

FLORIDA ATLANTIC UNIVERSITY

Workers' Compensation

FIRST REPORT OF INJURY FORM ~~ NON-MEDICAL TREATMENT INVOLVED ONLY ~~

~ Injured Employee ~

Name:	ID #:
Department Name:	Date of Accident:
Office Location:	Time of Accident:
Office Phone #:	Place of Accident:

Employee's Description of Accident (Include Cause of Injury): 	
Part of Body Affected:	Injury/Illness that Occurred:
Injured Employee's Signature:	

~ Supervisor ~

Supervisor's Name:	Supervisor's Signature:
Agree with Description of Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Office Phone #:
	Office Location (Bldg # & Room #):

Keep a copy in your office, and send original to:

**Human Resources Department
 ADM 114**