Workers' Compensation Injury Report

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Print

Clear Form

THE UNIVERSITY OF TENNESSEE

Injured Worker Contact Information:

Name: _____ Employee ID#: _____

Date of Birth: _____ Contact Phone #: _____

Contact Email: _____

Address: Street _____

City _____ State: _____ Zip Code: _____

Accident Information:

CorVel Claim #: 0546–WC - ___ - _____

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

Campus: _____ Building: _____ Room #: _____

Description of the accident:

_____

_____

_____

_____

Body Part(s) Injured: (check all)

◯ Left	☐ Toe/Foot	◯ Left	☐ Finger
◯ Right	☐ Ankle	◯ Right	☐ Hand
	☐ Shin		☐ Wrist
	☐ Knee		☐ Elbow
	☐ Thigh		☐ Arm
	☐ Hip/Buttock		☐ Shoulder
	☐ Abdomen/Groin		☐ Neck
	☐ Chest		☐ Head
	☐ 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