



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 drop off to, Alexa Gianos-Steinberg, Zilber Hall, 212.

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 at Time of Hire: _____ 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: _____