

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
Division of Workers' Compensation
710 James Robertson Parkway, Second Floor
Nashville, Tennessee 37243-0661

INSTRUCTIONS FOR COMPLETING FORM SD-1

Form SD-1 is required in all workers' compensation cases where the Court tries or approves a settlement or settlements are approved by the Tennessee Department of Labor and Workforce Development (TDOL & WFD).

The insurance carrier and their attorney, along with the cooperation of the employee and/or their representative, should complete Form SD-1. In cases that go through the Court, Form SD-1 must be filed and attached with the Final Order to the Court clerk who will mail Form SD-1 to the TDOL & WFD. An order of the Court will not be final until Form SD-1 is filed with the Court clerk's office.

In settlement cases the TDOL & WFD approves, Form SD-1 must be submitted to the Benefit Review Section with the approval request. A settlement approved by TDOL & WFD shall not become final until Form SD-1 is received by the TDOL & WFD.

THIS FORM MUST BE COMPLETE OR "N/A" MUST BE ENTERED IN ALL LINES THAT DO NOT APPLY.

The Final Order of the Court (tried or approved) must still be filed with the TDOL & WFD within 10 days of the order by the insurance carrier or their representative. The C-29 Form is no longer required in cases that the Court tries or approves nor when the TDOL & WFD approves a settlement. The C-29 is still required in all other cases involving lost time or when benefits other than medicals are paid and there is no Court Order or Approval by TDOL & WFD.

INSTRUCTIONS—(match the corresponding numbers on the form)

The TDOL & WFD issues a State File # for each workers' compensation claim. Indicate the state file #, Social Security Number and Date of Injury at the top of each page.

I. EMPLOYEE INFORMATION

- (1) Indicate the TDOL & WFD State File # for this workers' compensation claim.
- (2) Indicate Social Security Number of the employee/claimant.
- (3) Date of Injury:
- (4-6) Indicate First, Middle, Last Name of the employee/claimant.
- (7-10) Indicate current address of the employee/claimant, (at the time Form SD-1 is completed).
- (11) Indicate county & state where the employee/claimant lived at the time of the injury.
- (12) Indicate county & state where the employee resides at the time of the settlement or trial.
- (13) Indicate the insurance carrier's identifying number assigned to this claim.
- (14) Indicate the month-day-year of birth of the employee/claimant.
- (15) Indicate the month-day-year the employee/claimant was hired by the employer.
- (16) Show the highest degree of education for the employee/claimant.
- (17) Able to Return to Prior Employment? Yes/No If No, then mark appropriate answers to education and job skills.
- (18) General Work History: Check all job descriptions that apply.

II. CLAIM/INJURY INFORMATION

- (19) Indicate if the injury occurred within the State of Tennessee or out of the State of Tennessee.
- (20) If injury occurred within the State of Tennessee, indicate the name of the Tennessee county.
- (21) Show the dollar (\$) amount of the average weekly wage determined by the Court or reported on the wage statement received from the employer.
- (22) Show the compensation rate figured from two thirds of the average weekly wage, not to exceed minimum and maximum in effect at time of the injury.
- (23) Indicate if the employer continued to pay the employee their salary for any length of time that the physician had the employee off work.
- (24) Show the date of the first payment of temporary total benefits to the employee.

- (25) Indicate the nature of the injury or illness (amputation, carpal tunnel, hernia, herniated/ruptured/slipped disc, laceration, pinched nerve, sprain, strain, etc.)
- (26) State the body part affected (arm, back, foot, hand, leg, neck, wrist, etc.)
- (27) Indicate if surgery, pertaining to the injury, has been performed.
- (28) Indicate if the employee claimed a psychological injury.
- (29) Indicate if psychological injury was the only injury claimed.
- (30) Indicate whether or not the employee returned to work for the same employer.
- (31) Did the employee return to work at the same or higher pay they were making before the injury? If the pay changed, indicate the change.
- (32) Show the first date the physician took the employee off work due to the injury.
- (33) Indicate month-day-year that employee finally returned to work.
- (34) Show the total number of days the employee was off work, authorized by the physician.
- (35) Give the maximum medical improvement date indicated by the physician.
- (36) Show the month-day-year the physician returned the employee to work.
- (37) At the time of settlement or trial, is the employee working?
- (38) At the time of the settlement or trial, indicate if the employee is receiving Social Security Disability.
- (39) If yes, is the employee receiving Social Security Disability due to the workers' compensation injury?
- (40) Indicate if the employer, insurance carrier, or claim handler denied the claim.
- (41) If yes to #40, state basis of denial.
- (42) If the claim resulted in death of the employee, complete the names, addresses, relationship and date of birth of all dependents. If more than three (3) use back of form.

