



# Sequatchie County Schools

Achieving Tomorrow's Excellence Today

Sequatchie County Schools  
P.O. Box 488  
Dunlap, TN 37327  
(423)949-3617

## Employee Accident Report Form

Employee Name: First-\_\_\_\_\_ M.I. \_\_\_\_\_ Last \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone #: Cell \_\_\_\_\_ Home \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Married  
\_\_\_\_\_ Unmarried, Single, Widowed, Divorced, Separated

Date of Injury: \_\_\_\_\_

Time of Injury: \_\_\_\_\_ A.M. or P.M.

Briefly describe how the injury happened and exactly what body part it affected (left hand, right eye): BE SPECIFIC


Was attention given? \_\_\_\_\_ None; \_\_\_\_\_ First Aid; \_\_\_\_\_ Hospital; \_\_\_\_\_ Other

If first aid was given, by whom? \_\_\_\_\_

Give the name(s) of any witness(es) to the incident: \_\_\_\_\_

Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Principal or Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

The completed form should be sent to the Central Office the day of the accident. In Emergencies, the Central Office should be notified directly by telephone: please report to Rhonda Harmon or Pete Swafford. 

THIS SECTION IS FOR CENTRAL OFFICE USE ONLY

What steps have been/ will be taken to prevent a recurrence of this incident?

Signature of Safety Coordinator: \_\_\_\_\_ Date: \_\_\_\_\_

Form 10/10/17

Division of Workers' Compensation

Nashville, Tennessee 37243-0661

Website: [www.state.tn.us/labor-wfd/wcomp.html](http://www.state.tn.us/labor-wfd/wcomp.html)

Telephone: 1-800-332-2667

**EMPLOYEE'S 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.*

THIS FORM IS ONLY FOR USE BY GOVERNMENTAL ENTITIES ESTABLISHED BY TCA§29-20-401 AND SELF INSURED POOLS ESTABLISHED BY TCA§50-6-405(c)(1).

Employer: SEQUATCHIE COUNTY BOARD OF EDUCATION

Address: P.O Box 488 City: DUNLAP State: TN Zip: 37327

**PANEL OF PHYSICIANS**

Tennessee Code Annotated §50-6-204(a)(4)(A) requires an employer to offer a panel of three physicians to the injured employee. The injured employee must select a physician from the panel.

Physicians Name: **DEBORA DANIEL, MD** Phone: 423-949-6300

Address: 16931 RANKIN AVENUE City: DUNLAP State: TN Zip: 37327

Is Physician a Specialist? ☒ NoPhysicians Name: **FAST PACE Urgent Care** Phone: 423-443-3262

Address: 7449 State Route 28 City: DUNLAP State: TN Zip: 37327

Is Physician a Specialist? ☒ NoPhysicians Name: **FAST ACCESS Healthcare** Phone: 423-949-9200

Address: 15367 RANKIN AVENUE City: DUNLAP State: TN Zip: 37327

Is Physician a Specialist? ☒ No

IN THE EVENT OF EMERGENCY: Sequatchie Valley Erlanger ER in Dunlap, TN, or Erlanger Medical Center in Chattanooga, TN.

\*\*\*\*\*I hereby have selected the following physician from the list provided to me by my employer:

Physician Chosen: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date Selected: \_\_\_\_\_

**PLEASE CALL Sequatchie Co. Board of Education at 423-949-3617 to get an APPOINTMENT SCHEDULED!**

\*\*\*\*\* **OR** \*\*\*\*\*

I choose NOT to seek Medical Attention at this time.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*A copy of this form must be provided to the employee. The employer must keep the original form on file and upon request provide a copy to the Division of Workers' Compensation.*

This form is required to be in compliance with Tennessee Code Annotated §50-6-204. LB-0382

Revised 11-13-19

**ACCIDENT REPORT**

**SEQUATCHIE COUNTY SCHOOLS**

**DUNLAP, TN 37327**

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**This report is sent to the TEA Legal Services, Nashville, TN**

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**School Reporting Accident :** \_\_\_\_\_

**Name of Employee:** \_\_\_\_\_

**Date of Accident:** \_\_\_\_\_ **Time of Accident:** \_\_\_\_\_ **A.M. or P.M.**

**Type of Injury:** \_\_\_\_\_

**How did the Accident Happen?:** \_\_\_\_\_

**Where did the Accident happen?:** \_\_\_\_\_

**What first aid or other attention was given?:** \_\_\_\_\_

**Name of Witness to the Accident:** \_\_\_\_\_

**Signature of EMPLOYEE:** \_\_\_\_\_

**Signature of PRINCIPAL/ SUPERVISOR:** \_\_\_\_\_