

UNIVERSITY OF ILLINOIS
FIRST REPORT OF INJURY/ILLNESS

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

EMPLOYEE INFORMATION (* Federal Government/University Required Information)

Name _____ UIN # _____
Home address _____ 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 _____

Rev 6/17

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 <input type="checkbox"/> | Elbow <input type="checkbox"/> R <input type="checkbox"/> L | Hand <input type="checkbox"/> R <input type="checkbox"/> L | Neck <input type="checkbox"/> |
| Ankle <input type="checkbox"/> R <input type="checkbox"/> L | Eye <input type="checkbox"/> R <input type="checkbox"/> L | Head <input type="checkbox"/> | Shoulder <input type="checkbox"/> R <input type="checkbox"/> L |
| Arm <input type="checkbox"/> R <input type="checkbox"/> L | Face <input type="checkbox"/> | Hip <input type="checkbox"/> R <input type="checkbox"/> L | Toes <input type="checkbox"/> |
| Back <input type="checkbox"/> | Finger <input type="checkbox"/> R <input type="checkbox"/> L | Knee <input type="checkbox"/> R <input type="checkbox"/> L | Wrist <input type="checkbox"/> R <input type="checkbox"/> L |
| Chest <input type="checkbox"/> | Foot <input type="checkbox"/> R <input type="checkbox"/> L | Leg <input type="checkbox"/> R <input type="checkbox"/> L | |
| Ear <input type="checkbox"/> R <input type="checkbox"/> L | Groin <input type="checkbox"/> | Lungs <input type="checkbox"/> | Other _____ |

Type of Injury: (Check all that apply)

- | | | | |
|---------------------------------------|---------------------------------------|--|-------------|
| Absorption <input type="checkbox"/> | Fracture <input type="checkbox"/> | Laceration <input type="checkbox"/> | Other _____ |
| Amputation <input type="checkbox"/> | Inflammation <input type="checkbox"/> | Over-exertion <input type="checkbox"/> | |
| Bruise <input type="checkbox"/> | Ingestion <input type="checkbox"/> | Over-exposure <input type="checkbox"/> | |
| Burn <input type="checkbox"/> | Inhalation <input type="checkbox"/> | Puncture <input type="checkbox"/> | |
| Foreign Body <input type="checkbox"/> | Irritation <input type="checkbox"/> | Strain / Sprain <input type="checkbox"/> | |

Type of event: (Check all that apply)

- | | | | |
|--|---|--|----------------------------------|
| Body Motion / Body Position <input type="checkbox"/> | Fall on same level <input type="checkbox"/> | Temperature extreme <input type="checkbox"/> | Unknown <input type="checkbox"/> |
|--|---|--|----------------------------------|

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

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: Will the Office of Claims Management notify my supervisor and payroll office that I my claim was accepted or denied by workers compensation?

A: NO - It is your responsibility to inform your immediate supervisor, Payroll, and Human Resources of the status of your claim so that the appropriate benefits can be applied to your absence from work.

Q: Why do I have to complete and date 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, using an outdated version of the form, 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 and dated Injury/Illness Report should be e-mailed to the Office of Claims Management at WorkComp@uillinois.edu.

YOU MUST submit a **copy** of your Injury/Illness Report to your **HR Representative** and your **Campus Safety** contact:

UIC reports: Rich Anderson, safe@uic.edu, 223 PSB, MC-645

UIS reports: Dianne Rumme drumm2@uis.edu BSB 33B, MS BSB 43

UIUC reports: Jeremy Neighbors, jneighbo@uillinois.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 select up to 2 doctors of your choice.

Q: My doctor placed me on restrictions and my department can accommodate the restrictions, what happens if I decline the temporary restricted work assignment?

A: Your Workers Compensation benefits will cease due to noncompliance.

Q: Will I receive my regular paycheck amount while I am unable to work, due to a compensable illness/injury?

A: Your wages will be calculated at 66 2/3% of your average weekly wage during the 52 weeks preceding the accident or exposure.

Q: Who is responsible for submitting my time sheet to the Office of Workers' Compensation?

A: You will be responsible to work with your supervisor and department representative responsible for payroll to make sure time sheets are submitted to the Office of Claims Management no later than 10 am the Friday before pay week in order to receive benefits for the duration of your absence.

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.treasury.uillinois.edu/risk_management/workers_compensation/