



WORKERS' COMPENSATION EMPLOYEE'S NOTICE OF INJURY (COMPLETE ALL ITEMS)

EMPLOYEE'S NAME: (last)		(first)	
EMPLOYEE'S ADDRESS: (no.)		(street)	
(city)	(state)	(zip)	TELEPHONE: Home: _____ Work: _____
SOCIAL SECURITY NO.	DATE OF BIRTH (mo) (day) (year)	SEX: <input type="checkbox"/> Female <input type="checkbox"/> Male	
MARITAL STATUS: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widow(er) <input type="checkbox"/> Divorced		NUMBER OF DEPENDENT CHILDREN UNDER 18 AT DATE OF INJURY _____	
DATE OF INJURY OR ILLNESS (mo) (day) (year)	TIME: <input type="checkbox"/> AM <input type="checkbox"/> PM	LAST DAY WORKED: _____	
NAME OF AGENCY	ADDRESS OF AGENCY	WORK COUNTY	
REPORTED TO SUPERVISOR <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME OF SUPERVISOR	DATE & TIME REPORTED _____ (am) (pm) _____ (mo) (day) (year)	
IF NOT REPORTED ON DATE OF INCIDENT, EXPLAIN:			
HAVE YOU SOUGHT MEDICAL ATTENTION? <input type="checkbox"/> Yes <input type="checkbox"/> No		NAME, ADDRESS AND PHONE NO. OF DOCTOR:	
ANY SICK, VACATION OR PERSONAL DAYS USED FOR THIS INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No		NUMBER AND TYPE	
HAS ANY INSURANCE COMPANY PAID FOR TREATMENT AS A RESULT OF THIS INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No		NAME AND POLICY NO.	
WHAT DUTY WERE YOU PERFORMING AT TIME OF INJURY? (BE SPECIFIC)			
PLACE WHERE INJURY OCCURRED (BE SPECIFIC)			
DETAIL HOW INJURY OCCURRED (USE REVERSE SIDE IF NECESSARY)			
DID A THIRD PARTY CAUSE OR CONTRIBUTE TO ACCIDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No			
IF YES, EXPLAIN AND PROVIDE ADDRESS AND PHONE # OF NEGLIGENT PARTY (USE REVERSE SIDE IF NECESSARY):			
DESCRIBE INJURY (INDICATE PART(S) OF BODY AFFECTED)			
ANY WITNESS(ES) TO INJURY <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, NAME(S):	
HAVE YOU SUBMITTED ANY PREVIOUS CLAIMS FOR INJURY/ILLNESS? (IF YES, IDENTIFY EACH ON REVERSE SIDE.) <input type="checkbox"/> Yes <input type="checkbox"/> No			
DATE THIS FORM COMPLETED _____ (mo) (day) (year)		SIGNATURE OF INJURED EMPLOYEE	
IF INJURED EMPLOYEE UNABLE TO SIGN ABOVE, SIGNATURE OF INDIVIDUAL COMPLETING THIS FORM			

ADDITIONAL DETAILS HOW INJURY OCCURRED:

PREVIOUS INJURIES OR ILLNESSES

DATE(S) OF INJURY/ILLNESS	DESCRIBE INJURY/ILLNESS	WAS THIS WORKERS' COMPENSATION (YES OR NO)	NAME AND ADDRESS OF DOCTOR	IF YES, AMOUNT OF SETTLEMENT

ADDITIONAL DETAILS CONCERNING THIRD PARTY NEGLIGENCE

This is a written request for workers' compensation benefits as a result of the incident described therein.

Please fill out the form truthfully and accurately. Under Section 25.5 of the Illinois Workers' Compensation Act, it is unlawful for any person to intentionally make or cause to be made any false or fraudulent material statement or material representation for the purpose of obtaining any workers' compensation benefit. I have reviewed, understand and acknowledge the above statement.

Employee signature (if available to sign)

Date

Employer Signature

Date