Note: Indicate the state file #, Social Security Number and Date of Injury at the top of each page.

III. EMPLOYER INFORMATION

- (43) Indicate the "Doing Business As" name of the employer where the claimant was working at the time of injury (not the parent company name).
- (44) Show the Federal Employer Identification number of the "Doing Business As" name of employer where claimant was working at the time of injury (not the parent company FEIN).
- (45) Indicate county where the employer is located.
- (46-49) Show the complete address of the "Doing Business As" name where the claimant was working at the time of the injury. Do not list the address of the parent company or the corporate office.
- (50) Indicate if the employer had a certified drug-free work place program at the time of the injury.
- (51) Indicate whether or not the employer is self-insured. (Employers with high deductible policies are not self-insured)
- (52) Indicate full name of the employer's insurance carrier.
- (53) Indicate the Federal Employer Identification Number of the employer's insurance carrier.
- (54-57) Show the complete address of the insurance carrier.
- (58) Indicate firm name of the office handling the claim (If different from the insurance carrier).
- (59) Indicate the Federal Employer Identification Number of the Claims Administrator.
- (60-63) Show the full address of the claim handler.
- (64) Identify the firm name of the case management provider (not individual case manager name).
- (65) Indicate the Federal Employer Identification Number of the case management provider.
- (66-69) Show the complete address of the case management provider.

IV. MEDICAL AND VOCATIONAL EXPERTS

- (70-73) Indicate First, MI, Last names of treating physicians, select appropriate title, state license number, show permanent impairment rating given by treating physician, and identify the "Specific Scheduled Body Part" or "Body as Whole", if involved.
- (74-75) Indicate same information shown above for the employee's independent medical evaluation.

- (76-77) Indicate same information as in 77-79 for the employer's independent medical evaluation.
- (78-79) Indicate name of any employee's vocational expert and the vocational disability rate given.
- (80-81) Indicate name of any employer's vocational expert and the vocational disability rate given.
- (82) Indicate if claimant was treated by chiropractor and if so, the number of visits.
- (83) Indicate if claimant received physical therapy and if so, the number of visits.

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V. TYPE OF CONCLUSION AND COURT IDENTIFICATION INFORMATION

Select the appropriate type of conclusion for this case.

- (84) List all plaintiffs & defendants involved. Ex. –John Smith v ABC Corp. and ABC Insurance Co.
- (85) Complete the docket # on cases that are filed with the Court, (Complaint or Joint Petition).
- (86) Name the county in which the Court is located.
- (87) Identify the type of Court (District, Chancery, Circuit, Etc).
- (88) Indicate full name of the Trial Judge/Chancellor who tried the case.
- (89) Indicate month-day-year the lawsuit was filed.
- (90) Indicate month-day-year of the trial (date the judge tried the case).
- (91) Indicate month-day-year the joint petition was filed with the Court.
- (92) Indicate month-day-year the settlement was approved by the Court.
- (93) Indicate the name of the approving Judge/Chancellor.
- (94) Indicate month-day-year the settlement was approved by the Specialist.
- (95) Indicate name TDOL & WFD Specialist that approved the settlement.

VI. BENEFIT REVIEW CONFERENCE

- (96) Show the month-day-year the benefit review conference was held.
- (97) Indicate whether or not a settlement was reached at the benefit review conference.
- (98) Name of the departmental specialist who held the benefit review conference.

