Report of Accidental Disability

Tennessee Consolidated Retirement System
502 Deaderick Street
Nashville, Tennessee 37243-0201
1-800-770-8277 ◆ treasury.tn.gov/tcrs

Please complete Section 1. Section 2 is to be completed by your employer.

SECTION 1. MEMBER INFORMATION

Member ID	Last 4 SSN XXX-XX-	Date of Birth
Full Name		Gender ☐ Male ☐ Female
Mailing Address		
City	State	Zip Code
Email		Phone Number
(Was) Employed By (Department, County, City or Institution)		
Employer Address		
City	State	Zip Code
Title of Position		
Exact Location Where Injury Occurred		
Did Your Duties Require You to Be at this Location? ☐ Yes ☐ No		
Date of Injury		
Did You Leave Work on Day of Injury? ☐ Yes ☐ No		If Not, When?
Name Machine, Tool or Other Appliance With Which Injury Occurred		
In Detail, Describe Injury and How It Happened		

SECTION 1. MEMBER INFORMATION *(continues)*

When Was Employer First Notified?

Name of Person Notified

Notified Person's Position

Immediate Supervisor of Injured Person

Name the Body Part that Was Injured

Give Nature of Injury

Probable Length of Disability

Name of Physician Who Treated Injury

Physician Address

City | State | Zip Code | Phone Number

Applicant's Signature | Date

SECTION 2. EMPLOYER INFORMATION

Name of Department, County, City or Institution

Position Held By Employee When Injured

Was Employee Engaged in this Occupation When Injured? ☐ Yes ☐ No

If Not, Why?

Cause of Injury ☐ Willful Misconduct ☐ Intoxication ☐ Intentional Self-Infliction ☐ Failure or Refusal to Use Safety Equipment

When Was Employer First Notified?

Name Injured Body Part

Monthly Salary on Date of Injury $

Basis for Payment ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly

Will Employee Be on Leave Without Pay During Disability? ☐ Yes ☐ No

Give Any Relative Knowledge of Injury

Supervisor's Signature | Date