could not be determined**

Time Employee began work on injury date: ___:_____ ☐ **AM** ☐ **PM**

How injury or Illness occurred: Describe the incident including what the employee was doing just before, specify the body part, & exact location of the injuries (i.e. right, left, upper, lower) and object or substance that directly harmed the employee: _____

_____

_____

_____

Date of Employer Notified of Injury: **Date District Admin notified of Injury:**

Date Last Worked: _____ **Date Disability:** _____ **Date of Death (if applicable):** _____

Accident Location: _____ **Accident Location Phone:** (____) -_____- _____

Accident Address: _____ **City:** _____ **State:** ___ **Zip:** _____

TREATMENT:

Physician Name: _____

Address: _____ **City:** _____ **State:** ___ **Zip:** _____

Hospital/Clinic Name: _____

Address: _____ **City:** _____ **State:** ___ **Zip:** _____

INITIAL TREATMENT:

☐ **No Treatment** ☐ **Minor by Employer** ☐ **Minor by Clinic/Hospital**

☐ **Hospitalized ≥ 24 Hours** ☐ **Emergency Care** ☐ **Future Major Medical/Lost Time Anticipated**

TNRMT
TENNESSEE RISK MANAGEMENT TRUST
101 Tamaras Way, Hendersonville, TN 37075
888-743-4336 | Fax: 615-953-6292
wcclaims@tnrmt.com

SEC | SAFETY ENGINEERING & CLAIMS MANAGEMENT
111 Hazel Path, Hendersonville, TN 37075
615-826-4274 | Fax 615-826-6378
wcclaims@sectn.com

EMPLOYEE ACCIDENT REPORT

Employee Name: _____

Address: _____

Phone: _____ **Email Address:** _____

DOB: _____ **SS #:** _____ **Date of Hire:** _____

Job Title: _____ **School:** _____

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

Location of Accident: _____

Body Parts Injured:
Please specify whether right or left side for each body part. (example: right hand, left knee, low back)
Specific Fingers/Toes: Index/First, Middle/Second, Ring/Third, Pinky/Fourth, Thumb/Great Toe

_____
_____
_____

Describe Exactly What Happened: _____
_____
_____

Medical Treatment:
None at this time ____ **Minor by Employer** ____ **Hospital** ____ **Minor by Doctor/Clinic** ____

Name of Supervisor _____ **Was the injury reported to your supervisor?** _____

When was the injury reported? _____ **To whom was the injury reported?** _____

What did your supervisor do? _____

List All Witnesses _____
_____

Employee Signature _____ **Date** _____

Please submit all paperwork via fax or email after reporting claim online.

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wcclaims@sectn.com

ACCIDENT WITNESS REPORT

Witness Name: _____

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

Witness Email Address: _____

Job Title: _____ **Shift Start Time:** _____

Date of Accident: _____ **Time of Accident:** _____

Location of Accident: _____

Identify the Employee Involved in the Accident: _____

Did you see the accident happen? **Yes** _____ **No** _____

If no, explain what you were told. _____

_____

_____

If yes, describe exactly what you saw. _____

_____

_____

List Any Other Witnesses: _____

_____

Witness Signature _____ **Date** _____

Please submit all paperwork via fax or email after reporting claim online.

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wcclaims@sectn.com

SUPERVISOR ACCIDENT INVESTIGATION REPORT

Supervisor Name: _____

Work Number: _____ Alternate Number: _____

Job Title: _____ Department: _____

Identify the Employee Involved in the Accident: _____

Date of Accident: _____ Time of Accident: _____

Location of Accident: _____

Did the employee report the accident to you? Yes _____ No _____

If no, who reported the accident to you? _____

When did the employee report the accident to you? _____

What was reported to you about the accident? _____

_____

_____

Did the injured employee receive first aid? Yes _____ No _____

Was injury report or first aid delayed? Yes _____ No _____

If yes, why? _____

Was the employee referred for outside medical treatment? Yes _____ No _____

If so, where? _____

Was the employee provided a workers' comp panel? Yes _____ No _____

List Any Witnesses: _____

_____

Was corrective action required? Yes _____ No _____

If yes, what correction action was taken? _____

Supervisor Signature _____ Date _____

Please submit all paperwork via fax or email after reporting claim online.

TNRMT
TENNESSEE RISK MANAGEMENT TRUST

SEC | SAFETY ENGINEERING & CLAIMS MANAGEMENT

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.

Please submit with First Report of Injury Form within 24 hours

TNRMT
TENNESSEE RISK MANAGEMENT TRUST

SEC | SAFETY ENGINEERING & CLAIMS MANAGEMENT

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

Please submit with First Report of Injury Form within 24 hours

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 Gibson County Special School District Date of Injury _____

Employer Contact Trayce Wylie Phone 731-692-3969 Email wyliet@gcssd.org

Physician 1	**Physician 2**	**Physician 3**
Name Dr. James Williams II	Name Dr. Peter Gardner / Dr. Keith Moser	Name Dr. Thomas Nelson
Phone 731-222-5000	Phone 731-686-8688	Phone 731-665-7741
Address Christian Family Medicine	Address Physicians Quality Care	Address Rutherford Clinic
2017 South College Street, Suite C	15463 South First Street	104 East Main Street
City Trenton	City Milan	City Rutherford
State TN Zip 38382	State TN Zip 38358	State TN Zip 38369
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 _____

FORM C-42

TENNESSEE
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- **Send** completed form **back to your employer**.

TO BE COMPLETED BY THE **EMPLOYER:**

Employee Name _____ Date Panel Provided _____

Employer Gibson County Special School District Date of Injury _____

Employer Contact Trayce Wylie Phone 731-692-3969 Email wyliet@gcssd.org

Physician 1	**Physician 2**	**Physician 3**
Name Dr. Amanda Reiter (Walk in clinic)	Name Jackson Clinic Convenient Care	Name Dr. Peter Gardner
Phone 731-660-8360	Phone 731-422-0355	Phone 731-984-8400
Address Convenient Care North	Address See List	Address Physicians Quality Care
2859 Highway 45 Bypass	101 Garrett Drive	2075 Pleasant Plains Extension
City Jackson	City Medina	City Jackson
State TN Zip 38305	State TN Zip 38358	State TN Zip 38305
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 _____

LB-0382 (REV 10/21)

RDA 10183

Jackson Clinic Convenient Care
101 Garrett Drive
Medina, TN 38358
731-422-0355
(Each day is a different physician, but they all accept work comp)

Dr. Wright
Dr. Kennedy
Dr. McBride
Dr. Guidi
Dr. Ragon
Dr. Pagoaga
Dr. Reiter
Dr. Rodriguez
Dr. Nerland