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

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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	Contributing behaviors	Preventative Action – Supervisor will do
☐Duties or tasks not clear	☐Assistive device not used	☐Develop / revise safety procedures
☐Equipment or tool defect / failure	☐Failure to get assistance	☐Maintain good housekeeping
☐Equipment or tool unavailable	☐Improper tool / equipment used	☐Maintain tools / equipment
☐Ergonomic factors	☐Inattention to task	☐Post safety signs
☐Lighting / temperature / ventilation	☐Lack of communication	☐Perform job hazard analysis
☐Procedure lacking or unclear	☐Procedure not followed	☐Provide protection equipment
☐Training lacking or incomplete	☐Protective equipment not worn	☐Remove defective equipment
☐Work area setup / arrangement	☐Rushing or hurried	☐Schedule safety training
☐Unrecognized hazard	☐Unbalanced or poor position or motion	☐Other
☐Other	☐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 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 emailed 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:	Environmental Health & Safety, safe@uic.edu, 109 EHSO, MC-645
UIS reports:	Ravneet Chhokar, rchho2@uis.edu, BSB 33B, MS 43
UIUC reports:	Division of Safety and Compliance, oshs@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 select up to two 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
449 Henry Administration Building
506 S. Wright St., MC-300, Urbana IL 61801
(217) 333-1080;
fax (217) 244-5152
WorkComp@uillinois.edu
go.uillinois.edu/workcomp