HUMAN RESOURCES OFFICE
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LEE COLLEGE

Worker's Compensation First Report of Injury

Employee Name: _____ Empl ID #: _____

Job Title: _____ Department/Division: _____

Address: _____ City, State, and Zip: _____

Phone: _____ Date of Birth: _____

Marital Status: _____ Employee Sex: _____

Date/Time of Injury _____ Location of Injury: _____

Time employee began work: _____ Did employee return to work: _____

Witnesses Name: _____ Witness Phone: _____

Please describe the type of injury and the body parts effected:

_____

_____

_____

Please list all equipment, materials, or chemicals the employee was using when the injury occurred:

_____

_____

_____

Please give a detailed summary of how the injury occurred:

_____

_____

_____

_____

_____

I acknowledge that the information I provided above is correct to the best of my knowledge.

Preparer's Name (Print): _____ Preparer's Title: _____

Preparer's Signature: _____ Date: _____

This form was completed by the:

_____ Injured Employee, ____ Supervisor, or _____ LC Employee witness