

# INITIAL MEDICAL INFORMATION CHECKLIST

(NOTE: This checklist must accompany all reports of employee on-the-job injuries.)

University of Tennessee  
Workers' Compensation

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EMPLOYEE NAME (Please print): \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Social Security #: \_\_\_\_\_

\_\_\_\_\_ Employee did not seek medical attention.

OR

\_\_\_\_\_ Employee did seek medical attention, and received the following medical procedures or diagnoses. (Please check ALL that apply.)

\_\_\_\_\_ Hospitalization

\_\_\_\_\_ Fracture

\_\_\_\_\_ Sutures; rigid splint or cast (circle one)

\_\_\_\_\_ Prescription medications

\_\_\_\_\_ Foreign body embedded in eye or wound

\_\_\_\_\_ Foreign body embedded in wound

\_\_\_\_\_ Referred for further medical treatment or therapy

\_\_\_\_\_ First aid **only** : (defined as the following)

Non-prescription medications; tetanus shot; surface wound cleaning; wound coverings such as band-aids, bandages, gauze, Steri-strips, butterfly; non-rigid support such as wraps or elastic bandages; temporary immobilization devices while being transported; drilling nail to relieve pressure; draining fluid from blister; eye patch; finger guard; massage; fluids to relieve heat stress; simple irrigation or swab to remove foreign body from eye or wound.

## Return to work information:

\_\_\_\_\_ The employee has returned to work with no restrictions or time loss (other than day of injury).

\_\_\_\_\_ A physician has released the employee to return to work with the following restrictions:

Date released: \_\_\_\_\_

Restrictions: \_\_\_\_\_

\_\_\_\_\_ There **WILL** be time lost from work beyond the day of injury as a result of the injury.

**PLEASE ATTACH LOST TIME/RETURN TO WORK CALENDAR**

*I have spoken to the employee regarding his/her on-the-job injury and obtained the above information:*

*Signature of person obtaining information:* \_\_\_\_\_