Injury Report

Workers' Compensation Injury Report

THE UNIVERSITY OF TENNESSEE

Injured Worker Contact Information:

Name: _____ Employee ID#: _____

Date of Birth: _____ Contact Phone #: (_____) _____

Contact Email: _____

Mailing Address: Street _____

City _____ State: _____ Zip Code: _____

Accident Information:

Accident Date: _____ Accident Time: _____ A.M.__ P.M.__

Campus: _____ Building: _____ Room #: _____

Description of the accident:

_____

_____

_____

_____

Body Part(s) Injured: (check all)

o Left	o Toe	o Left	o Finger
o Right	o Foot	o Right	o Hand
	o Ankle		o Wrist
	o Shin		o Elbow
	o Knee		o Arm
	o Thigh		o Shoulder
	o Hip/ Buttock		o Neck
	o Abdomen/Groin		o Head
	o Back	OTHER:	

Person completing this Report: _____ (print)

Contact Phone #: _____ Date: _____

Office of Risk Management *Phone: (865) 974-5409 *Fax: (865) 974-0936

***Email: riskmanagement@tennessee.edu**