| FORM – 101 | **Metropolitan Government of Nashville and Davidson County, Record of Occupational Injury/Illness**<br><br>(SUPERVISOR MUST COMPLETE THIS FORM – ALL SPACES MUST BE COMPLETED) | Reporting:<br>Fax: 615-515-4838<br>E-mail:<br>metroclaims@ascrisk.com |
|---|---|---|
| **1. Case Number** | | |

| 2. Department | 3. Division | 4. Re-Injury ☐ Yes ☐ No | 5. Date of Report |
|---|---|---|---|

| 6. Name of Employee Last First Middle Initial | 7. | 8. Date of Birth | 9. Sex ☐ Male ☐Female | 10. Employee Number |
|---|---|---|---|---|

| 11 Employee Home Address | 12 Employee Phone Number<br>Home: Work |
|---|---|

| 13 Date of Injury/Illness | 14 Time of Injury/Illness ☐AM ☐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 (3rd finger on right hand, lower back, left leg – be specific) |
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| 19. Name and address of Medical Facility attended. | 20. Was the Employee admitted for overnight stay at Medical Facility? ☐ Yes ☐ No |
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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, to 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. | |
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| 29. Name the object or substance that directly injured employee. | 30. Would protective clothing or devices prevented or reduced Injury/Illness ☐Yes ☐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.) |
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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?

______________________________________________
Print Name of Supervisor

Supervisor Contact Phone Number: ____________________________________________

_________________________________________ _______
Signature of Supervisor Date

35. SAFETY COORDINATOR: Is corrective action satisfactory? ☐ Yes ☐ No If no, describe proper action.

_________________________________________ _______
Signature of Safety Coordinator Date