Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002
800-332-2667

STATISTICAL DATA FORM FOR INJURIES ON/AFTER JULY 1, 2014—Form SD-2

EMPLOYEE INFORMATION

Docket #________________________ State File #______________________ Date of Injury______________________

Employee's Last Name____________________________ First Name_____________________________ MI__________

Social Security #__________________ Date of Birth____________________________Date of Hire _________________

Education Level ☐ *Less Than High School* ☐ *High School* ☐ *More than High School*

CLAIM/INJURY INFORMATION

Employer____ Is Employer Self-Insured? ☐ Yes ☐ No

Is Employer a member of the Bureau's Tennessee Drug Free Workplace Program? ☐ Yes ☐ No

Insurer____ TPA____

Injury occurred in TN ☐ Yes ☐ No County of Injury__________________________________

First date out of work_________________ Date of return to work_________________ Total # of days lost____________

Date of MMI_______________________________ ATP Impairment Rating %________________________

Average Weekly Wage______________________ Compensation Rate_______________________________

Was claim denied? ☐ Yes ☐ No If yes, basis of denial? ☐ *Statute of Limitations* ☐ *Notice* ☐ *Not Work-Related*

Vocational Assessment performed? ☐ Yes ☐ No ☐ *Intoxication/+ Drug Test* ☐ *Other (Specify)*____________

Nature of Primary Injury/Body Part___________________________________ Occupational Illness? ☐Yes ☐No

Chiropractic Treatment? ☐ Yes ☐ No Physical Therapy? ☐Yes No Case Manager? ☐Yes ☐No

Was there an Employee IME? ☐ Yes ☐ No If yes, Impairment Rating %_____________________________

Was there an Employer IME? ☐ Yes ☐ No If yes, Impairment Rating %_____________________________

SETTLEMENT / HEARING INFORMATION

Type of Conclusion: ☐ **Compensation Hearing** ☐ **Settlement Approval**

Was Bureau Mediation conducted? ☐Yes ☐No If yes, was dispute resolved in mediation? ☐ Yes ☐ No

If concluded by a Compensation Hearing: Date of Hearing _________________________

Style of Case ____

Name of Approving/Hearing Judge ____________________________

Date of Settlement Approval_______________ Impairment Rating % used to settle the claim____________________

Has Initial Compensation Period expired? ☐ Yes ☐ No If no, date this Period will expire__________________

PPD increased benefits awarded? ☐Yes ☐ No Vocational Impairment for Increased Benefits _____________ %

If yes, check all that apply: ☐Did not return to work ☐40+ years old ☐Unemployment Rate ☐Education level

Was there a trial for increased benefits? Yes ☐No Was there a judgment for increased benefits? ☐Yes ☐No

Was there a judgment for the Employer? Yes No If yes, what was the basis: ☐Notice ☐Not work related

☐Statute of limitations ☐No permanency ☐Intoxication ☐Willful Misconduct ☐Other __________________

Did Employee return to work for any Employer? ☐Yes ☐No If yes, was return to work pay ☐Higher

Was claim settled pursuant to T.C.A. §50-6-240(e)? ☐Yes ☐No ☐Same ☐Less

SUBSEQUENT INJURY AND VOCATIONAL RECOVERY FUND INFORMATION

Was there a judgment entered against the Subsequent Injury and Vocational Recovery Fund? ☐ Yes ☐ No

If there was a judgment against the Subsequent Injury and Vocational Recovery Fund, how was the settlement apportioned?

Employer %_____ # of Weeks_____ Subsequent Injury and Vocational Recovery Fund %_____ # of Weeks____

MONETARY AMOUNTS PAID

Temporary Total Disability	n/a		# of weeks, # of days	$
Temporary Partial Disability	n/a		# of weeks, # of days	$
Permanent Partial Disability	n/a	PPD %	# of weeks, # of days	$
Permanent Total Disability (including those to be paid)	n/a	PTD %	# of weeks, # of days	$
Increased Permanent Partial Disability Benefits	n/a			$
Death Benefits (including those to be paid)	n/a			$
Burial Benefits	n/a			$
Medical Benefits	n/a			$
Future Medical Expenses Closure	n/a	Date closed	After prior settlement? ☐ Yes ☐ No	$
Lump Sum per T.C.A. §50-6-240(e)	n/a			$
			Total Paid for all above columns	$
Amount of Settlement Paid in Lump Sum: $ (do not include this amount in total)		Date Settlement Lump Sum Paid:		

Employee's Attorney Fee $______________ % of Settlement___________ Was fee approved by Court? ☐ Yes ☐ No

Employer's Attorney Fee Range ☐ **Under $1,500** ☐ **$1,501-$3,000** ☐ **$3,001-$10,000** ☐ **Over $10,000**

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.

Printed name of Employee Signature Date

Printed name of Employee's Attorney BPR# Signature Date

Printed name of Adjuster Signature Date

Printed name of Employer's Attorney BPR# Signature Date