REPORT OF EMPLOYEE INJURY OF ILLNESS

TO BE COMPLETED BY EMPLOYEE

Employee Name:_____ Phone # (___)_____-_____ Date of Birth: ____/____/____

Address:_____ SSN# _____ Sex: ___ Male ___ Female

City/State/Zip: _____ Occupation: _____ Date of Hire: ____/____/____

Employer: _____ Witnesses: (name & dept)_____

Time employee started shift on date of incident: _____ □ AM □ PM

Date of Incident: ____/____/____ Time of Incident: ____:____ □ AM □ PM Shift:_____ Dept:_____ Dept Code # _____

Part of Body Injured? _____ Where did incident occur?_____

Description of Incident:_____

Employee's Signature:_____ Date: ____/____/____

TO BE COMPLETED BY SUPERVISOR

Injury Occurred: ____/____/____ Time: ___:___ □ AM □ PM Injury Reported: ____/____/____ Time: ___:___ □ AM □ PM

Part of Body Injured: _____ Nature of Injury: _____

Cause of Injury: _____ Where did Incident occur:_____

Describe incident: _____

Does witness confirm accident as described? □Yes □No Witness Name & Dept: _____

Did accident involve exposure to blood or body fluid? □ Yes □ No

What unsafe act or condition contributed to the accident: _____

Corrective action taken: _____

Supervisor's Signature:_____ Date: ____/____/____

TO BE COMPLETED BY EMPLOYEE HEALTH / ER PHYSICIAN NURSE

Past Medical History:_____

Allergies: _____ Current Medications: _____

History of injury/ nursing assessment: _____

Physician's assessment: _____

_____

Treatment / Follow up care rendered:_____ Diagnosis: _____

Lab Tests: □Yes □ No Hepatitis Vaccine: □Yes □ No Modified Duty: □Yes □No

X-rays: □Yes □ No Tetanus/Diphtheria Toxoid: □Yes □ No Return to Work: □Yes □ No

EHS/Doctor's Signature: _____ Date: ___/___/___ Time____:____ □ Yes □ No

SAFETY DIRECTOR/COMMITTEE REVIEW

Was the incident properly reported and investigated? □ Yes □ No If no, why? _____

Has proper corrective action been taken to avoid a similar occurrence? □ Yes □ No

If no, What corrective action should be taken? _____

_____

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

I the undersigned, authorize and direct that all of the hospitals, clinics, physicians, physical and occupational therapists and other licensed [Illinois, Missouri, Indiana, Iowa, Kentucky and Wisconsin] health care providers that have treated me, released me, whenever requested by Illinois Compensation Trust or its representatives, any and all documents, statements, or other information, in any form, regarding my: medical history, pre-existing medical conditions, and treatment prior or subsequent to the injury giving rise to my workers' compensation claim, consultation reports, prescriptions and treatment records, including but not limited to x-ray films and copies of all hospital or medical reports with respect to any illness or injury for which I have received medical treatment.

I also hereby direct each physician, nurse, therapist, clinic, consulting facility or any person providing medical treatment to me to provide to Illinois Compensation Trust or its representatives upon their written or oral request, any information, or interpretation of that information about my medical history, symptoms, diagnosis, prognosis, and causation of the condition(s) for which treatment has been provided to me, orally, in writing, or in any other fashion, without any formal process of discovery or adjudication. The purpose of these disclosures is to allow Illinois Compensation Trust to review, assess and consider payment for my workers' compensation claim and treatment.

I understand the medical information described above is confidential and by the execution of this document, I hereby waive that confidentiality. I also understand that my refusal to sign this authorization may result in Illinois Compensation Trust delaying the payment for the medical treatment provided by my health care providers under my workers' compensation claim until my medical records are provided to Illinois Compensation Trust. This authorization shall remain in force until my workers' compensation claim is settled or concluded. I may revoke this authorization at any time by sending a written notice to Illinois Compensation Trust by fax or by mail delivery with return receipt confirmation of service.

Employee Signature _____ Date _____

Please mail to:
Illinois Compensation Trust
1151 E Warrenville Rd
PO Box 3015
Naperville, IL 60566

CLAIM NUMBER:_____

WITNESS STATEMENT

Name: _____

Address: _____

City:_____ State:_____ Zip:_____

Telephone Number: (____) _____

What day/date did the incident occur? _____

Exactly where did it occur? _____

What were you doing just before this happened? _____

_____

_____

_____

_____

_____

Who was involved? _____

What exactly happened? _____

_____

_____

_____

_____

_____

Was there any discussion after the incident? _____

_____

Were there any other witnesses? □ Yes □ No If Yes, who? _____

_____

I certify that all the facts on this form are true and correct to the best of my knowledge.

_____ _____

Name / Signature ***Date***

(Please use back of page if more room is necessary.)