



THE UNIVERSITY OF TENNESSEE  
INCIDENT REPORT

Office of Campus Safety  
3 N. Dunlap Street, S206  
Memphis, TN 38163

Phone: (901) 448-6114  
Fax: (901) 448-7774  
Email: [labsafety@uthsc.edu](mailto:labsafety@uthsc.edu)  
Website: <https://www.uthsc.edu/campus-safety>

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:		
<b>Incident Report</b>	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 (UT PD)			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			
	<b>Supervisor's Comments</b>	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: _____	