

# Workers' Compensation Injury Report



## THE UNIVERSITY OF TENNESSEE

Workers' Compensation Injury Report

### Injured Worker Contact Information:

Name: \_\_\_\_\_ Employee ID#: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Contact Phone #: \_\_\_\_\_  
 Contact Email: \_\_\_\_\_  
 Address: Street \_\_\_\_\_  
 City \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### Accident Information:

CorVel Claim #: 0546-WC - \_\_\_\_ - \_\_\_\_\_

Accident Date: \_\_\_\_\_ Accident Time: \_\_\_\_\_ A.M. \_\_\_ P.M. \_\_\_

Campus: \_\_\_\_\_ Building: \_\_\_\_\_ Room #: \_\_\_\_\_

Description of the accident:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Body Part(s) Injured: (check all)

<input type="checkbox"/> Left	<input type="checkbox"/> Toe/Foot	<input type="checkbox"/> Left	<input type="checkbox"/> Finger
<input type="checkbox"/> Right	<input type="checkbox"/> Ankle	<input type="checkbox"/> Right	<input type="checkbox"/> Hand
	<input type="checkbox"/> Shin		<input type="checkbox"/> Wrist
	<input type="checkbox"/> Knee		<input type="checkbox"/> Elbow
	<input type="checkbox"/> Thigh		<input type="checkbox"/> Arm
	<input type="checkbox"/> Hip/Buttock		<input type="checkbox"/> Shoulder
	<input type="checkbox"/> Abdomen/Groin		<input type="checkbox"/> Neck
	<input type="checkbox"/> Chest		<input type="checkbox"/> Head
<input type="checkbox"/> Back		OTHER: _____	

Person completing this Report: \_\_\_\_\_ (print)

Contact Phone #: \_\_\_\_\_ Date: \_\_\_\_\_

Office of Risk Management • Phone: (865) 974-5409 • Fax: (865) 974-0936

Email: [riskmanagement@tennessee.edu](mailto:riskmanagement@tennessee.edu)