



**THE UNIVERSITY OF TENNESSEE
INCIDENT REPORT**

Office of Risk Management
5723 Middlebrook Pike
Suite 218
Knoxville, TN 37996

Phone: (865)974-5409
Fax: (865) 974-0936
Email: riskmanagement@tennessee.edu
Website: http://riskmanagement.tennessee.edu

Date of Report

Claim #

Name:		Relationship to UT:		Employee ID#:	
Home Address:	Street:	City:	State:	Zip Code:	
Email Address:			Telephone Number:		
Witness:					
Name:		Telephone Number:	Email Address:		Relationship to UT:

Incident Report	Campus or Facility of Incident:		Date of Incident:	Time of Incident:
	Exact Location of Incident: Bldg. Name: _____ Room #: _____ Address: _____		Type of Incident: <input type="checkbox"/> Injury <input type="checkbox"/> Unsafe Conditions <input type="checkbox"/> Property <input type="checkbox"/> Other (Explain) _____ <input type="checkbox"/> Security	
	Police Department Contacted (Ex: KPA, UTPD, etc.): _____		If yes, accident report #: _____	
	Description of Incident (Use separate page if necessary):			
	Property Damaged (Description of Damage):			
	Nature of Injury or Illness (Fracture, Cut, Allergic Reactions, etc.): Body Part Affected: _____			
	Medical Treatment Required: <input type="checkbox"/> No <input type="checkbox"/> Yes – First Aid Only <input type="checkbox"/> Yes – Doctor/Clinic <input type="checkbox"/> Yes – Emergency Room			
	Where Treated:		Date of First Treatment:	
	Type of Medical Treatment: <input type="checkbox"/> Hospitalization <input type="checkbox"/> Fracture <input type="checkbox"/> Suture <input type="checkbox"/> Referred for further treatment <input type="checkbox"/> Prescription Medication <input type="checkbox"/> Foreign Body Removal <input type="checkbox"/> Rigid Splint or Cast <input type="checkbox"/> Other Medical Treatment (List) _____			
	Time lost from work beyond day of accident: <input type="checkbox"/> Yes <input type="checkbox"/> No		Released to Return to Work: <input type="checkbox"/> No <input type="checkbox"/> At Full Duty <input type="checkbox"/> Follow-up Visit to be Scheduled <input type="checkbox"/> Yes: <input type="checkbox"/> With Restrictions	

Supervisor's Comments	Could this incident have been prevented? If so, how?	
	Name:	Email Address:

COMPLETING THIS FORM IS FOR INFORMATIONAL PURPOSES ONLY AND DOES NOT MEAN A CLAIM HAS BEEN FILED. TO FILE A CLAIM, CONTACT THE UT OFFICE OF RISK MANAGEMENT AT 865-974-5409. THANK YOU.

Person Injured or Person who sustained damages:	Supervisor or Person completing report:
Signature: _____	Signature: _____