STATE FILE #	SOCIAL SECURITY NO:	DATE OF INJURY:

FORM SD1

Revised 12-07

WORKERS' COMPENSATION STATISTICAL DATA FORM

Fraud Warning. 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 area for Department use only.	THIS FORM MUST BE FILED WITH THE CLERK OF THE COURT CONTEMPORANEOUSLY WITH THE FINAL ORDER IN ALL WORKERS' COMPENSATION CASES IN WHICH THE COURT EITHER TRIES THE CASE OR APPROVES A SETTLEMENT. FOR SETTLEMENTS SUBMITTED TO THE DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT FOR APPROVAL, SUBMIT THIS FORM WITH THE APPROVAL REQUEST. **NEITHER THE ORDER OF THE COURT NOR THE DEPARTMENT'S APPROVAL IS FINAL UNTIL THIS FORM IS FULLY COMPLETED AND FILED WITH THE APPROPRIATE ENTITY.** [STATUTORY AUTHORITY: TCA 50-6-244(b), (d)]	This area for Court use only.

I. EMPLOYEE INFORMATION

1. STATE FILE #:	2. SOCIAL SECURITY NO:	3. DATE OF INJURY:
4. FIRST NAME:	5. MIDDLE INITIAL:	6. LAST NAME:
7. ADDRESS:	8. CITY:	9. STATE: / 10. ZIP:
11. COUNTY & STATE OF RESIDENCE AT CONCLUSION OF CASE COUNTY: STATE:	12. COUNTY & STATE OF RESIDENCE AT TIME OF INJURY: COUNTY: STATE:	
13. INSURER FILE #:	14. DATE OF BIRTH:	15. DATE OF HIRE:

16. EDUCATION LEVEL: LESS THAN 9TH GRADE ☐ SOME HIGH SCHOOL ☐ GED ☐ HIGH SCHOOL DIPLOMA ☐ SOME COLLEGE/ASSOC DEGREE ☐ GRADUATE/ PROFESSIONAL ☐

17. ABLE TO RETURN TO PRIOR EMPLOYMENT? YES ☐ NO ☐	18. REASONABLY TRANSFERRABLE JOB SKILLS? YES ☐ NO ☐

19. READ & WRITE AT 8TH GRADE LEVEL? YES ☐ NO ☐

II. CLAIM/INJURY INFORMATION

20. INJURY OCCURRED: IN TN ☐ OUT OF STATE ☐	21. TN COUNTY OF INJURY:	22. AVERAGE WEEKLY WAGE:	23. WEEKLY COMP RATE

24. NATURE OF PRIMARY INJURY/ILLNESS:

25. BODY PART:

26. WAS CLAIM DENIED? YES ☐ NO ☐	27. IF "YES" TO 26, STATE BASIS OF DENIAL: STATUTE OF LIMITATIONS ☐, NOTICE ☐, NOT WORK RELATED ☐, INTOXICATED/POSITIVE DRUG TEST ☐, OTHER, SPECIFY,

28. WAS SURGERY PERFORMED? YES ☐ NO ☐	29. WAS PSYCHOLOGICAL INJURY CLAIMED? YES ☐ NO ☐	30. WAS PSYCHOLOGICAL INJURY SOLE CLAIM? YES ☐ NO ☐

31. DID EMPLOYEE RETURN TO WORK FOR SAME EMPLOYER? YES ☐ NO ☐	32. RETURN TO WORK PAY WAS: LESS ☐, SAME ☐, HIGHER ☐

33. DATE OF FIRST TTD PAYMENT:	34. FIRST DATE OUT OF WORK:	35. FINAL RETURN TO WORK DATE:	36. TOTAL NUMBER OF DAYS LOST:

37. MMI DATE:	38. DATE RETURNED TO WORK BY PHYSICIAN:	39. IS EMPLOYEE CURRENTLY EMPLOYED? YES ☐ NO ☐

40. IS EMPLOYEE CURRENTLY RECEIVING SOCIAL SECURITY DISABILITY? YES ☐ NO ☐

41. DID INJURY RESULT IN DEATH? YES ☐ NO ☐ IF YES, THEN LIST DATE OF BIRTH, AND RELATIONSHIP OF ALL DEPENDENTS:

42. CLAIMS ADMINISTRATOR OR TPA FIRM NAME: (*If Different From Insurance Carrier*)	43. CLAIMS ADM/TPA FEIN:

44. ADDRESS:	45. CITY:	46. STATE:	47. ZIP:

48. NAME OF CASE MGMT PROVIDER:

III. EMPLOYER INFORMATION

49. EMPLOYER NAME: (not parent co., DBA where injured employee works)	50. FEIN:

51. ADDRESS:	52. CITY:	53. STATE:	54. ZIP:

55. DID EMPLOYER HAVE A CERTIFIED DRUG FREE WORKPLACE PROGRAM? YES ☐ NO ☐

56. IF SELF INSURED, NAME OF SELF INSURED PROGRAM	57. SELF INSURED PROGRAM FEIN

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58. NAME OF INSURANCE CARRIER:		59. INSURANCE CARRIER FEIN:	
60. ADDRESS:	61. CITY:	62. STATE:	63. ZIP:

