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?	**Office Phone #:**
○ **Yes** ◉ **No**	**Office Location (Bldg # & Room #):**

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

Human Resources Department
Bldg # IS-04 Room # 114