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INFORMATION NECESSARY FOR FILING YOUR CLAIM UNDER THE ILLINOIS WORKERS' COMPENSATION ACT

INFORMATION ABOUT YOU, THE INJURED WORKER:

Name _____ ☐ Male ☐ Female

Home Address _____

City _____ State_____ Zip_____

Home Telephone Number _____ Cell Phone Number _____

Work Phone Number_____ Email Address _____

Social Security Number_____-_____-_____ Date of Birth_____/_____/_____ Age _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse's Name _____

Please list all of your children/dependents under the age of 18:

Child's Name _____ Age_____ Relationship _____

Child's Name _____ Age_____ Relationship _____

Child's Name _____ Age_____ Relationship _____

Please provide us with the name and phone number of a person who is not part of your household, whom we can contact in case of an emergency:_____

EDUCATION

Grammar School Number of years attended_____ Did you graduate? ☐ Yes ☐ No

High School Number of years attended_____ Did you graduate? ☐ Yes ☐ No

College Number of years attended_____ Did you graduate? ☐ Yes ☐ No

Trade/Business Number of years attended_____ Did you graduate? ☐ Yes ☐ No

Military Service ☐ Yes ☐ No

Hobbies _____

INFORMATION ABOUT YOUR EMPLOYMENT AT THE TIME OF YOUR INJURY

Name of employer you were working for at time of injury _____

Employer's Address _____

City _____ State_____ Zip_____

Telephone Number _____ Length of employment: Start Date_____ Years _____

Job title at the time of your injury _____

Your job duties at the time of your injury _____

Your foreman or immediate supervisor _____

Number of hours you were working per week at the time of your injury: Regular_____ Hourly rate_____

Overtime hours per week_____ Is the overtime MANDATORY? ☐ Yes ☐ No Explain _____

_____

Gross earnings per week (before taxes) $_____ Overtime $_____

Were you a union member? ☐ Yes ☐ No If yes, which union and local? _____

Did you have a 2nd job at the time of your injury? ☐ Yes ☐ No Where? _____

Was your employer aware of your 2nd job? ☐ Yes ☐ No Gross earnings/wk. from 2nd job: $ _____

Present employer, if different from above: _____

Name of employer's workers' comp insurance carrier at the time of your injury: _____

Address _____

City _____ State_____ Zip_____

Claim Number_____ Adjuster_____ Phone Number _____

INFORMATION ABOUT YOUR INJURY OR ILLNESS

Date of Injury _____/_____/_____ Time of day _____:_____ ☐ AM ☐PM

Location of Accident (Plant, office, etc.) _____

City _____ State_____ Zip_____

Did you report the accident to your employer? ☐ Yes ☐ No If yes, when? _____

To whom?_____ Individual's Position _____

Witnesses: _____

_____

_____

Describe how you were injured. _____

_____

_____

_____

_____

_____

What parts of your body were injured? (Please specify right, left, etc.) _____

_____

_____

Did you break any bones in this accident? ☐ Yes ☐ No If yes, which ones? _____

_____

What physical complaints do you currently have?_____

_____

_____

INFORMATION ABOUT YOUR MEDICAL TREATMENT

Did you go to any hospital because of this injury? ☐ Yes ☐ No

Hospital #1 _____ Address _____

City_____ State_____ Zip_____ Phone Number _____

Emergency Room Only? ☐ Yes ☐ No X-Rays Only? ☐ Yes ☐ No Length of Stay_____

Hospital #2 _____ Address _____

City_____ State_____ Zip_____ Phone Number _____

Emergency Room Only? ☐ Yes ☐ No X-Rays Only? ☐ Yes ☐ No Length of Stay_____

Names and addresses of the doctors you have seen for this injury:

Doctor #1_____ Address _____

City_____ State_____ Zip_____ Phone Number _____

Doctor #2_____ Address _____

City_____ State_____ Zip_____ Phone Number _____

Doctor #3_____ Address _____

City_____ State_____ Zip_____ Phone Number _____

Doctor #4_____ Address _____

City_____ State_____ Zip_____ Phone Number _____

What did the doctors say is wrong with you?_____

_____

What kind(s) of treatment did you receive?_____

_____

Surgery? ☐ Yes ☐ No If yes, what kind of surgery?_____

X-Rays? ☐ Yes ☐ No MRI? ☐ Yes ☐ No CAT Scan? ☐ Yes ☐ No

Cast? ☐ Yes ☐ No Brace? ☐ Yes ☐ No Physical Therapy? ☐ Yes ☐ No

Physical Therapist #1_____ Address _____

City_____ State_____ Zip_____ Phone Number _____

Physical Therapist #2_____ Address _____

City_____ State_____ Zip_____ Phone Number _____

What kinds of home treatment do you provide yourself?_____

_____

Please define all areas in which you have complaints of disability (Check all that apply.):

☐ Scarring ☐ Swelling ☐ Limited Range of Motion

☐ Soreness ☐ Stiffness ☐ Weakness

☐ Numbness ☐ Pain ☐ Other _____

Location(s)_____

Have any doctors released you to return to work? ☐ Yes ☐ No If so, were there restrictions? ☐ Yes ☐ No

Please list any work restriction(s):_____

_____

Have you been released from active medical care? ☐ Yes ☐ No

If not, from which doctor(s) are you still receiving active treatment? _____

_____

Prior Injuries and Illnesses _____

_____

_____

INFORMATION ABOUT YOUR WORKERS' COMPENSATION BENEFITS

Did you lose any time from work because of this injury? ☐ Yes ☐ No

If so, when? From _____/_____/_____ To _____/_____/_____

Did your employer or their insurance company pay you money for the time you missed? ☐ Yes ☐ No

If so, how much were you paid per check? $_____

Are you still receiving disability payments? ☐ Yes ☐ No

On what date did you return to work? _____/_____/_____

Were you placed on light-duty employment by your employer when you returned to work? ☐ Yes ☐ No

If yes, what type of light duty were you given, and for how long? _____

_____

_____

Is there anything else you would like to tell us about yourself?_____

_____

_____

_____

_____

_____