IV. MEDICAL AND VOCATIONAL EXPERTS

NAMES OF TREATING PHYSICIANS

64.	(A) LAST NAME:	(B) FIRST NAME:	(C) MI:	(D) TITLE: MD ☐ DO ☐ DC ☐	(E) LICENSE NUMBER:
	(F) IMPAIRMENT RATING (%)	(G) TO BODY OR SPECIFIC MEMBER:		(H) SCHEDULED MEMBER LOCATION LEFT ☐ RIGHT ☐	
	(A) LAST NAME:	(B) FIRST NAME:	(C) MI:	(D) TITLE: MD ☐ DO ☐ DC ☐	(E) LICENSE NUMBER:
	(F) IMPAIRMENT RATING (%)	(G) TO BODY OR SPECIFIC MEMBER:		(H) SCHEDULED MEMBER LOCATION LEFT ☐ RIGHT ☐	

EMPLOYEE'S IME(S)

65.	(A) LAST NAME:	(B) FIRST NAME:	(C) MI:	(D) TITLE: MD ☐ DO ☐ DC ☐	(E) LICENSE NUMBER:
	(F) IMPAIRMENT RATING (%)	(G) TO BODY OR SPECIFIC MEMBER:		(H) SCHEDULED MEMBER LOCATION LEFT ☐ RIGHT ☐	

EMPLOYER'S IME(S)

66.	(A) LAST NAME:	(B) FIRST NAME:	(C) MI:	(D) TITLE: MD ☐ DO ☐ DC ☐	(E) LICENSE NUMBER:
	(F) IMPAIRMENT RATING (%)	(G) TO BODY OR SPECIFIC MEMBER:		(H) SCHEDULED MEMBER LOCATION LEFT ☐ RIGHT ☐	

EMPLOYEE'S VOCATIONAL EXPERT

67.	(A) LAST NAME:	(B) FIRST NAME:	(C) MI:	(D) TITLE: PHD ☐ MA ☐ OTHER ☐	(E) VOCATIONAL DISABILITY RATING:

EMPLOYER'S VOCATIONAL EXPERT

68.	(A) LAST NAME:	(B) FIRST NAME:	(C) MI:	(D) TITLE: PHD ☐ MA ☐ OTHER ☐	(E) VOCATIONAL DISABILITY RATING:

CHIROPRACTIC/PHYSICAL THERAPY

69. CHIROPRACTIC TREATMENT? YES ☐ NO ☐ IF YES, NUMBER OF VISITS?	70. PHYSICIAL THERAPY? YES ☐ NO ☐ IF YES, NUMBER OF VISITS?

V. TYPE OF CONCLUSION AND COURT IDENTIFICATION INFORMATION

☐ **TRIAL (Applicable only when the case has been <u>TRIED</u> by the court.)**

☐ **SETTLEMENT APPROVED BY COURT -COMPLAINT FILED (Applicable only when a lawsuit has been initiated by the filing of a complaint and summons.)**

☐ **SETTLEMENT APPROVED BY COURT - COMPLAINT NOT FILED. (Applicable only when a lawsuit has NOT been initiated by the filing of a complaint – term "joint petition" used to refer to this type of procedure for purposes of this form.)**

71. STYLE OF CASE:		72. COURT DOCKET NO:
73. COUNTY:	74. COURT:	75. FULL NAME OF TRIAL JUDGE/CHANCELLOR:
76. DATE COMPLAINT FILED:	77. DATE OF TRIAL:	78. DATE JOINT PETITION FILED:
79. DATE OF SETTLEMENT APPROVAL:	80. NAME OF APPROVING JUDGE/CHANCELLOR	

☐ **SETTLEMENT APPROVED BY DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT (Applicable only when the approval is by the Department.)**

81. DATE OF SETTLEMENT APPROVAL BY SPECIALIST:	82. NAME OF SPECIALIST APPROVING SETTLEMENT:

VI. BENEFIT REVIEW CONFERENCE

83. DATE OF CONFERENCE:	84. SETTLED? YES ☐ NO ☐	85. NAME OF SPECIALIST:

VII. TRIAL RESULTS

86. PPD% YES ☐ NO ☐ IF YES, NUMBER OF WEEKS?	TO BODY OR SPECIFIC MEMBER:	LEFT ☐ RIGHT ☐
87. PTD? YES ☐ NO ☐ IF YES, NUMBER OF WEEKS?	88. DEATH CLAIM? YES ☐ NO ☐	

