TNRMT
TENNESSEE RISK MANAGEMENT TRUST

SEC | SAFETY ENGINEERING & CLAIMS MANAGEMENT

WORKERS' COMPENSATION CHECKLIST

Employee Name: _____

Date of Injury: _____

First Report of Injury

Verified Wage Statement

- Gross wages for 52 weeks preceding and including date of injury
- Fully complete Wage Statement
- Total Paid
- Rate per Day or Rate per Hour
- Average per Week

Panel of Physicians – signed by employee

HIPAA Release – signed by employee

C-31 Medical Waiver

Employee Accident Report

Supervisor's Accident Investigation Report

Written Job Description

Employee's Prior Employment History as contained within your personnel records

Employee's Highest Level of Education

Preparer's Name: _____

Phone Number: _____

Email Address: _____

Please submit with First Report of Injury Form within 24 hours