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.

(Updated 10/07)