MARQUETTE
UNIVERSITY

# Workers' Compensation First Report of Incident

Complete this form with your supervisor and send via email to the Office of Risk Management (riskmanagement@marquette.edu) or Alexa Gianos-Steinberg (alexa.gianos-steinberg@marquette.edu).

Date of Incident: ___________________ Time of Incident: __________________________

Employee Name:_____________________________ Employee ID:______________________________

Home Address: ______________________________ Home Phone: ____________________________

______________________________ Sex: ___ M ___ F

______________________________ DOB: __/__/____

Job Title: ___________________________________ Supervisor: _______________________________

Date hired by MU: _______________

Wage : _____________________ Per: ___ hr. ___ wk. ___ mo. ___ yr.

What is the nature of the Injury: _________________________________________________________________

Location of the Incident:______________________

How did the incident happen? What caused the incident to occur?

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

How could this have been prevented?

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Medical attention sought: ____ Y ____ N

If yes, please provide name of doctor/provider/hospital/clinic:

______________________________________________________________________________________________
______________________________________________________________________________________________

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

If injured, have you ever had a similar problem? If so, please explain:

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Any Time Lost: ___ Y ___N

If Yes, please provide details:

______________________________________________________________________________________________
______________________________________________________________________________________________

Anticipated Date Return to Work: ______________

Employee Signature: ________________________________________ Date: ______________