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 ______________

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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