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:____
Date Time(AM/PM)

Employee Name:____ Sex: M F Age:________________________

Home Address:____ Home Phone:___________________________

Job Title:____ Date hired by MU:________________________

Incident Date & Time (AM/PM):__________________________________ Location:_____________________________________

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

____

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'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 Name:____

Employee Signature/Date:____
MUWCF10(06142)