



CMCSS ON-THE-JOB EMPLOYEE INJURY STATEMENT

Contact Phone Numbers: (931) 920-7836 / 7806 / 7917 / 7976

621 Gracey Avenue Clarksville, TN 37040

After hours Emergency Phone Numbers: (931) 216-1971; 220-3317; 980-2613

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, this form must be kept with the monthly log by the OJI Building Representative and sent in at the end of each month. When an employee completes a written report of injury (Employee Injury Statement- OJI-F003), eligible employees then have 30 calendar days in which to seek medical treatment. Employees should be aware that all OJI claims are investigated by the Risk Management Department. Completion of an Employee Injury Statement or attempting to file a claim does not automatically guarantee acceptance of the individual claim. Therefore, after an investigation of the OJI claim, the claim may be non-compensable although the employee may have already seen an OJI Physician with OJI office approval. By filing an OJI claim, the employee waives any right of privacy and will be subject to an investigation, which will include an inquiry of the occurrence of the injury, past and current medical care, and treatment of the medical condition and any other relevant inquiry of their claim. If that occurs, bills prior to the investigation will be paid in full by the Risk Management Department and the employee will be responsible for any further treatment or medication. By completing a written report of injury (Employee Injury Statement- OJI-F003), the employee is authorizing the release of their protected health information from health care providers. This authorizes CMCSS Risk Management Department to request their medical record and is the responsibility of the employee to provide to CMCSS Risk Management Department, regardless of stated areas of injury and may be used in making a determination as to their eligibility for benefits under the On-the-Job Injury program. This authorization is in effect for 365 days. Any person making a false or fraudulent claim will be subject to disciplinary action up to termination from employment with the Clarksville-Montgomery County School System. 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 Name (First, Middle Initial, Last Name) _____
Address _____
City, State, Zip _____
Phone: Hm _____
Work _____
Cell _____
SSN ____ / ____ / ____ Gender (circle): Male or Female
Eligible to receive Medicare Benefits? (circle) Yes or No

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

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? _____

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	Genital	Groin	Hand	Head	Hip	Jaw	Knee	Leg	Mouth	Nose			
Skin	Stomach	Shoulder	Teeth	Thigh	Throat	Toe	Wrist	Foot	Ribs				

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

CMCSS will designate a physician and appointment time for the injured employee, once the designated Building Representative contacts the Risk Management / Safety 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.

Employee Signature: _____ Date: ____ / ____ / ____

**OJI Building Rep Signature: _____ Date: ____ / ____ / ____

OJI Office Signature: _____ Date: ____ / ____ / ____