

STATE FILE #	SOCIAL SECURITY NO:	DATE OF INJURY:
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**WORKERS' COMPENSATION STATISTICAL DATA FORM**Revised 06-07  
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Fraud Warning. 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 area for Department use only.	THIS FORM MUST BE FILED WITH THE CLERK OF THE COURT CONTEMPORANEOUSLY WITH THE FINAL ORDER IN ALL WORKERS' COMPENSATION CASES IN WHICH THE COURT EITHER TRIES THE CASE OR APPROVES A SETTLEMENT. FOR SETTLEMENTS SUBMITTED TO THE DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT FOR APPROVAL, SUBMIT THIS FORM WITH THE APPROVAL REQUEST. <b>NEITHER THE ORDER OF THE COURT NOR THE DEPARTMENT'S APPROVAL IS FINAL UNTIL THIS FORM IS FULLY COMPLETED AND FILED WITH THE APPROPRIATE ENTITY.</b> [STATUTORY AUTHORITY: TCA 50-6-244(b), (d)]	This area for Court use only.

**I. EMPLOYEE INFORMATION**

1. STATE FILE #	2. SOCIAL SECURITY NO:	3. DATE OF INJURY:	
4. FIRST NAME:	5. MIDDLE INITIAL:	6. LAST NAME:	
7. ADDRESS:	8. CITY:	9. STATE:	10. ZIP:
11. COUNTY & STATE OF RESIDENCE AT CONCLUSION OF CASE COUNTY: STATE:		12. COUNTY & STATE OF RESIDENCE AT TIME OF INJURY: COUNTY: STATE:	
13. INSURER FILE #	14. DATE OF BIRTH:	15. DATE OF HIRE:	
16. EDUCATION LEVEL: LESS THAN 9TH GRADE <input type="checkbox"/> SOME HIGH SCHOOL <input type="checkbox"/> GED <input type="checkbox"/> HIGH SCHOOL DIPLOMA <input type="checkbox"/> SOME COLLEGE/ASSOC DEGREE <input type="checkbox"/> BS/BA <input type="checkbox"/> GRADUATE/ PROFESSIONAL <input type="checkbox"/>			
17. ABLE TO RETURN TO PRIOR EMPLOYMENTS? YES <input type="checkbox"/> NO <input type="checkbox"/>	18. REASONABLY TRANSFERRABLE JOB SKILLS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
19. READ & WRITE AT 8TH GRADE LEVEL? YES <input type="checkbox"/> NO <input type="checkbox"/>			

**II. CLAIM/INJURY INFORMATION**

20. INJURY OCCURRED: IN TN <input type="checkbox"/> OUT OF STATE <input type="checkbox"/>	21. TN COUNTY OF INJURY:	22. AVERAGE WEEKLY WAGE:	23. WEEKLY COMP RATE
24. NATURE OF PRIMARY INJURY/ILLNESS:			
25. BODY PART:			
26. WAS CLAIM DENIED? YES <input type="checkbox"/> NO <input type="checkbox"/>	27. IF "YES" TO 26, STATE BASIS OF DENIAL: STATUTE OF LIMITATIONS <input type="checkbox"/> , NOTICE <input type="checkbox"/> , NOT WORK RELATED <input type="checkbox"/> , INTOXICATED/POSITIVE DRUG TEST <input type="checkbox"/> , OTHER, SPECIFY,		
28. WAS SURGERY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	29. WAS PSYCHOLOGICAL INJURY CLAIMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	30. WAS PSYCHOLOGICAL INJURY SOLE CLAIM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
31. DID EMPLOYEE RETURN TO WORK FOR SAME EMPLOYER? YES <input type="checkbox"/> NO <input type="checkbox"/>	32. RETURN TO WORK PAY WAS: LESS <input type="checkbox"/> , SAME <input type="checkbox"/> , HIGHER <input type="checkbox"/>		
33. DATE OF FIRST TTD PAYMENT:	34. FIRST DATE OUT OF WORK:	35. FINAL RETURN TO WORK DATE:	36. TOTAL NUMBER OF DAYS LOST:
37. MMI DATE:	38. DATE RETURNED TO WORK BY PHYSICIAN:	39. IS EMPLOYEE CURRENTLY EMPLOYED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
40. IS EMPLOYEE CURRENTLY RECEIVING SOCIAL SECURITY DISABILITY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
41. DID INJURY RESULT IN DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, THEN LIST DATE OF BIRTH, AND RELATIONSHIP OF ALL DEPENDENTS:			
42. CLAIMS ADMINISTRATOR OR TPA FIRM NAME: (If Different From Insurance Carrier)		43. CLAIMS ADM/TPA FEIN:	
44. ADDRESS:	45. CITY:	46. STATE:	47. ZIP:
48. NAME OF CASE MGMT PROVIDER:			

