NOTE: Please contact Department of Public Safety for medical aid and transport.

MARQUETTE UNIVERSITY
Campus Incident Report

Date: _____

Please fill out the following portion of this report in regard to the incident occurring on: _____

Student: ◯ Yes ◯ No Visitor: ◯ Yes ◯ No

Program Participant (EOP, etc.): ◯ Yes ◯ No

(If an employee , please complete the Worker's Compensation First Report of Incident)

Visitor Name: _____ Sex: ◯ M ◯ F Age: _____

Home Address: _____ Home Phone/Contact: _____

_____

Date & Time Incident Occurred: _____ Location: _____

What were you doing at time of incident? (Use additional page if more space is needed.)

How did the incident happen (Explain Fully)?

What caused the incident to occur?

Witnesses? List Names:

How could the incident have been prevented?

Medical attention sought? ◯ Yes ◯ No If yes, Doctor/Provider's Name: _____

If no, do you intend to seek medical attention in the future? ◯ Yes ◯ No

If injured, have you ever had a similar problem? ◯ Yes ◯ No

If yes, explain:

Have you previously received treatment for this condition? ◯ Yes ◯ No

If yes, Doctor/Provider's Name: _____

Employee Signature/Date:_____