Supervisor's Report of Employee Accident

IN ORDER TO COMPLY with OSHA reporting regulations, Supervisors must provide the following information immediately following all work-related injuries, whether medical treatment is required or not. Completed form should be routed to campus Workers' Compensation office in accordance with campus procedures. This form must accompany the completed State of Tennessee "Accident Report" claim form.

IMPORTANT: If the employee does seek medical attention, remind him or her that medical services must be from a State network provider in order for medical expenses or lost time to be paid.

1. EMPLOYEE
   - Name _______________________________
   - Male   Female (circle one)
   - Job Title ___________________________
   - Personnel No. _______________________
   - Time employee began work ________________
   - Cost Center _______________________

2. ACCIDENT CIRCUMSTANCES
   - Date of Accident _____________________
   - Time of Accident _____________________
   - Date Reported _______________________
   - Time cannot be determined ________________

   Was employee engaged in job duties at the time of accident? YES NO

   Describe the conditions or circumstances which caused this accident to occur (what, who, when, how and why). Please be specific. Use additional paper if necessary.

   __________________________________________
   __________________________________________

   Witnesses, if any ________________________________

3. INJURIES
   - Extent of injury and affected body part/s __________________________

   Was employee hospitalized for this injury overnight? YES NO

   Was employee treated in an emergency room? YES NO

   When did employee first receive medical treatment for this injury? __________________________
   - Where? __________________________

4. OUTCOMES
   - Will the employee lose work time other than the day of injury? YES NO
   - When? ________________
   - How much? ________________

   Could this accident have been prevented? Explain. __________________________________________
   __________________________________________

   What actions will be taken to prevent future accidents? __________________________________________
   __________________________________________

5. OTHER COMMENTS

DEPARTMENT INFORMATION
   - Department ___________________________
   - Name of Supervisor _______________________
   - Supv. Signature _______________________
   - Campus Phone _______________________
   - Date _______________________

rev. 3/2002