SEWANEE
THE UNIVERSITY OF THE SOUTH

Enclosure checklist:

_____ Letter with Workers' Compensation carrier details and a list of participating pharmacies

_____ Workers' Compensation statement from the Staff Handbook

_____ Mileage reimbursement form

_____ Physician panel

_____ Employee Choice of Physician Form

_____ Injury Report

I received and have read the above listed information.

Please sign and return to: _____

Employee's Signature _____Date_____

SEWANEE
THE UNIVERSITY OF THE SOUTH

Workers' Compensation Carrier:	Travelers Insurance Company P.O. Box 682165 Franklin, TN 37068 800-342-4064
Participating Pharmacies:	Bennett's Pharmacy Blue Front Drug CVS Pharmacy Kroger Mike's Pharmacy Walmart Pharmacy

Make sure you tell the pharmacy that the prescription is a workers' compensation claim. **They will need to have your date of injury and social security number to file your claim.**

209 WORKERS' COMPENSATION (EXCERPT FROM STAFF HANDBOOK)

All staff members are protected under Tennessee's workers' compensation law. This benefit covers accidental injuries or occupational illnesses that are caused by, arise out of, and occur in the course of employment at the University. Benefits continue uninterrupted until the staff member has reached maximum medical improvement, and an assessment of ability to return to work has been made, as defined by the workers' compensation laws.

If a staff member is injured while working, no matter how slightly, the injury must be reported immediately to the Office of Risk Management (phone 931.598.1189). If the accident occurs outside normal working hours, a voice mail message should be left immediately after the accident occurs, and the supervisor of the injured staff member should contact the Office of Risk Management as soon as possible to report the details of the accident. Medical treatment for work-related injuries must be provided by one of the University's panel of doctors unless the staff member is referred by a panel doctor to another physician.

Staff members who are absent from work due to a work-related injury are only compensated by the University for the time missed on the day of the injury. No cash benefits will be paid by the workers' compensation insurer for the first seven calendar days, excluding the day of injury, unless the disability extends to 14 calendar days. Staff members off work for 14 calendar days or less receive no wage replacement for the first seven days. Regular staff members will be allowed to use accrued sick leave and/or vacation leave to compensate them for the first seven calendar days of disability not paid by the workers' compensation insurer. When a staff member is off work for 14 calendar days or more because of the work-related injury, the workers' compensation insurer will pay the staff member for the first seven calendar days. This payment is known as a "wage replacement benefit" and is computed on a percentage (66 2/3 percent) of the average weekly compensation.

Staff members who are off work due to a work-related injury for a full pay period do not accrue vacation, sick leave, or short-term disability leave, and are not paid for holidays.

Each time a staff member is not at work due to a workers' compensation injury, the total amount of the staff members' Family and Medical Leave Act (FMLA) benefits will be reduced by the amount of workers' compensation leave utilized.

Any medical expenses incurred as a result of such injury at work will be paid for by the workers' compensation insurer.

Staff members who are involved in a work-related accident will be subject to drug and alcohol testing and possible disciplinary action as stated in Work Rule V.G.

Staff members who are not able to perform all of their job functions (such as heavy lifting) may be assigned to positions that are within the limitations set by their physician when such positions are available. If light duty work is available, an employee may be assigned to such work for a maximum of eight weeks, and only one light duty assignment will be made within a 12-month period.

FORM C-31

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
Division of Workers' Compensation

MEDICAL WAIVER AND CONSENT

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 MEDICAL AUTHORIZATION FORM ONLY PERMITS THE EMPLOYER OR THE DIVISION OF WORKERS' COMPENSATION TO OBTAIN MEDICAL INFORMATION THROUGH ORAL OR WRITTEN COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, CHARTS, FILES, RECORDS, AND REPORTS IN THE POSSESSION OF A MEDICAL PROVIDER AUTHORIZED BY THE EMPLOYER PURSUANT TO T.C.A. § 50-6-204 AND A MEDICAL PROVIDER THAT IS REIMBURSED BY THE EMPLOYER FOR THE EMPLOYEE'S TREATMENT.

I, _____, having filed a claim for workers' compensation benefits, do hereby waive any physician-patient, psychiatrist-patient, or chiropractor-patient privilege I may have and hereby authorize

_____
(Name of Medical Provider)

to furnish to the employer (or the employer's representative, such as the insurance company) and/or the Division of Workers' Compensation any information reasonably related to my work-related injury. The authorization includes, but is not restricted to, a right to review and obtain copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

This authorization shall remain valid for 180 days following its execution. A photocopy of the authorization may be accepted in lieu of the original.

Dated: _____, 20____.

_____ _____
Patient Social Security last four numbers

_____
Witness

Pursuant to the Rules of the Department of Labor and Workforce Development 0800-2-17-.15, any physician, psychiatrist, chiropractor, podiatrist, hospital or health care provider shall, within a reasonable time, not to exceed thirty (30) days, provide the requesting party with any information or written material reasonably related to the injury for which the employee claims compensation.

MILEAGE REIMBURSEMENT REQUEST CLAIM NUMBER:

You are entitled to reasonable reimbursement related to travel incurred for medical treatment. Please complete the attached form and return it to us. *Please note that if you do not have a physical originating address (PO Box is not acceptable) and a destination name and address, this will delay the processing of your mileage.

