# CMCSS ON-THE-JOB EMPLOYEE INJURY STATEMENT

Contact Phone Numbers: (931) 920-7836 / 7806 / 7917 / 7976 / 7827

621 Gracey Avenue Clarksville, TN 37040 After hours Emergency Phone Numbers: (931) 216-1971; 220-3317

*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), 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. If, after the investigation, the claim is deemed non-compensable, bills for treatment prior to the investigation will be paid in full by CMCSS, and 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

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

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?

_____

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 physician when deemed necessary)*:

CMCSS will designate a healthcare provider and appointment time for the injured employee, once the Building Representative 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.