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FACILITIES SERVICES

Incident Reporting Form
Update: 4/2017

1. Incident Information

Incident Type: ☐ Injury ☐ Illness ☐ Property Damage ☐ Environmental Spill ☐ Near Miss (Injury Free)

Incident Date: _____

Incident Time: _____ ○ AM ○ PM

Building Name: _____

Floor #/Room #: _____

Location: ○ Inside Building ○ Outside Building

2. Employee Information

Name: _____

FS Unit/Subunit: _____

Witnesses: _____

Was employee working overtime? ○ Yes ○ No

Was employee performing their normal work? ○ Yes ○ No

Was employee in normal work area? ○ Yes ○ No

3. Injury Information

Nature of Injury:

- ☐ Abrasion
- ☐ Amputation
- ☐ Burn
- ☐ Contusion
- ☐ Eye injury
- ☐ Exposure
- ☐ Fracture
- ☐ Foreign body (splinter)
- ☐ Laceration or puncture
- ☐ Loss of consciousness
- ☐ Repetitive injury
- ☐ Skin condition or rash
- ☐ Strain or sprain
- ☐ No injury

Injured Body Part:

- ☐ Arm
- ☐ Back
- ☐ Elbow
- ☐ Eye
- ☐ Finger
- ☐ Foot/ankle
- ☐ Head/neck
- ☐ Hand/wrist
- ☐ Knee
- ☐ Leg
- ☐ Shoulder
- ☐ Torso
- ☐ Whole body
- ☐ None

OSHA Case Type:

- ☐ First aid
- ☐ Medical treatment
- ☐ Restricted work day
- ☐ Lost work day

Reportable to OSHA? ○ Yes ○ No

- ☐ Amputation
- ☐ Loss of eye
- ☐ Fatality

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

6. Unsafe Actions (Choose all that apply):

- ☐ Distraction/inattention to hazard
- ☐ Improper use of equipment
- ☐ Operating defective equipment
- ☐ Unsafe lifting, pushing, or pulling
- ☐ Using wrong tool/equipment
- ☐ Unnecessary haste
- ☐ Failure to use PPE
- ☐ Improper judgment
- ☐ Use of drugs/alcohol
- ☐ No unsafe action
- ☐ Failure to warn or secure
- ☐ Bypassing safety devices
- ☐ Horseplay
- ☐ Failure to lockout
- ☐ 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
- ☐ Improve safety rules
- ☐ Mandatory pre-job instruction
- ☐ Job reassignment for employee
- ☐ Improved inspection procedure
- ☐ Improved clean-up procedure
- ☐ Improved enforcement
- ☐ Improve illumination/ventilation
- ☐ Repair/replace equipment
- ☐ Improve storage/arrangement
- ☐ Improve design/construction
- ☐ Establish Safe Work Instruction (SWI for job)
- ☐ Revise Safe Work Instruction (SWI for job)
- ☐ Install/adjust safety guard or device
- ☐ Require personal protective equipment (PPE)
- ☐ Preventative instruction of others who perform task
- ☐ Re-instruction of employees involved
- ☐ Reprimand/discipline of employee involved
- ☐ Other - Please describe:

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

Date:

Send-to Names:

Send-to Emails:

Send to Unit

THE UNIVERSITY OF TENNESSEE
INCIDENT REPORT

Date of Report _____

Claim # _____

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

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:
☐ Injury ☐ Property ☐ Security
☐ Incident/Near Miss ☐ Unsafe Conditions ☐ 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 ☐ Yes – First Aid ☐ Yes – Doctor/Clinic ☐ Yes – Emergency Room

Place Treated:

Date of First Treatment:

Type of Medical Treatment:
☐ Hospitalization ☐ Fracture ☐ Suture ☐ Referred for further treatment
☐ Prescription Medication ☐ Foreign Body Removal ☐ Rigid Splint or Cast ☐ Other Medical Treatment (List) _____

Time lost from work beyond day of accident:
☐ Yes ☐ No

Released to Return to Work:
☐ No ☐ At Full Duty ☐ Follow-up Visit to be Scheduled
☐ Yes: ☐ 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:

Signature: _____

Supervisor or Person completing report:

Signature: _____


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