Filed Date Stamp Here

PETITION FOR BENEFIT DETERMINATION
Tennessee Bureau of Workers' Compensation
Court of Workers' Compensation Claims
www.tn.gov/workforce/section/injuries-at-work
wc.ombudsman@tn.gov
1-800-332-2667

Applies to injuries on or after July 1, 2014

For BWC Use Only

Docket No._____
State File No._____
RFA No._____
Date of Injury_____

Prior PBD Filed: ☐ Yes ☐ No
Assigned Judge_____

General Information

The Petition for Benefit Determination (PBD) is the form to file with the Bureau of Workers' Compensation to begin to resolve disputes. The legal process for a workers' compensation claim begins with this filing. This form will serve as the basis for your claim. It is important that the form be filled out as completely and accurately as possible. For assistance with completing this form, please call: 1-800-332-2667.

Completion of this Form

Because this form outlines your claim, certain information is required. This is generally the who, what, when, where, why, and how of your case. You may not be able to fill in every blank. Do the best you can. However, remember that the more information provided the better. A sample of a completed form is available at https://www.tn.gov/content/dam/tn/workforce/documents/injuries/Completed_PBD_Example.pdf

Time-Sensitive

In most cases, this form must be filed within one (1) year after the accident resulting in injury; one (1) year from the last authorized medical treatment; or one (1) year from the time the employer ceased to make payments of compensation to or on behalf of the employee, whichever is later. If you fail to timely file this form, you may be denied benefits.

Section A: Identify the people and the companies involved.

Employee Name _____ Date of Injury_____

SSN _____ Date of Birth _____

Mailing Address _____

City _____ State _____ ZIP _____ County _____

Phone _____ Email _____

Employee Attorney _____BPR # _____

Address _____ City _____ State____ ZIP _____

Phone _____ Fax _____ Email _____

Office Contact Person_____ Email _____

Employer(s)_____ Phone _____

Mailing Address _____

City _____ State _____ ZIP _____ County _____

Employer Contact Person_____ Email _____

Employer Attorney _____ BPR # _____

Address _____ City _____ State____ ZIP _____

Phone _____ Fax _____ Email _____

Office Contact Person_____ Email _____

Insurance Company: _____

Third Party Administrator: _____

Ins. Adjuster Name _____Email _____

Mailing Address _____ City _____ State _____ ZIP _____

Phone _____ Fax _____ Ins. Claim#_____

The Subsequent Injury Fund (SIF) provides benefits to employees who have a prior permanent physical disability and who become permanently and totally disabled by a later work injury. To preserve a claim against the SIF, Employee must submit this form via fax to 615-741-4169, email to: WC.SIFLegal@tn.gov or mail to: SIF Director, Legal Section, 220 French Landing Drive, 3B, Nashville, TN 37243.

Is the Employee seeking recovery from the Subsequent Injury Fund? ☐YES ☐NO ☐Unknown

SIF Attorney Name (If known): _____ ☐Unknown

Section B: Identify the problem you are having with the workers' compensation claim.

I, _____, have the following problem: ***(Attach additional sheets if necessary.)***
Insert name.

Section C: Provide details about the work injury.

THE DATE OF INJURY IS _____.

Tell us about the injury; include how and where the injury occurred, the body part(s) injured, and the work that was being done. Include the names of all persons involved or who witnessed the accident. Be as specific as possible. Also, please attach any documents you have, such as accident reports or medical records, which support your claim. The alleged injury occurred in the following manner: ***(Attach additional sheets if necessary.)***

Employee reported the injury to_____ on _____.
Insert Name. Insert Date.

Section D: Identify the workers' compensation issues that apply to the claim. (Select all that apply.)

Medical Benefits

- ☐ Employee received a list of physicians on _____ (Date) and selected _____ (Insert Doctor or Clinic Name.).
- ☐ Employee has not received a list of physicians.
- ☐ Employee has not received medical care from Employer or the insurance company.
- ☐ Employee has not received medical care as required by a court order. (Provide court order.)
- ☐ Employee was been denied medical care after receiving it. (Provide relevant medical records.)
- ☐ Employee has not received medical care ordered by the doctor. (Provide relevant medical records.)
- ☐ Employee sought medical care from a physician who was not on the list provided by employer. (Provide relevant medical records and bills.)