EMPLOYEE NAME: _____

EMPLOYER NAME: The University of the South_____

MAILING ADDRESS: _____

CITY: _____ STATE _____ ZIP _____

DATE	FROM	TO	PURPOSE OF TRIP	MILES

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material misrepresentation for the purpose of obtaining or denying worker's compensation benefits or payments is guilty of a felony.

I HAVE REVIEWED, UNDERSTAND, AND ACKNOWLEDGE THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

EMPLOYEE SIGNATURE: _____

IF YOU ARE INJURED AT WORK

FOR EMERGENCIES CALL 911
Otherwise:
REPORT THE INJURY
To your supervisor

TREATMENT will be arranged from one of the medical providers listed below.

MEDICAL PROVIDERS		
First Choice Health 2118 Cowan Hwy Winchester, TN 37398 931-962-4040 Dr. Lynn Williams Dr. Shon Nolin Hours: M-F 7a-7p, Sat 8a-4p	Mountain Medical Clinic 21 First St. Monteagle, TN 37356 931-924-8000 Dr. Michelle S. Val Hours: M-F 7a-7p by appointment	Fast Pace Health Urgent Care 2401 Decherd Blvd Winchester, TN 37398 931-313-1388 Hours: M-F 8a-8p, Sa 8a-6p, Su 1p-5p
Emergencies		
STRHS - Sewanee 1260 University Avenue Sewanee, TN 37375 931-598-5691	STRHS - Winchester 185 Hospital Road Winchester, TN 37398 931-967-8200	

The University of the South
735 University Ave.
Sewanee, TN 37383-1000

TRAVELERS

FORM C-42

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
Division of Workers' Compensation
220 French Landing Dr.
Nashville, Tennessee 37243-1002

AGREEMENT BETWEEN EMPLOYER/EMPLOYEE CHOICE OF PHYSICIAN

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.

In compliance with The Tennessee Workers' Compensation Law, T.C.A. Section 50-6-204

The injured employee shall accept the medical benefits afforded hereunder; provided, the employer shall designate a group of three (3) or more reputable physicians or surgeons not associated together in practice, if available in that community, from which the injured employee shall have the privilege of selecting the operating surgeon and the attending physician. If the injury is a back injury, the statutory panel must be expanded to 4, one of whom must be a chiropractor with treatment limited to 12 chiropractic visits. Further, if the injury or illness requires the treatment of a physician or surgeon who practices orthopedic or neuroscience medicine, the employer may appoint a panel practicing orthopedic or neuroscience medicine consisting of 5 physicians, with no more than 4 physicians affiliated in practice. If the employer provides this panel, the injured employee shall be entitled to have a second opinion on the issue of surgery, impairment, and a diagnosis from that same panel.

Dr. Ephraim Gammada	931-962-1004		
1509 Old Cowan Road	Winchester	TN	37398
Dr. James Stensby	931-967-5646		
186 Hospital Road, Ste 500	Winchester	TN	37398
Sewanee Family Practice	931-598-5648		
1314 University Avenue	Sewanee	TN	37375
J. Lynn Williams	931-962-0561	TN	37324
2006 Decherd Blvd.	Decherd		
Dr. Michelle S. Val (Mountain Medical Clinic)	931-924-8000		
21 First St.	Monteagle	TN	37356

(d)(1) "The injured employee must submit to examination by the employer's physician at all reasonable times if requested to do so by the employer, but the employee shall have the right to have the employee's own physician present at such examination, in which case the employee shall be liable to such physician for such physician's services."
(7) "If the injured employee refuses to comply with any reasonable request for examination or to accept the medical or specialized medical services which the employer is required to furnish under the provisions of this law, such injured employee's right to compensation shall be suspended and no compensation shall be due and payable while such injured employee continues such refusal."

According to the provisions of this agreement, I hereby have selected the following physician from the list provided to me by my employer.

Physician chosen:_____

Date of injury:_____

Date of selection:_____

Date of appointment:_____

University of the South
735 University Avenue
Sewanee, TN 37383
931-598-1381

_____
Employee's Name

_____
Employee's Address

_____
Employee's Phone

_____
Employee's Signature

_____
Employer's Signature

_____
Employee's SSN

Employee's Report of Injury Form

Instructions: Employees shall use this form to report all work related injuries, illnesses, or "near hit" events (which could have caused an injury or illness). This helps us to identify and correct hazards before they cause serious injuries. This form shall be completed by the employee as soon as possible after an event and given to his/her supervisor for further action by Risk Management.

I am reporting a work related: __ Injury __ Illness __ Near Hit	
Your Name:	
Job Title:	
Supervisor:	
Have you told your supervisor about this injury/near hit? __Yes __ No	
Description of Incident: Describe in detail the actual event including injury and how the injury occurred.	
Date of Injury / Near Hit:	Time of Injury / Near Hit:
Names of Witnesses (if any):	
Where, exactly, did it happen?	
What were you doing at the time?	
Describe step by step what led up to the injury / near hit? (continue on separate sheet if necessary)	
What could have been done to prevent this injury / near hit?	
What parts of your body were injured? If a near hit, how could you have been hurt?	

Are you requesting medical treatment from a physician about this injury/illness? __Yes __No	
Have you spoken to a doctor about this injury / illness? __ Yes __ No If yes, who and when (date & time)?	
Has this part of your body been injured before? __ Yes __ No If yes, when?	
List any additional information relevant to the injury/illness?	
Your Signature:	Date: