

**TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
EMPLOYER'S FIRST REPORT OF WORK INJURY OR ILLNESS**

C20

CLAIMS ADM/CARRIER	JURISDICTION CLAIM # (STATE FILE #)		CLAIM TYPE CODE ☐ MED ONLY ☐ INDEMNITY ☐ BECAME LOST TIME ☐ BECAME MED ONLY ☐ NOTIFY ONLY ☐ TRANSFER		The use of this form is required under the provisions of the Tennessee Workers' Compensation Law and must be completed and filed with your insurance carrier immediately after notice of injury. 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. If you have questions, the state now has a benefit review system where a Workers' Compensation Specialist can provide assistance. Call 1-800-332-2667 (TDD).		
	CLAMS ADM CLAIM # (INSURER CLAIM #)						
	OSHA LOG CASE #						
	NAME OF INSURANCE CARRIER City of Johnson City – Self Insured		CARRIER FEIN				
	CLAIMS ADMIN FIRM NAME (if different from carrier) Lodestar Claims & Risk Services, Inc.		FEIN OF CLMS ADM 232652239				
	CLAIMS ADJUSTER NAME		CLMS ADJ PHONE # (866) 886-6305				
	CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2 PO Box 4314		CITY Clinton				
EMPLOYER	EMPLOYER NAME City of Johnson City, Tennessee		EMPLOYER FEIN 62-6000320		SIC CODE		PHONE NUMBER (423) 434-6000
	EMPLOYER ADDRESS LINE 1 AND LINE 2 601 E. Main St., PO Box 2150				NATURE OF BUSINESS Incorporated Municipality		
	CITY Johnson City	STATE TN	ZIP 37605-	INSURED REPORT NUMBER		EMPLOYER LOCATION #	
POLICY	INSURED NAME (parent co. if different than employer)		POLICY NUMBER Self Insured		EFF DATE 10/15/2026		EMPLOYMENT STATUS CODE ☐ FULL TIME/REGULAR ☐ PART TIME ☐ PIECE WORKER ☐ SEASONAL ☐ VOLUNTEER ☐ APPRENTICE FULL TIME ☐ APPRENTICE PART TIME
			SELF INSURED? ☒ YES ☐ NO		EXP DATE 10/15/2027		
EMPLOYEE	EMPLOYEE LAST NAME		PHONE INCL AREA CODE		GENDER ☐ MALE ☐ FEMALE ☐ UNKNOWN		
	FIRST	MI	DEPARTMENT REGULARLY WORKED		OCCUPATION DESCRIPTION		
	ADDRESS LINE 1 & 2						
	CITY	STATE	ZIP	MARITAL STATUS ☐ UNMARRIED, SINGLE, DIVORCED		☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	NCCI CLASS CODE
	SSN	DATE OF BIRTH	DATE OF HIRE				
WAGE	WAGE	PERIOD ☐ HOURLY ☐ DAILY	☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY	NUMBER OF DAYS WORKED PER WEEK		SALARY CONTINUED IN LIEU OF COMPENSATION ☐ YES ☐ NO	
					FULL WAGES PAID FOR DATE OF INJURY ☒ YES ☐ NO		
ACCIDENT/INJURY	DATE OF INJURY		TIME OF INJURY COULD NOT BE DETERMINED ☐		TIME EMPLOYEE BEGAN WORK ON INJURY DATE		
	DATE EMPLOYER NOTIFIED OF INJURY		BODY PART AFFECTED CODE		NATURE OF INJURY CODE		CAUSE OF INJURY CODE
	DATE CLAIM ADM NOTIFIED OF INJURY		HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE INCIDENT INCLUDING WHAT THE EMPLOYEE WAS DOING JUST BEFORE, THE PART OF THE BODY AFFECTED AND HOW, AND OBJECT OR SUBSTANCE THAT DIRECTLY HARMED THE EMPLOYEE.				
	DATE LAST DAY WORKED						
	DATE DISABILITY BEGAN						
	RETURN TO WORK DATE (IF APPLICABLE)						
	DATE OF DEATH (IF APPLICABLE)						
	DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO		IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP ☐ WIDOW ☐ FATHER ☐ SISTER ☐ DAUGHTER ☐ BROTHER ☐ SON ☐ HANDICAPPED CHILD		TOTAL # DEPENDENTS		
	ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES) CITY STATE ZIP						COUNTY OF INJURY
	TREATMENT	PHYSICIAN NAME			HOSPITAL OR OFF SITE TREATMENT NAME		
ADDRESS LINE 1 AND 2			ADDRESS LINE 1 AND 2				
CITY		STATE	ZIP	CITY	STATE	ZIP	
INITIAL TREATMENT ☐ NO MEDICAL TREATMENT		☐ MINOR BY EMPLOYER ☐ MINOR BY CLINIC/HOSPITAL	☐ HOSPITALIZED > 24 HRS ☐ EMERGENCY CARE		☐ FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED		
OTHER	DATE PREPARED		EMPLOYEE'S SIGNATURE		CITY OF JOHNSON CITY, TN		PHONE NUMBER (423) 434-6006