Temporary Disability Benefits **[Provide wage statement or check stubs if you have them.]**

- ☐ Doctor _____ (Insert name.) took employee off work and/or assigned restrictions of:

_____

- ☐ Employee has missed the following days from work due to the injury:

_____

- ☐ Employee has not been paid for missing work and/or believes he/she is owed more than received.
- ☐ Employee has been paid while missing work at the rate of $_____ per week.

Death Benefits

- ☐ The claim has been accepted.
- ☐ There is a dependent spouse.
- ☐ There are _____ (Number) dependent children.
- ☐ The claim was denied.
- ☐ There are other dependents other than children.
- ☐ A guardian ad litem needs to be appointed.

Discovery (If a PBD is already on file, it is not necessary to file another PBD for discovery.)

- ☐ A subpoena is needed. (Include completed subpoena.)
- ☐ Interrogatories have not been returned. (Include interrogatories.)
- ☐ Other _____

Permanent Disability Benefits **[Provide Final Medical Report (C30A) or most recent Physician's Report, if available.]**

- ☐ Parties do not agree on the amount of the disability benefit.
- ☐ Employee is eligible for increased benefits because Employee did not return to work.
- ☐ Employee reached maximum medical improvement on _____.
- ☐ Dr. _____ assigned an impairment rating of _____% to the body as a whole.
- ☐ Dr. _____ assigned an impairment rating of _____% to the body as a whole.
- ☐ Dr. _____ assigned permanent restrictions of: _____

_____

Section E: Indicate Your Mediation Preferences:

Before a dispute can be brought before a judge, the matter must go through mediation. Mediation is a process in which a mediator working for the state, without a stake in the outcome, works with the parties to resolve the dispute on a voluntary basis, otherwise known as settling the dispute. Most disputes are settled without going before a judge.

☐ I prefer to mediate over the phone. **(If marked, skip to Section F.)**

☐ I prefer to mediate in person. Was this Court-ordered? ☐ Yes ☐ No

In-Person mediations must be scheduled with agreement between the employee and the employer's representative. Please contact all parties and indicate the three (3) agreed upon dates and times below. Please circle desired time slot.

_____	_____	_____
9:00 am or 1:00 pm	9:00 am or 1:00 pm	9:00 am or 1:00 pm

☐ By checking this box, I certify that the above dates and times have been agreed upon by all parties.
☐ I have made three (3) attempts to schedule mediation; however, the other party has not cooperated.

Section F: Notice

A copy of this form **must** be provided to the parties or their attorney. Indicate how you sent them a copy of this form. Service sent to: means the address, fax number, email address or company. Click here for an example.

☐ **Employee**_____
Service by: ☐ By Hand ☐ Mail ☐ Facsimile ☐ Email
Service Sent to: _____

☐ **Employer(s)**_____
Service by: ☐ By Hand ☐ Mail ☐ Facsimile ☐ Email
Service Sent to: _____

☐ **Employee's Atty**_____
Service by: ☐ By Hand ☐ Mail ☐ Facsimile ☐ Email
Service Sent to: _____

☐ **Employer(s)' Atty(s)**_____
Service by: ☐ By Hand ☐ Mail ☐ Facsimile ☐ Email
Service Sent to: _____

☐ **Carrier(s)**__ _____
Service by: ☐ By Hand ☐ Mail ☐ Facsimile ☐ Email
Service Sent to: _____

☐ **SIF's Atty** _____
Service by: ☐ By Hand ☐ Mail ☐ Facsimile ☐ Email
Service Sent to: _____

Section G: Certify the information contained in the Petition for Benefit Determination is correct.

I, _____, state that the information provided in this Petition for Benefit Determination is true and accurate to the best of my knowledge, information, and belief. Further, I certify a copy of the Petition for Benefit Determination has been sent to the parties as described above.

