



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 #	05000
Location #	MARTIN

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(MARTIN)
- 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 _____ How much time? _____
- 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 _____ : _____ .M.
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