

TENNESSEE TECHNOLOGICAL UNIVERSITY
DEPARTMENT OF CAMPUS DEVELOPMENT AND FACILITIES PLANNING
SAFETY SECTION
NOTIFICATION OF ACCIDENT OR OCCUPATIONAL ILLNESS

Name _____ Banner ID - T _____

Address _____

Age _____ Sex _____ Marital Status _____ Classification - Check one:

Full-time Employee () - Part-time Employee () - Temporary Employee () - Student Worker ()

Student () - Campus Visitor () - Other _____

If Employee, Department _____ Occupation _____

If Student, Indicate Classification FR () - SO () - JR () - SR () - GRAD ()

Date of Accident _____ Time of Accident _____ Time Reported _____

To whom was accident/illness first reported? _____

Exact location of accident _____

Weather conditions at time of accident _____

Object or substance which directly caused the injury or illness _____

Description of what happened and the nature of injury or illness (Name Body Parts Affected). Use back or attach additional sheet if necessary.

Was injury or illness caused by or related to an existing condition? No _____. Yes _____ If yes, What? _____

In your opinion, was there a violation of approved safety practices and/or standards? Yes _____. No _____. If yes, what? _____

How was the ill/injured person instructed to prevent accident from re-occurring? _____

If employee, was the ill or injured person unable to work on the day of or days after the accident? No _____. Yes _____. If yes, last day worked _____

Other Remarks: _____

Date _____ Signature _____ Title _____

This report must be completed by the person's immediate supervisor or person in charge after every accident, including those requiring first aid treatment only. This report is to be sent to the Human Resource Services Office no later than the first regularly scheduled work day following the incident.