Workers' Compensation Frequently Asked Questions (FAQs)

Q: What is a work related injury/illness?
A: The Illinois Workers' Compensation Commission defines it as a system of benefits provided by law to employees whose injuries arise out of and in the course and scope of their employment. The amount of benefits paid is limited by law. Not all injuries/illnesses at work are covered by workers' compensation.

Q: How will I know if my claim is Accepted or Denied?
A: U of I Office of Claims Management makes a compensability decision on each claim as quickly as possible. Depending upon the completeness of the accident reports and the availability of medical information, this is commonly done within 24 hours of report receipt. You will receive written correspondence advising you of the status of your claim as soon as compensability is determined.

Q: Why do I have to complete the First Report of Injury/Illness form in its entirety?
A: Every question that is asked on the Injury/Illness Report is very important information needed to process your claim. Leaving some fields blank or providing vague or conflicting information can delay handling of your claim and payment of benefits. It may also result in your claim being denied.

Q: How do I submit my Injury/Illness Report to the Office of Claims Management?
A: To expedite handling of your claim the signed original Injury/Illness Report signed should be mailed to the Claims Management office *or* sent via email to WorkComp@uillinois.edu. Effective 1/1/2012 faxed reports will no longer be accepted.

Please remember to submit a **copy** *of your Injury/Illness Report to your campus' safety contact:*

UIC reports – Rich Anderson, safe@uic.edu, 223 PSB, MC-645
UIS reports – Bob Lael, rlael2@uis.edu, HRB 30
UIUC reports – Tom Anderson, tjanders@illinois.edu, 1501 S. Oak Street, MC-821

Q: Where can I obtain medical evaluation and treatment?
A: The Illinois Worker's Compensation Act allows you to choose up to 2 doctors on your own. However, if your claim is accepted as covered under Workers' Compensation and you are seen in one of the Occupational Medicine Departments listed below, all reasonable charges (including referrals) involving the treatment of the on-the-job injury or illness will be paid.

UIC - **University Health Services;** Weekdays 7:00 am – 4:00 pm; Wednesdays 7:00 am – 3:00 pm; 835 S. Wolcott Avenue, # E144; Chicago, IL 60612; (312) 996-7420; *After hours and weekends:* **University of Illinois Hospital Emergency Department;** 1740 W. Taylor Street; Chicago, IL 60612; (312) 996-7298

Peoria/Rockford – reference Injury Brochure: http://www.obfs.uillinois.edu/risk/workers_compensation/injury_brochures/

UIS - **Midwest Occupational Health Associates (MOHA);** Weekdays 8:00 am – 5:00 pm; 775 Engineering Avenue; Springfield, IL 62703; (217) 522-4300; *After hours and weekends:* **Memorial Medical Center Emergency Department** 701 N. 1st Street; Springfield, IL 62781; (217) 788-3000

UIUC – **SAFEWORKS OF ILLINOIS;** Weekdays 8:00 am – 5:00 pm; 1806 N. Market Street; Champaign, Illinois 61820; (217) 356-6150; *After hours and weekends:* **Provena Covenant Hospital Emergency Department;** 1400 W. Park Street; Urbana, IL 61801; (217) 337-2131

Carle Occupational Medicine; Weekdays 8:00 am – 5:00 pm; 810 W. Anthony Drive; Urbana, IL 61801; (217) 383-3077; *After hours and weekends:* **Carle Hospital Emergency Department;** 602 W. University Avenue; Urbana, IL 61801; (217) 383-3313

For further questions about Workers' Compensation benefits and claims, contact:
Office of Workers' Compensation and Claims Management
100 Trade Centre Drive, Suite 103, MC-686, Champaign, IL 61820
(217) 333-1080; fax (217) 244-5152; e-mail: WorkComp@uillinois.edu
Website: http://www.obfs.uillinois.edu/risk/workers_compensation/

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UNIVERSITY OF ILLINOIS

FIRST REPORT OF INJURY/ILLNESS

Submit via campus mail or electronically to WorkComp@uillinois.edu
(To be completed within 24 hours of incident by employee)

EMPLOYEE INFORMATION (* Federal Government/University Required Information)

Name_____ UIN #_____

Street_____ Phone #_____

City_____ State_____ ZIP_____

Birth date_____ Sex: **M / F** Marital Status: **S / M / Sep / W / D** # Children under the age of 18 _____

*Applied for or been denied Social Security Disability Insurance (SSDI)? □Yes □No If **yes**, when_____

*Applied for or been denied SURS benefits? □Yes □No If **yes**, when_____ *Currently on Medicare? □ Yes □ No

Job Classification: □ Academic Professional □ Faculty □ Staff □ Student □ Extra Help

Date of hire_____ Job Title_____ Department _____

Years in current job_____ Previous job title _____ # Years in previous job _____

Work days scheduled per week: **M T W R F S S** Work hours: _____□am □pm to _____ □am □pm Hours per week_____
(Circle all that apply)

EMPLOYEE'S REPORT OF INJURY/ILLNESS (Attach additional sheets as needed)

Date of Injury/Illness_____ Time _____□am _____□pm Day of week _____

Date Reported_____ To _____

Exact location where accident occurred _____

If on U of I property, include name of building / address / room # _____

Amount of training on the job prior to incident _____

Working overtime when accident happened? □ Yes □ No

Do you have a second job? □Yes □No If **yes**, where _____

Body part injured_____ Type of injury /illness_____

Describe in detail what happened:_____

_____

Recommendation for prevention: _____

Witnesses (list names and phone numbers): _____

Did you receive medical treatment? □Yes □No If **yes**, where?_____

Have you been placed out of work over 3 days? □Yes □No If **yes**, last day worked _____