**III. EMPLOYER INFORMATION**

49. EMPLOYER NAME: (not parent co., DBA where injured employee works)			50. FEIN:
51. ADDRESS:	52. CITY:	53. STATE:	54. ZIP:
55. DID EMPLOYER HAVE A CERTIFIED DRUG FREE WORKPLACE PROGRAM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
56. IF SELF INSURED, NAME OF SELF INSURED PROGRAM		57. SELF INSURED PROGRAM FEIN	

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58. NAME OF INSURANCE CARRIER:		59. INSURANCE CARRIER FEIN:	
60. ADDRESS:	61. CITY:	62. STATE:	63. ZIP:

#### IV. MEDICAL AND VOCATIONAL EXPERTS

<b>NAMES OF TREATING PHYSICIANS</b>					
64.	(A) LAST NAME:	(B) FIRST NAME	(C) MI:	(D) TITLE: MD <input type="checkbox"/> DO <input type="checkbox"/> DC <input type="checkbox"/>	(E) LICENSE NUMBER:
	(F) IMPAIRMENT RATING (%)	(G) TO BODY OR SPECIFIC MEMBER:	(H) SCHEDULED MEMBER LOCATION LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/>		
<b>EMPLOYEE'S IME(s)</b>					
65.	(A) LAST NAME:	(B) FIRST NAME	(C) MI:	(D) TITLE: MD <input type="checkbox"/> DO <input type="checkbox"/> DC <input type="checkbox"/>	(E) LICENSE NUMBER:
	(F) IMPAIRMENT RATING (%)	(G) TO BODY OR SPECIFIC MEMBER:	(H) SCHEDULED MEMBER LOCATION LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/>		
<b>EMPLOYER'S IME(s)</b>					
66.	(A) LAST NAME:	(B) FIRST NAME	(C) MI:	(D) TITLE: MD <input type="checkbox"/> DO <input type="checkbox"/> DC <input type="checkbox"/>	(E) LICENSE NUMBER:
	(F) IMPAIRMENT RATING (%)	(G) TO BODY OR SPECIFIC MEMBER:	(H) SCHEDULED MEMBER LOCATION LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/>		
<b>EMPLOYEE'S VOCATIONAL EXPERT</b>					
67.	(A) LAST NAME:	(B) FIRST NAME	(C) MI:	(D) TITLE: PHD <input type="checkbox"/> MA <input type="checkbox"/> OTHER <input type="checkbox"/>	(E) VOCATIONAL DISABILITY RATING:
<b>EMPLOYER'S VOCATIONAL EXPERT</b>					
68.	(A) LAST NAME:	(B) FIRST NAME	(C) MI:	(D) TITLE: PHD <input type="checkbox"/> MA <input type="checkbox"/> OTHER <input type="checkbox"/>	(E) VOCATIONAL DISABILITY RATING:
<b>CHIROPRACTIC/PHYSICAL THERAPY</b>					
69. CHIROPRACTIC TREATMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, NUMBER OF VISITS?			70. PHYSICAL THERAPY? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, NUMBER OF VISITS?		

#### V. TYPE OF CONCLUSION AND COURT IDENTIFICATION INFORMATION

<input type="checkbox"/> TRIAL (Applicable only when the case has been <b>TRIED</b> by the court.)		
<input type="checkbox"/> SETTLEMENT APPROVED BY COURT -COMPLAINT FILED (Applicable only when a lawsuit has been initiated by the filing of a complaint and summons.)		
<input type="checkbox"/> SETTLEMENT APPROVED BY COURT - COMPLAINT NOT FILED. (Applicable only when a lawsuit has NOT been initiated by the filing of a complaint – term “joint petition” used to refer to this type of procedure for purposes of this form.)		
71. STYLE OF CASE:	72. COURT DOCKET NO:	
73. COUNTY:	74. COURT:	75. FULL NAME OF TRIAL JUDGE/CHANCELLOR:
76. DATE COMPLAINT FILED:	77. DATE OF TRIAL:	78. DATE JOINT PETITION FILED:
79. DATE OF SETTLEMENT APPROVAL:	80. NAME OF APPROVING JUDGE/CHANCELLOR	
<input type="checkbox"/> SETTLEMENT APPROVED BY DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT (Applicable only when the approval is by the Department.)		
81. DATE OF SETTLEMENT APPROVAL BY SPECIALIST:	82. NAME OF SPECIALIST APPROVING SETTLEMENT:	

#### VI. BENEFIT REVIEW CONFERENCE

83. DATE OF CONFERENCE:	84. SETTLED? YES <input type="checkbox"/> NO <input type="checkbox"/>	85. NAME OF SPECIALIST:
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#### VII. TRIAL RESULTS

