



**ACCIDENT REPORT**  
**STATE OF TENNESSEE**  
**DIVISION OF CLAIMS ADMINISTRATION**  
 9TH FLOOR ANDREW JACKSON BUILDING  
 NASHVILLE, TN 37219-5066  
 (615) 741-2734

BUDGET ACCOUNT# \_\_\_\_\_

State Agency	Univ. of TN
Budget Code #	01000
Location #	UT-Knoxville

This form must be used exclusively by all state employees in presenting claims for workers' compensation. All questions must be answered.

**TO BE COMPLETED BY EMPLOYEE:** Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

- Employee's name \_\_\_\_\_  
First M.I. Last
- Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Job Title \_\_\_\_\_  
Mo. Day Year
- Home Address \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_
- Supervisor \_\_\_\_\_ State Agency Univ. of TN Campus ( \_\_\_\_\_ )
- Office Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone # \_\_\_\_\_
- Date Employed by State \_\_\_\_\_
- Exact location of project where injury occurred \_\_\_\_\_  
 \_\_\_\_\_ County \_\_\_\_\_
- Do duties of employee require being at this location? \_\_\_\_\_
- Did employee leave work on day of injury? \_\_\_\_\_ If not, when did incapacity begin? \_\_\_\_\_
- Date of Accident \_\_\_\_\_

**DESCRIPTION OF THE INJURY:**

- State name of machine, tool, or other appliance with which injury occurred \_\_\_\_\_
- Describe the injury in detail and state how it occurred \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- What part of person was injured? \_\_\_\_\_
- Probable length of disability \_\_\_\_\_
- Did employee lose time from work? \_\_\_\_\_ How much time? \_\_\_\_\_
- Physician's name \_\_\_\_\_ Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # ( \_\_\_\_\_ ) \_\_\_\_\_
- Date of first visit \_\_\_\_\_
- Who authorized visit to physician? \_\_\_\_\_
- Was employee hospitalized? \_\_\_\_\_ Where? \_\_\_\_\_

**TO BE COMPLETED BY SUPERVISOR:**

- What position did employee hold when injured? \_\_\_\_\_
- Was injury caused by (a) employee's willful misconduct? \_\_\_\_\_  
 (b) intentional self-inflicted injury? \_\_\_\_\_  
 (c) intoxication? \_\_\_\_\_  
 (d) failure or refusal to use safety appliance furnished him? \_\_\_\_\_  
 (e) failure to perform a duty required by law? \_\_\_\_\_
- When was first notice of injury given to employer? Date \_\_\_\_\_ Time \_\_\_\_\_  
 To Whom? \_\_\_\_\_ Position \_\_\_\_\_
- Monthly salary on date of injury \$ \_\_\_\_\_ Biweekly employee hourly rate \_\_\_\_\_
- If disabled, will employee be on leave without pay during disability? \_\_\_\_\_
- Relate any knowledge you may have of injury or what the employee reported to you \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

We, the undersigned, certify that all statements contained herein and on any attachments hereto are true and that the injuries reported were actually incurred. We also acknowledge that it is a misdemeanor to file a false claim with the Division of Claims Administration.

\_\_\_\_\_  
 Claimant

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Supervisor

\_\_\_\_\_  
 Date