

MARQUETTE UNIVERSITY
Worker's Compensation
Employee First Report of Incident

Date: _____

Supervisor: _____ Dept.: _____ Ext.: _____

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

Employee Name: _____ Sex: M F Age: _____

Home Address: _____ Home Phone: _____

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Job Title: _____ Date hired by MU: _____

Incident Date & Time (AM/PM): _____ Location: _____

What were you doing at time of incident? (Attach additional page if necessary)

How did the incident happen (Explain Fully)?

What caused the incident to occur?

How could the incident have been prevented?

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

Employee Signature/Date: _____