East Tennessee State University

Office of Human Resources

THIS INJURY AND ILLNESS INCIDENT REPORT IS ONE OF THE FIRST FORMS THAT MUST BE FILLED OUT WHEN A RECORDABLE WORK-RELATED INJURY OR ILLNESS HAS OCCURRED. PLEASE FOLLOW THE FORM INSTRUCTIONS CAREFULLY.

- **PLEASE NOTE**: The form must be printed on one sheet of paper with the first page of the form printed on the front and the second page of the form printed on the back.
- This form, along with the OSHA's Form 301 – Injury and Illness Incident Report, should be completed as soon as possible after an accident or illness.
- This form should be typed.
- This form must be used exclusively by all state employees in presenting claims for workers' compensation. All questions must be answered.
- Question 4 – State Agency should be " ETSU- " department name.
- Question 5 – Office Address should be "807 University Pkwy, Box" and the box number of the department.
- Upon completion, please sign and return the completed form to:

HUMAN RESOURCES
BOX 70564

Your assistance in completing this form correctly is appreciated.

Version0109

ACCIDENT REPORT
STATE OF TENNESSEE
DIVISION OF CLAIMS ADMINISTRATION

9TH FLOOR ANDREW JACKSON BUILDING
NASHVILLE, TN 37243
(615) 741-2734

State Agency _____
Budget Code # _____
Location # _____

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 # _____

1. Employee's name _____ _____ _____
   First M.I. Last
2. Birthdate _____ Sex _____ Job Title _____
   Mo. Day Year
3. Home Address _____ City _____
   State _____ Zip _____ Home Phone (_____) _____
4. Supervisor _____ State Agency _____
5. Office Address _____ City _____
   State _____ Zip _____ Work Phone (_____) _____
6. Date Employed by State _____
7. Exact location of project where injury occurred _____
   _____ County _____
8. Do duties of employee require being at this location? _____
9. Did employee leave work on day of injury? _____ If not, when did incapacity begin? _____
10. Date of Accident _____

DESCRIPTION OF THE INJURY:

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

TO BE COMPLETED BY SUPERVISOR:

1. What position did employee hold when injured? _____

2. 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? _____

3. When was first notice of injury given to employer? Date _____ Time _____

   To Whom? _____ Position _____

4. Monthly salary on date of injury $_____

5. If disabled, will employee be on leave without pay during disability? _____

6. 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