

FORM – 101		Metropolitan Government of Nashville and Davidson County, Record of Occupational Injury/Illness			Reporting: Fax: 615-515-4838 E-mail: metroclaims@ascrisk.com	
1. Case Number		(SUPERVISOR MUST COMPLETE THIS FORM – ALL SPACES MUST BE COMPLETED)				
2. Department		3. Division		4. Re-Injury <input type="checkbox"/> Yes <input type="checkbox"/> No		5. Date of Report
6. Name of Employee Last First Middle Initial		7.		8. Date of Birth	9. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
11 Employee Home Address				12 Employee Phone Number Home: Work		
13 Date of Injury/Illness		14 Time of Injury/Illness <input type="checkbox"/> AM <input type="checkbox"/> PM		15. Exact Address of accident		
16. Give full account of duties being performed at time of the Injury/Illness and what caused the injury/illness:						
17. Nature of Injury/Illness (cut, bruise, sprain, fracture, etc.)				18. Part of body affected (3 rd finger on right hand, lower back, left leg – be specific)		
19. Name and address of Medical Facility attended.				20. Was the Employee admitted for overnight stay at Medical Facility? <input type="checkbox"/> Yes <input type="checkbox"/> No		
21 State treatments or medicines given to the employee or prescribed for the employee at above Medical Facility						
22. I hereby authorize any Physician or Medical Facility to whom a copy or photocopy of this authorization is delivered to furnish any information, reports, or copies of records which relate directly or indirectly to the above described Injury/Illness the department listed in Number 2 of this form, the Civil Service Medical Examiner for the Metropolitan Government or the Metropolitan Employee Benefit Board or any third party entity contracted to the Employee Benefit Board.						
23. Witness of Employee Signature			24. Employee Signature		25. Date:	
26. Witness of the Injury/Illness						
27. Employee's job classification				28. If Fatality, Date of Death.		
29. Name the object or substance that directly injured employee.		30. Would protective clothing or devices prevented or reduced Injury/Illness <input type="checkbox"/> Yes <input type="checkbox"/> No		31. Describe protective clothing or devices you recommend.		
32 Unsafe condition (no guardrail, no fire extinguisher, etc.)			33. Unsafe act of employee (Inattention to footing, not wearing safety glasses, etc.)			
34. Immediate Supervisor: What action have you taken to prevent future similar injuries? (Be specific Do Not Use – Be more careful or just part of the job). Were safety rules violated? If so, what action was taken?						
Supervisor Contact Phone Number: _____				_____ Print Name of Supervisor		
				_____ Signature of Supervisor		_____ Date
35. SAFETY COORDINATOR: Is corrective action satisfactory? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, describe proper action.						
				_____ Signature of Safety Coordinator		_____ Date