VII. TRIAL RESULTS—This section must be completed if the parties are unable to settle and a trial was conducted by the Court. The dollar (\$) amounts will be listed in corresponding columns in Section X (Monetary Amounts Paid).

- (99) Indicate percentage amount of permanent partial disability, naming the “Specific Scheduled Body Part” or the “Body As Whole”, and Indicate value (number of weeks).
- (100) If the Court awarded permanent total disability, show the total # of weeks the award represents.
- (101) Indicate if claim that was tried is a death claim.
- (102) Indicate whether or not the trial decision was for the employer, and mark the appropriate basis.

VIII. SETTLEMENT TERMS- Complete this section in any case where a settlement is reached between the parties and approved by the Court or the TDOL & WFD. The dollar (\$) amounts will be shown under Section X (Monetary Amounts Paid).

- (103) Indicate percentage amount of permanent partial disability, naming the “Specific Scheduled Body Part” or the “Body As Whole”, and Indicate value (number of weeks).
- (104) Specify if the settlement is based on permanent total disability, and Indicate number of weeks that the settlement represents.
- (105) Indicate if the settled claim was a death claim.
- (106) If the medicals were not closed for a monetary sum in the settlement, indicate if open for life or for only a specific period.
- (107) Indicate if money was paid to close future medicals.
- (108) Indicate specific date medicals were or will be closed.
- (109) Complete this section only if employee had injury to “Body as Whole” and employer returned employee to employment at the same or greater pay.

- (110) Indicate yes or no. 50-6-206 (b) provides a disputed case may be settled without regard to whether the employee is receiving the benefits provided by Law if the Court or TDOL & WFD determines the settlement is in the best interest of the employee.

IX. SECOND INJURY FUND– Complete this section if case involves the Second Injury Fund.

- (111) Indicate if the Second Injury Fund was sued.
- (112) Indicate if a judgement (ordered or settled) was entered against the Second Injury Fund.
- (113) Indicate percentage, number of weeks, and total amount the employer/insurance carrier was required to pay and the percentage, number of weeks, and total amount the Second Injury Fund was required to pay.

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X. MONETARY AMOUNTS PAID — This section must be completed to show all dollar (\$) amounts paid on the case.

- (114-119) Enter any amounts paid prior to the trial or settlement, and/or pursuant to the trial award or settlement, in the appropriate columns. You must total each line, and also show a total from lines 114 thru 124 on line 125.
- (120) Medical expenses should include medicine, physical therapy, chiropractic treatment, hospital costs, physician charges and costs of tests. (case management costs should be given under 121)
- (121) Indicate case management costs.
- (122) Indicate discretionary costs.
- (123) If money was paid to terminate future medical benefits, indicate dollar (\$) amount.
- (124) Complete this line if a case is settled for a lump sum, which is not based specifically on any of the benefits listed on lines 114-122. The date the lump sum was or will be paid to the employee, is required.
- (125) This is a total of all amounts listed on lines 114-124.
- (126) If any of the amounts in lines 114-119 are paid in a lump sum or partial lump sum, identify the amount paid and the date the employee was or will be paid.

XI. ATTORNEY FEES —

- (127) Show the percentage and the dollar (\$) amount of money the employee’s attorney received as a fee.
- (128) Indicate if employee attorney fees were approved by the Court or TDOL & WFD.
- (129) Indicate the dollar (\$) range for fees that will be received by the employer’s attorney.
- (130) Indicate if employer attorney fees were approved by the Court or TDOL & WFD.

XII. CERTIFICATION AND SIGNATURES

- (131) Print name of employee’s attorney and give the BPR# of the attorney. If the employee does not have an attorney, you must indicate “N/A” for “not applicable” in this space. Do not leave blank.
- (132) Print name of employer’s attorney and give the BPR# of the attorney. If employer does not have an attorney, employer representative must be given in #134.
- (133) Print name of employee.
- (134) Print name of adjuster/carrier/employer representative.

(rev. 03/02)