TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
Division of Workers' Compensation
220 French Landing Drive, 1st Floor
Nashville, TN 37243-1002
FAX: 615-253-6256

REQUEST FOR INVESTIGATION

(Failure to complete this form may cause a delay or result in the form being returned to requesting party)

A) **EMPLOYER**

Name of Employer: _____

Employer's Federal Employment Identification Number (FEIN): _____

Name of Owner(s) of Employer if different from Employer: _____

_____

Name of immediate supervisor or manager, or a contact person at Employer's place of business:

_____

Street Address: _____

City: _____ State: _____ Zip: _____

County: _____ Business Phone: _____

Home Phone: _____ Cell Phone: _____ Fax: _____

How Many Employees Work for Employer (including part-time employees): _____

Describe what kind of work the Employees of this Employer perform: _____

_____

_____

_____

B) **EMPLOYEES**

Names, addresses and phone numbers of Employees who work for Employer, part-time or full time (please attach additional pages if necessary to list all Employees known to requesting party).

Name: _____

Address: _____

City: _____ State _____ Zip: _____

County: _____ Phone: _____ Fax: _____

C) **REQUESTING PARTY**

I hereby request the Department of Labor and Workforce Development to investigate whether the Employer listed above currently has and/or has had since January 1, 2001 Workers' Compensation coverage.

Printed Name of Requesting Party: _____ Date: _____

Signature of Requesting Party: _____