89. JUDGMENT FOR EMPLOYER? YES ☐ NO ☐, SELECT BASIS: STATUE OF LIMITATIONS ☐; NOTICE ☐; NOT WORK RELATED ☐; NO PERMANENCY ☐; INTOXICATION ☐; WILLFUL MISCONDUCT ☐; OTHER, SPECIFY

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VIII. SETTLEMENT TERMS

90. PPD% YES ☐ NO ☐ IF YES, NUMBER OF WEEKS?	TO BODY OR SPECIFIC MEMBER:	LEFT ☐ RIGHT ☐
91. PTD? YES ☐ NO ☐ IF YES, NUMBER OF WEEKS?	92. DEATH CLAIM? YES ☐ NO ☐	
93. FUTURE MEDICAL EXPENSE: CLOSED ☐; OPEN FOR LIFE ☐; OR, OPEN FOR A SPECIFIED PERIOD? ☐		
94. WAS MONEY PAID TO CLOSE FUTURE MEDICALS? YES ☐ NO ☐	95. DATE MEDICALS WERE OR WILL BE CLOSED:	
96. WAS CASE SETTLED PURSUANT TO TCA 50-6-206(b)? YES ☐ NO ☐		

IX. SECOND INJURY FUND

97. IS THIS A SECOND INJURY FUND CLAIM? YES ☐ NO ☐	98. WAS JUDGMENT ENTERED AGAINST SECOND INJURY FUND? YES ☐ NO ☐	
99. APPORTIONMENT:	(1) EMPLOYER; ____ %; #WKS; _____TOTAL AMT.	(2) SECOND INJ FUND ____ %; #WKS; _____ TOTAL AMT.

X. MONETARY AMOUNTS PAID

TYPE OF BENEFIT	PAID PRIOR TO TRIAL/ SETTLEMENT	PAID PURSUANT TO TRIAL RESULTS	PAID PURSUANT TO SETTLEMENT TERMS	TOTAL PAYMENTS
100. TEMP TOTAL DISABILITY				0.00
101. TEMP PARTIAL DISABILITY				0.00
102. PERMANENT PARTIAL DISABILITY				0.00
103. PERMANENT TOTAL DISABILITY				0.00
104. DEATH BENEFITS				0.00
105. BURIAL EXPENSES				0.00
106. MEDICAL EXPENSES TOTAL (includes medicine, PT, chiro, hospital, MD/DO costs, tests)				0.00
107. CASE MANAGEMENT COSTS				0.00
108. DISCRETIONARY COSTS				0.00
109. AMOUNT PAID TO CLOSE FUTURE MEDICAL EXPENSE				0.00
110. LUMP SUM PAYMENT (not based on specific disability %)				0.00
111 DATE LUMP SUM PAID (not based on specific disability %):				$ 0.00
112. TOTALS (ADD TOTALS FROM LINES 100 THRU 110)		0	0.00	0.00
113. AMOUNT PAID IN LUMP SUM FROM LINES 100 THRU 105; _____ (DO NOT ADD THIS AMOUNT TO TOTAL PAYMENTS. IT IS ALREADY INCLUDED IN THE TOTALS ABOVE.)			114. DATE LUMP SUM PAID FROM LINES 100 THRU 105 _____	

XI. ATTORNEYS FEES

115. EMPLOYEE'S ATTORNEY FEE; AMOUNT OF AWARD _____ % OF AWARD _____	116. WAS FEE APPROVED BY COURT ☐ OR TDLWD ☐
117. EMPLOYER'S ATTORNEY FEE (SPECIFY RANGE): UNDER $1500 ☐; $1501-3000 ☐; $3000-$10,000 ☐; OVER $10,000 ☐	

XII. CERTIFICATION AND SIGNATURES

By providing my BPR number and my signature, I hereby certify that I have read the contents of the form and the information provided is true and correct to the best of my knowledge. ***ATTORNEY MUST PROVIDE BPR#.***

118. NAME OF EMPLOYEE'S ATTORNEY: BPR#	119. NAME OF EMPLOYER'S ATTORNEY: BPR#
120. NAME OF EMPLOYEE:	121. NAME OF ADJUSTER/CARRIER/EMPLOYER REPRESENTATIVE:

SIGNATURE OF EMPLOYEE	DATE SIGNED	SIGNATURE OF ADJUSTER/CARRIER/EMPLOYER REP	DATE SIGNED
SIGNATURE OF EMPLOYEE'S ATTORNEY	DATE SIGNED	SIGNATURE OF EMPLOYER'S ATTORNEY	DATE SIGNED