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: _____________________________

Á ___´ ´ ´ _______________________________

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: ____

MUWCF10(06142)