

REQUEST FOR ASSISTANCE



TENNESSEE DEPT OF LABOR & WORKFORCE DEVELOPMENT
Division of Workers' Compensation
http://www.tn.gov/labor-wfd/wcomp.html
Toll Free Help Line: 1-800-332-2667

SF #

RFA #

STAMP-DATE RECEIVED

THIS FORM COVERS: Temporary Disability Benefits, 25% Penalty (For Late or Non-Payment of Benefits), Medical Benefits, Discovery Issues, Open Medical Coverage

PLEASE NOTE: ALL FIELDS MARKED WITH AN ASTERISK * ARE MANDATORY

Failure to complete the required information on this form shall result in the form being returned to the requesting party for completion.

* Please give a brief explanation of disputed issues:

A) * SOCIAL SECURITY NUMBER: * DATE of INJURY:

* EMPLOYEE'S NAME: * DATE of BIRTH:

* Mailing Address:

* City: * State: * Zip:

* County of Residence: * Telephone: Email:

* If the Employee is represented by an attorney, all fields in this section are also mandatory.

EE's ATTORNEY: BPR#:

Mailing Address:

City: * State: * Zip:

Telephone: Fax: Email:

B) * EMPLOYER NAME: * Contact:

* Mailing Address:

* City: * State: * Zip:

* Telephone: * Fax: * Email:

* If the Employer is represented by an attorney, all fields in this section are also mandatory.

ER's ATTORNEY: BPR#:

Mailing Address:

City: * State: * Zip:

Telephone: Fax: Email:

C) * **INSURANCE CARRIER:** _____

* **CLAIM HANDLER / TPA:** _____

* **Adjuster's Name:** _____ **CLAIM #:** _____

* **Adjuster's Mailing Address:** _____

* **City:** _____ * **State:** _____ * **Zip:** _____

* **Telephone:** _____ * **Fax:** _____ * **Email:** _____

D) * **BRIEF DESCRIPTION of INJURY:** _____

* Does Employer have 5 or more Employees? **Yes** **No** * How long has Employee worked for this Employer? _____ Years _____ Months

* Does Employee still work for this Employer? **Yes** **No** * Did the Employee report injury to their Employer? **Yes** **No** **Unknown**

* If **Yes**; on what date? _____ To whom? Name: _____ Position Title: _____

* TN County of Injury: _____, or did the injury occur Out of State? **If Yes, Which State?** _____

List names of witnesses to the injury, if any: _____

E) * **MEDICAL TREATMENT:** Has the Employer provided a panel of at least three (3) approved physicians (or four for back injuries) to the Employee for selection? * **Yes** **No** If **Yes**, name physician selected from the panel: * _____

* Name all doctors seen for this injury: _____

* Has an approved physician placed the Employee on light duty work restrictions due to this injury? **Yes** **No**

* Has an approved physician taken the Employee completely off work due to this injury? **Yes** **No**

* If "**Yes**" to either question, please give the doctor's name: _____

REQUESTING PARTY

I hereby request the Department of Labor and Workforce Development to assist in any disputed workers' compensation issues related to the above-detailed injury. I also authorize the Department of Labor and Workforce Development to contact any person who has information regarding that injury. If the requesting party is the Injured Employee or the Injured Employee's legal representative, authorization is also given to the Department of Labor and Workforce Development to use the Injured Employee's social security number in a manner necessary to provide the requested assistance. Further, by signature the requesting party or the party's representative certifies that each of the above-detailed answers is true. 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.

* **BY CHECKING THE BOX AND SIGNING BELOW, THE REQUESTING PARTY CERTIFIES THAT A COMPLETED COPY OF THIS REQUEST FOR ASSISTANCE HAS BEEN FORWARDED TO THE OPPOSING PARTIES**

* **PRINT NAME:** _____ * **SIGNATURE:** _____

* **DATE:** _____



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Please return the completed form to the office listed below that is closest to the home address of the Employee named in Section A of the Request for Assistance (C40A form).

If you need help in completing this form, please call the office nearest you or our toll-free help line listed above.

CHATTANOOGA

TDLWD/WORKERS' COMPENSATION DIVISION
State Office Bldg, 600W
540 McCallie Avenue
Chattanooga, TN 37402-2066
Phone: 423-634-6422
Fax: 423-634-3115

KINGSPORT

TDLWD/WORKERS' COMPENSATION DIVISION
1908 Bowater Drive
Kingsport, TN 37660-4136
Phone: 423-224-2057
Fax: 423-224-2056

KNOXVILLE

TDLWD/WORKERS' COMPENSATION DIVISION
1610 University Avenue, 2nd Floor
Knoxville, TN 37921-6741
Phone: 865-594-5177
Fax: 865-594-5172

COOKEVILLE

TDLWD/WORKERS' COMPENSATION DIVISION
410 Spring Street, Suite G
Cookeville, TN 38501-3791
Phone: 931-520-4290
Fax: 931-520-4316

MURFREESBORO

TDLWD/WORKERS' COMPENSATION DIVISION
845 Esther Lane
Murfreesboro, TN 37129-5537
Phone: 615-848-6743
Fax: 615-217-9378

NASHVILLE

TDLWD/WORKERS' COMPENSATION DIVISION
2222 Rosa L. Parks Boulevard
Nashville, TN 37228-1306
Phone: 615-741-1383
Fax: 615-253-1223

JACKSON

TDLWD/WORKERS' COMPENSATION DIVISION
225 Dr. Martin L. King Jr. Drive
1st Floor, Suite 120, Box 26
Jackson, TN 38301-6985
Phone: 731-423-5646
Fax: 731-265-7022

MEMPHIS

TDLWD/WORKERS' COMPENSATION DIVISION
170 North Main Street, 11th Floor
Memphis, TN 38103-1820
Phone: 901-543-6077
Fax: 901-543-6039