

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

Division of Workers' Compensation

220 French Landing Dr.
Nashville, Tennessee 37243-1002



FINAL REPORT OF PAYMENT AND RECEIPT OF COMPENSATION

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

State File #:		Social Security #:	
Employee First Name:		MI	Last:
Address:			
City:		State:	Zip:
Employer's Name (doing business as):		FEIN:	
Business Address:			
City:		State:	Zip:
Insurance Co/Claim Handler Name:		Insurer File #:	
Insurance Co/Claim Handler Address:			
City:		State:	Zip:
Date of Injury:	First date out of work:	Date physician returned claimant to work:	Maximum Improvement Date:
Total # of days lost:	Returned to: Same Employer <input type="checkbox"/> or New Employer <input type="checkbox"/>	Wages changed? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, From \$ _____ to \$ _____	
Date of Birth:	Average Weekly Wage: \$ _____	Weekly Compensation Rate: \$ _____	

Compensation payments were made on the following basis:

Temporary Total Amount: \$ _____	Temporary Partial Amount: \$ _____
Permanent Partial Amount: \$ _____	Permanent Total Amount: \$ _____
Permanent Partial based on: _____ weeks _____ days	Permanent Total based on: _____ weeks, _____ days
Death Benefit Amount: \$ _____	Funeral Expenses: \$ _____
Total Medical Paid to Date: \$ _____	Employees legal fees: \$ _____
Was salary paid in lieu of comp? Yes <input type="checkbox"/> No <input type="checkbox"/>	Employers/Ins Co. legal fees: \$ _____
Mark appropriate box of payments listed above that was paid in lump sum. List date paid under type:	
Temp. Total <input type="checkbox"/>	Temp Partial <input type="checkbox"/> Permanent Partial <input type="checkbox"/> Permanent Total <input type="checkbox"/> Death Benefits <input type="checkbox"/>
State Physicians % rating and scheduled body part: _____	Payments based on (% rate and scheduled body part): _____

I certify by signing that I have received Workers' Compensation benefit amounts as itemized above.

I understand that this is not a release. _____

Employee's Signature _____

Reason the injured employee did not sign this report: _____

Insurance Carrier Representative _____ Position _____