_____	_____	_____
Print Name	**Signature**	**Date**

For more information about workers' compensation benefits or how to complete this form, please visit our website at http://www.tn.gov/workforce/section/injuries-at-work or call 1-800-332-2667.

Please return the completed form to the office in the region of the Employee's home address per the map below.

Chattanooga
TN Bureau of Workers' Compensation
1301 Riverfront Pkwy., Ste. 202
Chattanooga, TN 37402
Fax: 423-634-3115
Email: wc.ombudsman@tn.gov

Cookeville
TN Bureau of Workers' Compensation
444 – A Neal Street
Cookeville, TN 38501-027
Fax: 931-520-4316
Email: wc.ombudsman@tn.gov

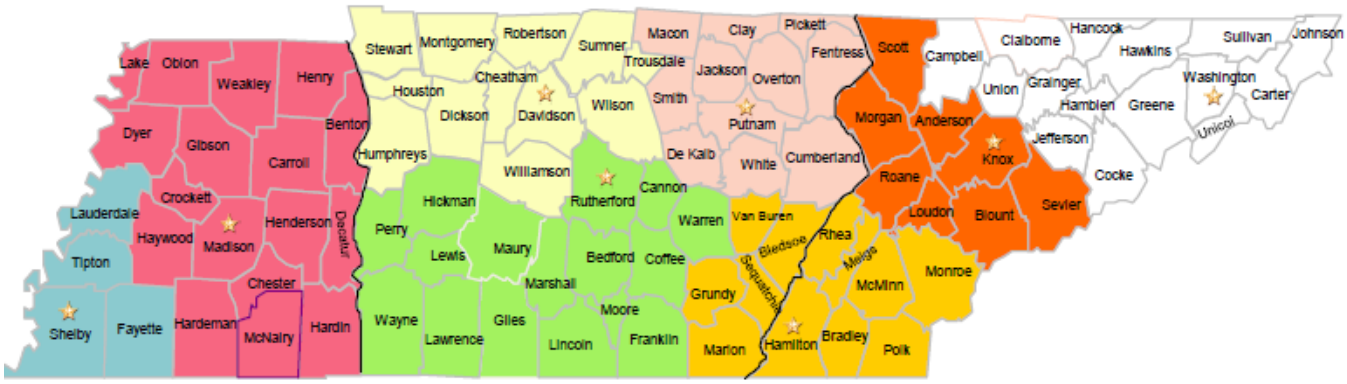
Gray
TN Bureau of Workers' Compensation
5788 Bobby Hicks Highway
Gray, TN 37615-3190
Fax: 423-239-7844
Email: wc.ombudsman@tn.gov

Knoxville
TN Bureau of Workers' Compensation
520 Summit Hill, Ste. 103
Knoxville, TN 37902
Fax: 865-594-5172
Email: wc.ombudsman@tn.gov

Jackson
TN Bureau of Workers' Compensation
225 Dr. Martin L. King Jr. Dr.
1st Floor, Suite 120, Box 16
Jackson, TN 38301-6920
Fax: 731-265-7022
Email: wc.ombudsman@tn.gov

Workers' Comp Court Clerk
TN Bureau of Workers' Compensation
220 French Landing Drive, 1-B
Nashville, TN 37243-1002
Fax: 615-253-2480
Email: wc.ombudsman@tn.gov

Memphis
TN Bureau of Workers' Compensation
One Commerce Square
40 South Main St., Ste. 500
Memphis, TN 38103-1820
Fax: 901-543-6039
Email: wc.ombudsman@tn.gov

Murfreesboro
TN Bureau of Workers' Compensation
845 Esther Lane
Murfreesboro, TN 37129-5537
Fax: 615-217-9378
Email: wc.ombudsman@tn.gov

Nashville
TN Bureau of Workers' Compensation
220 French Landing Drive, 1-B
Nashville, TN 37243-1002
Fax: 615-253-1223
Email: wc.ombudsman@tn.gov