86. PPD% YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, NUMBER OF WEEKS?	TO BODY OR SPECIFIC MEMBER:	LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/>
87. PTD? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, NUMBER OF WEEKS?	88. DEATH CLAIM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
89. JUDGMENT FOR EMPLOYER? YES <input type="checkbox"/> NO <input type="checkbox"/> ; SELECT BASIS: STATUE OF LIMITATIONS <input type="checkbox"/> ; NOTICE <input type="checkbox"/> ; NOT WORK RELATED <input type="checkbox"/> ; NO PERMANENCY <input type="checkbox"/> ; INTOXICATION <input type="checkbox"/> ; WILLFUL MISCONDUCT <input type="checkbox"/> ; OTHER, SPECIFY		

#### VIII. SETTLEMENT TERMS

90. PPD% YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, NUMBER OF WEEKS?	TO BODY OR SPECIFIC MEMBER:	LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/>
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91. PTD? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, NUMBER OF WEEKS?	92. DEATH CLAIM? YES <input type="checkbox"/> NO <input type="checkbox"/>
93. FUTURE MEDICAL EXPENSE: CLOSED <input type="checkbox"/> ; OPEN FOR LIFE <input type="checkbox"/> ; OR, OPEN FOR A SPECIFIED PERIOD? <input type="checkbox"/>	
94. WAS MONEY PAID TO CLOSE FUTURE MEDICALS? YES <input type="checkbox"/> NO <input type="checkbox"/>	95. DATE MEDICALS WERE OR WILL BE CLOSED:
96. WAS CASE SETTLED PURSUANT TO TCA 50-6-206(b)? YES <input type="checkbox"/> NO <input type="checkbox"/>	

**IX. SECOND INJURY FUND**

97. IS THIS A SECOND INJURY FUND CLAIM? YES <input type="checkbox"/> NO <input type="checkbox"/>	98. WAS JUDGMENT ENTERED AGAINST SECOND INJURY FUND? YES <input type="checkbox"/> NO <input type="checkbox"/>
99. APPORTIONMENT: (1) EMPLOYER; _____ %; #WKS; _____ TOTAL AMT.	(2) SECOND INJ FUND _____ %; #WKS; _____ TOTAL AMT.

**X. MONETARY AMOUNTS PAID**

TYPE OF BENEFIT	PAID PRIOR TO TRIAL/ SETTLEMENT	PAID PURSUANT TO TRIAL RESULTS	PAID PURSUANT TO SETTLEMENT TERMS	TOTAL PAYMENTS
100. TEMP TOTAL DISABILITY				
101. TEMP PARTIAL DISABILITY				
102. PERMANENT PARTIAL DISABILITY				
103. PERMANENT TOTAL DISABILITY				
104. DEATH BENEFITS				
105. BURIAL EXPENSES				
106. MEDICAL EXPENSES TOTAL (includes medicine, PT, chiro, hospital, MD/DO costs, tests)				
107. CASE MANAGEMENT COSTS				
108. DISCRETIONARY COSTS				
109. AMOUNT PAID TO CLOSE FUTURE MEDICAL EXPENSE				
110. LUMP SUM PAYMENT (not based on specific disability %)				
111. DATE LUMP SUM PAID (not based on specific disability %): _____				
112. TOTALS (ADD TOTALS FROM LINES 100 THRU 110)				
113. AMOUNT PAID IN LUMP SUM FROM LINES 100 THRU 105; _____ (DO NOT ADD THIS AMOUNT TO TOTAL PAYMENTS. IT IS ALREADY INCLUDED IN THE TOTALS ABOVE.)			114. DATE LUMP SUM PAID FROM LINES 100 THRU 105 _____	

**XI. ATTORNEYS FEES**

115. EMPLOYEE'S ATTORNEY FEE; AMOUNT OF AWARD _____ % OF AWARD _____	116. WAS FEE APPROVED BY COURT <input type="checkbox"/> OR TDLWD <input type="checkbox"/>
117. EMPLOYER'S ATTORNEY FEE (SPECIFY RANGE): UNDER \$1500 <input type="checkbox"/> ; \$1501-3000 <input type="checkbox"/> ; \$3000-\$10,000 <input type="checkbox"/> ; OVER \$10,000 <input type="checkbox"/>	

**XII. CERTIFICATION AND SIGNATURES**

*By providing my BPR number and my signature, I hereby certify that I have read the contents of the form and the information provided is true and correct to the best of my knowledge. ATTORNEY MUST PROVIDE BPR#.*

118. NAME OF EMPLOYEE'S ATTORNEY: _____ BPR# _____	119. NAME OF EMPLOYER'S ATTORNEY: _____ BPR# _____
120. NAME OF EMPLOYEE: _____	121. NAME OF ADJUSTER/CARRIER/EMPLOYER REPRESENTATIVE: _____

_____ SIGNATURE OF EMPLOYEE	_____ DATE SIGNED	_____ SIGNATURE OF ADJUSTER/CARRIER/EMPLOYER REP	_____ DATE SIGNED
_____ SIGNATURE OF EMPLOYEE'S ATTORNEY	_____ DATE SIGNED	_____ SIGNATURE OF EMPLOYER'S ATTORNEY	_____ DATE SIGNED