Is this a recurrence or aggravation of a previously reported injury / illness? □Yes □No If **yes**, please explain _____

_____

Number of incidents in past 3 years_____

EMPLOYEE AUTHORIZATION - I attest that the above information is true and correct. I authorize my treating medical provider to release appropriate medical information to the University of Illinois Office of Workers' Compensation and Claims Management ('U of I") in order to determine compensability of my claim. I understand that pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"), a covered entity may disclose protected health information as authorized by laws relating to workers' compensation or similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault. I understand that the medical information relating to my workers' compensation claim and received by U of I and its legal representatives does not constitute protected health information. I understand that without the first report of injury/illness and pertinent medical information my claim may be denied. I further understand it is unlawful to present a fraudulent claim for workers' compensation benefits and doing so may result in disciplinary action.

_____ _____
Signature of Employee Date

In addition to sending this report to the WC office, submit a **copy** of this report to the applicable campus safety contact:
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UNIVERSITY OF ILLINOIS

FIRST REPORT OF INJURY/ILLNESS

Submit via campus mail or electronically to WorkComp@uillinois.edu

(To be completed within 24 hours of incident by supervisor)

Employee's name_____ UIN # _____

Employee's department _____ Job title_____

Supervisor's name_____ Supervisor's phone #_____Campus location _____

Is employee on university payroll? □Yes □No Wage account paid from on date of accident _____

Is employee currently working? □Yes □No If **no**, last day worked _____

Date of incident _____ Time of incident _____ Time began work _____ Time stopped work _____

Date employee reported incident _____ Incident location (street, bldg, room) _____

Witnesses to incident (include phone #) _____

What activity was the employee doing just before the incident occurred? (Attach additional sheets as needed.)

_____

_____

What happened? (Explain in detail how the incident occurred, attach additional sheets as needed)

_____

_____

_____

_____

What object or substance directly harmed the employee?

_____

_____

Body part(s) affected: **(Check all that apply)**

Abdomen □	Elbow □**R** □**L**	Hand □**R** □**L**	Neck □
Ankle □**R** □**L**	Eye □**R** □**L**	Head □	Shoulder □**R** □**L**
Arm □**R** □**L**	Face □	Hip □**R** □**L**	Toes □
Back □	Finger □**R** □**L**	Knee □**R** □**L**	Wrist □**R** □**L**
Chest □	Foot □**R** □**L**	Leg □**R** □**L**	
Ear □**R** □**L**	Groin □	Lungs □	Other _____

Type of Injury: **(Check all that apply)**

Absorption □	Fracture □	Laceration □	Other _____
Amputation □	Inflammation □	Over-exertion □	
Bruise □	Ingestion □	Over-exposure □	
Burn □	Inhalation □	Puncture □	
Foreign Body □	Irritation □	Strain / Sprain □	

Type of event: **(Check all that apply)**

Body Motion / Body Position □	Fall on same level □	Temperature extreme □	Unknown □
Caught in / under / between □	Repetitive motion □	Vehicle Accident □	Other _____
Electrical contact □	Slip / Twist □	Struck by / struck against □	
Explosion □	Slip / Trip / Fall □	Fall from elevation □	

Where was the employee referred for medical care? _____

_____

Drug screen performed? □Yes □No Breath alcohol test performed? □Yes □No

Contributing conditions:

- □ Duties or tasks not clear
- □ Equipment or tool defect / failure
- □ Equipment or tool unavailable
- □ Ergonomic factors
- □ Lighting / temperature / ventilation
- □ Procedure lacking or unclear
- □ Training lacking or incomplete
- □ Work area set-up / arrangement
- □ Unrecognized hazard
- □ Other

Contributing behaviors:

- □ Assistive device not used
- □ Failure to get assistance
- □ Improper tool / equipment used
- □ Inattention to task
- □ Lack of communication
- □ Procedure not followed
- □ Protective equipment not worn
- □ Rushing or hurried
- □ Unbalanced or poor position or motion
- □ Other

Preventative Action – Supervisor will do:

- □ Develop / revise safety procedures
- □ Maintain good housekeeping
- □ Maintain tools / equipment
- □ Post safety signs
- □ Perform job hazard analysis
- □ Provide protection equipment
- □ Remove defective equipment
- □ Schedule safety training
- □ Other

What could the employee have done to avoid the injury? (Attach additional sheets as needed)

_____

_____

List any other actions that will be taken or control measures that will be put in place to prevent recurrence (Attach additional sheets as needed)_____

_____

_____

Was disciplinary action issued for an unsafe act? □Yes □No If **yes**, explain (Attach additional sheets as needed)

_____

Are you concerned about the validity of this claim? □Yes □No If **yes**, explain (Attach additional sheets as needed)

_____

_____

Temporary Transitional / Modified Work - on a **temporary** basis, allows the injured worker the opportunity to engage in meaningful, appropriate work duties based on medical limitations.

Department will provide transitional /modified work: □Yes □No

Please explain answer _____

_____

Department requests assistance in designing transitional /modified work: □Yes □No

Please explain assistance needed _____

_____

_____

Supervisor's Signature / Date

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