THE UNIVERSITY OF TENNESSEE
REPORT OF ON-THE-JOB INJURY or ILLNESS

To be used for Workers' Compensation claim reporting.

Initial Information

Injured Employee Name | **Social Security #** | **Date and Time of Incident** | **Date of Report**

Position | **Department** | **Supervisor's Name** | **Supv. Telephone**

Exact Location of Incident (campus building/room or street address of non-campus location)

Description of Incident (work activity employee was engaged in, causes of incident, machinery in use, etc.)

(Use separate page to continue if needed.)

Nature of injury or illness (fracture, cut, allergic reaction, etc.)

Injured Body Part

Witness name | Telephone | Address | Relationship to UT

Witness name | Telephone | Address | Relationship to UT

Complete if incident resulted in medical treatment

Medical Treatment Required:

- ☐ Yes - First Aid only
- ☐ Yes - Doctor / Clinic — Where?
- ☐ Yes - Emergency Room — Where?

Date of First Treatment

Released to return to work:

- ☐ At full duty
- ☐ With restrictions
- ☐ Not released
- ☐ Follow-up visit to be scheduled

Any Other Medical Information / Comments:

Supervisor Comments

Could incident have been prevented?

Other comments?

Employee Signature **Date** **Supervisor Signature** **Date**