CMCSS ON-THE-JOB EMPLOYEE INJURY STATEMENT

Contact Phone Numbers: (931) 920-7836 / 7806 / 7917 / 7976 / 7827 **Fax:** 931-905-7908 621 Gracey Avenue Clarksville, TN 37040

After hours Emergency Phone Numbers: (931) 291-2480; (931) 257-0042; (931) 216-1971

This form must be completed by the injured employee at the time of any incident (within 24 hours). ***If seeing a physician is not necessary at the time of the incident, please submit this form to the Safety and Health Department. When*** *an employee completes a written report of injury (Employee Injury Statement- OJI-F003), the employee does so with the knowledge that all OJI claims are investigated by the Safety and Health Department. By filing an OJI claim, the employee waives any right of privacy and understands the investigation may include an inquiry of the injury/illness occurrence, past and current medical treatment and care, treatment of the medical condition, and any other inquiry relevant to his/her claim. Completion of an Employee Injury Statement or attempting to file such a claim does not guarantee the approval of said claim. After an investigation of the OJI claim, the claim may be deemed non-compensable despite the fact that the employee may have received treatment by an OJI medical provider with Safety and Health Department approval. After the investigation, if the claim is deemed non-compensable the bills for treatment prior to the investigation will be paid in full by CMCSS. The employee will be responsible for all further treatment and medication. Any employee making a false or fraudulent claim will be subject to disciplinary action up to and including termination from employment with CMCSS.* ***As allowed by T.C.A. 50-6-106, CMCSS has opted to withdraw from the TN Worker's Compensation Act, and has instead chosen to implement an On-the-Job Injury Program administered by the Clarksville Montgomery County School System.***

PLEASE PRINT

Employee (First, Middle Initial, Last Name)

Name ______________________________

Address ______________________________

City, State, Zip ______________________________

Phone: Hm ______________________________

Work ______________________________

Cell ______________________________

Gender (circle): Male or Female

Date of Injury _____/ _____/ _____

Time of Injury _____: _____ am pm

Date of birth _____/ _____/ _____

Work Location ______________________________

Job Position ______________________________

Supervisor ______________________________

Work shift begins at _____: _____ am pm

Work shift ends at _____: _____ am pm

Date of Report _____/ _____/ _____

Time of Report _____: _____ am pm

Who witnessed the injury (name)?

____

Injury location______________________________

Date of hire (leave blank if unknown) _____/ _____/ _____

What safety equipment were you wearing?

____

Eligible to receive Medicare Benefits? (circle) Yes or No

If Medicare Eligible, please list your HICN (Health Information Claim Number): ______________________________

In your own words, describe what happened. Please be sure to state what you were doing just before the injury occurred. ______________________________

____

Affected area (please circle all appropriate areas- if multiple areas, please circle and beside each of them and specify RIGHT (R) or LEFT (L) :

Ankle	Arm	Back	Buttock	Cheek	Chest	Ear	Elbow	Eye	Face	Finger
Forehead	Foot	Genital	Groin	Hand	Head	Hip	Jaw	Knee	Leg	Mouth
Nose	Ribs	Skin	Stomach	Shoulder	Teeth	Thigh	Throat	Toe	Wrist	

Injury type: (please circle all appropriate areas- if multiple areas, please circle all of them):

Burn	Chemical	Cut / Broken Skin	Human Bite	Insect Bite
Lifting	Machine Injury	Slip / Fall	Student Assault	

Physician Panel (CMCSS has the option to choose a physician when deemed necessary):
CMCSS will designate a healthcare provider and appointment time for the injured employee, once the building representative/injured employee contacts the Safety and Health Department at the numbers above.

☐ Please "X" here if you decline this agreement for the On-the-Job Injury Physicians to me under this program and will provide my own medical insurance. I understand that this will deny me all rights for care and medical bills under the OJI program.

*Note to employee: Please review / read form prior to signature.

*Employee Signature: ______________________________ Date: _____/ _____/ _____

OJI Building Rep Signature: ______________________________ Date: _____/ _____/ _____

OJI Office Signature:______________________________ Date: _____/ _____/ _____

*Note to all healthcare providers: (Please see box at the top of the page.) The employee's signature above authorizes copies of all protected health information; such as medical records, including but not limited to emergency room reports, doctors' summaries, x-ray reports, x-ray summarizations, physician's bills, et cetera, concerning the employee listed for the purpose of eligibility for benefits under the OJI program.