# Workers' Compensation Injury Report

Workers' Compensation Injury Report

Print

Clear Form

THE UNIVERSITY OF TENNESSEE

## 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)

| | | | |
|---|---|---|---|
| ◯ Left | ☐ Toe/Foot | ◯ Left | ☐ Finger |
| ◯ Right | ☐ Ankle | ◯ Right | ☐ Hand |
| | ☐ Shin | | ☐ Wrist |
| | ☐ Knee | | ☐ Elbow |
| | ☐ Thigh | | ☐ Arm |
| | ☐ Hip/Buttock | | ☐ Shoulder |
| | ☐ Abdomen/Groin | | ☐ Neck |
| | ☐ Chest | | ☐ Head |
| | ☐ 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**