TNRMT
TENNESSEE RISK MANAGEMENT TRUST

SEC | SAFETY ENGINEERING & CLAIMS MANAGEMENT

EMPLOYEE ACCIDENT REPORT

Employee Name: _____

Address: _____

Phone: _____

Job Title: _____ **Department:** _____

Date of Accident: _____ **Shift Start Time:** _____

Time of Accident: _____ **A.M. or P.M.:** _____

Supervisor: _____

Location of Accident: _____

Describe the Nature of the Injury: _____

_____

Describe Exactly What Happened: _____

_____

_____

_____

List Any Witnesses: _____

_____

To Whom Did You Report the Accident/Injury? _____

What did you tell your Supervisor? _____

_____

What did your Supervisor Do? _____

_____

_____ _____

Employee Signature **Date**

Please submit with First Report of Injury Form within 24 hours