RESET FORM

State of Tennessee Treasury Department
Criminal Injuries Compensation Program
Division of Claims Administration
9th Floor, Andrew Jackson Building
Nashville, Tennessee 37243-0243
Telephone: (615) 741-2734 - Fax: (615) 532-4979
Web site: www.treasury.state.tn.us/injury/
E-mail: Criminal.Injury@state.tn.us

FOR OFFICE USE ONLY
CLAIM # _____

EMPLOYER'S STATEMENT

Part I: Employee Information (to be completed by employee)

Name (Last)	(First)	(Maiden)	(Middle)
S.S.#			

Part II: Employer Information (to be completed by employer)

Name of Employer	Telephone ( )		
Street Address	City	State	Zip

Part III: Employment Information (to be completed by employer)

Employee's Occupation: _____

Employee's Date of Hire (month, day and year): _____

Average Weekly Wage: $_____ Hours per day worked: _____ Days per week worked: _____

Did employee miss any time from work because the employee was a victim of a crime? ☐ No ☐ Yes

If yes, how many days did the employee miss? _____ What was the date the employee first missed? _____

Has the employee returned to work? ☐ No ☐ Yes

If yes, what was the date the employee returned (month, day and year)? _____

Was the crime work related? ☐ No ☐ Yes

If yes, has the victim applied for workers' compensation or other employer benefits? ☐ No ☐ Yes

Indicate below if the employee received or will receive any payment from the following sources as a result of missing work during the previously mentioned period.

Source	No	Yes	Amount per week	From (date) to (date)
Sick Leave/Employers Group Plan	☐	☐	$ _____	_____ to _____
Disability Pay/Union Plan	☐	☐	$ _____	_____ to _____
Private Health Plan	☐	☐	$ _____	_____ to _____
Vacation	☐	☐	$ _____	_____ to _____
Workers' Compensation	☐	☐	$ _____	_____ to _____
Other, specify	☐	☐	$ _____	_____ to _____

Part IV: Certification By Employer

I hereby certify that the information stated above is true and correct to the best of my knowledge.

_____ _____
Signature of Employer Date

_____
Printed Name and Title