

1. Incident Information			
Incident Type:	Injury	Property Damage	Incident Date:
	Illness	Environmental Spill	
		Near Miss (Injury Free)	Incident Time: AM PM
Building Name:			Location: Inside Building
Floor #/Room #:			Outside Building

2. Employee Information			
Name:	Was employee working overtime?	Yes	No
FS Unit/Subunit:	Was employee performing their normal work?	Yes	No
Witnesses:	Was employee in normal work area?	Yes	No

3. Injury Information				
Nature of Injury:		Injured Body Part:		OSHA Case Type:
Abrasion	Foreign body (splinter)	Arm	Hand/wrist	First aid
Amputation	Laceration or puncture	Back	Knee	Medical treatment
Burn	Loss of consciousness	Elbow	Leg	Restricted work day
Contusion	Repetitive injury	Eye	Shoulder	Lost work day
Eye injury	Skin condition or rash	Finger	Torso	Reportable to OSHA? Amputation Yes No Loss of eye Fatality
Exposure	Strain or sprain	Foot/ankle	Whole body	
Fracture	No injury	Head/neck	None	

4. Incident Description

Please describe how the incident occurred, the work being performed, any machinery, equipment, or chemicals involved, and further details about the injury, illness, damage, spill, or near miss. Use an additional page if needed.

5. Unsafe Conditions (Choose all that apply):

- | | | |
|------------------------------|-------------------------------|----------------------------|
| Unsafe storage | Excessive noise | Defective equipment/tools |
| Hazardous arrangement/layout | Fire/explosion hazard | Inadequate illumination |
| Protruding object hazard | Inadequate tool/equipment | Inadequate fall protection |
| Inadequately guarded | Poor housekeeping | Congested work area |
| Slippery conditions | Insufficient knowledge of job | No unsafe condition |
| Other - Please describe: | | |


6. Unsafe Actions (Choose all that apply):

- | | | |
|-------------------------------------|----------------------|---------------------------|
| Distraction/inattention to hazard | Unnecessary haste | Failure to warn or secure |
| Improper use of equipment | Failure to use PPE | Bypassing safety devices |
| Operating defective equipment | Improper judgment | Horseplay |
| Unsafe lifting, pushing, or pulling | Use of drugs/alcohol | Failure to lockout |
| Using wrong tool/equipment | No unsafe action | |
| Other - Please describe: | | |

7. Corrective Actions (choose all that apply):

What actions have been taken or are planned to prevent recurrence?

- | | |
|----------------------------------|---|
| Use safer materials/supplies | Establish Safe Work Instruction (SWI for job) |
| Improve safety rules | Revise Safe Work Instruction (SWI for job) |
| Mandatory pre-job instruction | Install/adjust safety guard or device |
| Job reassignment for employee | Require personal protective equipment (PPE) |
| Improved inspection procedure | Preventative instruction of others who perform task |
| Improved clean-up procedure | Re-instruction of employees involved |
| Improved enforcement | Reprimand/discipline of employee involved |
| Improve illumination/ventilation | Other - Please describe: |
| Repair/replace equipment | |
| Improve storage/arrangement | |
| Improve design/construction | |

 Person(s) responsible for implementing:

 Target completion date:

8. Further Instructions:

Completed by:

Email:

Date:

You have now completed the Facilities Services portion of the Incident Report & Investigation. *Thank you!*

Please **continue to Page 3** for the initial Worker's Compensation Incident Report.

At the end of the document, click the **Submit** button to send all pages of the form via email. You will receive a follow-up email with additional Worker's Compensation documents.

For T&D Use Only

Send-to Names:

Date:

Send-to Emails:



**THE UNIVERSITY OF TENNESSEE
INCIDENT REPORT**

Office of Risk Management
5723 Middlebrook Pike
Suite 218
Knoxville, TN 37996

Phone: (865)974-5409
Fax: (865) 974-0936
Email: riskmanagement@tennessee.edu
Website: http://riskmanagement.tennessee.edu

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:	

Incident Report	Campus or Facility of Incident:	Date of Incident:	Time of Incident:	Time Employee began work on date of injury:	
	Exact Location of Incident: Bldg. Name: _____ Room #: _____ Address: _____		Type of Incident: <input type="checkbox"/> Injury <input type="checkbox"/> Property <input type="checkbox"/> Security <input type="checkbox"/> Incident/Near Miss <input type="checkbox"/> Unsafe Conditions <input type="checkbox"/> Other (Explain) _____		
	Police Department Contacted (Ex: UTPD, Local PD, State PD etc.):		If yes, accident report #: _____		
	Description of Incident (Use separate page if necessary):				
	Property Damaged (Description of Damage): * If UT property, complete Property Claim Packet *				
	Nature of Injury or Illness (Fracture, Cut, Allergic Reactions, etc.): Body Part Affected: _____				
	Medical Treatment Required: No <input type="checkbox"/> Yes – First Aid <input type="checkbox"/> Yes – Doctor/Clinic Yes – Emergency Room				
	Place Treated:		Date of First Treatment:		
	Type of Medical Treatment: Hospitalization <input type="checkbox"/> Fracture <input type="checkbox"/> Suture Referred for further treatment Prescription Medication <input type="checkbox"/> Foreign Body Removal <input type="checkbox"/> Rigid Splint or Cast 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		

Supervisor's Comments	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: _____

