REPORTING WORKER'S COMPENSATION INJURIES/ILLNESSES

Required Steps

1. Injured employees **MUST** notify direct supervisor **IMMEDIATELY** after injury occurs.

2. School/Department Secretary fills out Illinois FORM 45: Employer's First Report of Injury, and has employee's supervisor or principal sign the form. It is then sent to Rosie Berry via e-mail (rberry@wps60.org)

3. Injured employees fills out Employee's Report of Injury and Authorization for Medical Records and Reports. Form(s) should be e-mail to Rosie Berry at rberry@wps60.org.

Emergency/Non-Emergency Care

If an employee needs immediate emergency medical attention please call 911.

If an employee needs non-emergency medical attention please complete the Authorization for Treatment or Exam referral form and have the employee go to:

Waukegan Immediate Care
1075 N. Greenbay Rd
Waukegan, IL60085
(847) 782-7120

Please Note: you must have a referral from school/department or you will not get treatment

All forms are available in paper format or online. Please go to Inside Edition>Forms>Risk Management or see your school/department secretary.

Please understand that if you have a follow up appointment you must schedule that appointment during non-working hours or the time will be counted as sick time. This does not include the initial visit. No worker's compensation benefit will be paid without a physician's statement taking the employee off of work (or giving restrictions that prevent the employee from working per their union contract).

ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

Please type or print.

Employer's FEIN	Date of report	Case or File #	Is this a lost workday case? Yes No
Employer's name		Doing business as	
Employer's mailing address			Employer's email address
Nature of business or service			SIC code
Name of workers' compensation carrier/admin.		Policy/Contract #	Self-insured? Yes No
Employee's full name			Birthdate
Employee's mailing address			Employee's e-mail address
Gender Male Female	Marital status Married Single	# Dependents	Employee's average weekly wage
Job title or occupation			Date hired
Time employee began work	Date and time of accident		Last day employee worked
If the employee died as a result of the accident, give the date of death.		Did the accident occur on the employer's premises? Yes No	
Address of accident			
What was the employee doing when the accident occurred?			
How did the accident occur?			
What was the injury or illness? List the part of body affected and explain how it was affected.			
What object or substance, if any, directly harmed the employee?			
Name and address of physician/health care professional			
If treatment was given away from the worksite, list the name and address of the place it was given.			
Was the employee treated in an emergency room? Yes No		Was the employee hospitalized overnight as an inpatient? Yes No	
Report prepared by	Signature	Title and telephone #	Email address

Please send this form to: ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE RD SPRINGFIELD, IL 62703

By law, employers must keep accurate records of all work-related injuries and illness (except for certain minor injuries). Employers shall report to the Commission all injuries resulting in the loss of more than three scheduled workdays. Filing this form does not affect liability under the Workers' Compensation Act and is not incriminatory in any way. This information is confidential. IC45 8/12

WAUKEGAN IMMEDIATE CARE

1075 N. Green Bay Rd.
Waukegan, IL 60085
www.WaukeganIC.com
PH (847) 782-7120 Fax (847) 782-7140
Office Hours:
Mon – Fri: 8AM – 8PM / Sat & Sun: 9AM – 3PM

Authorization for Treatment or Exam

Client Information: **Date**_____

Employee Name: _____

Employer Name: _____

Company Contact: _____

Phone: _____ Fax: _____

Type of Service Requested: Please check one

Occupational Injury/Illness Injury Date _____/_____/_____

☐ Description: _____

☐ Pre-employment and DOT Physicals: _____

☐ EKG: _____
(Patient must have an office visit for this)

☐ Flu Vaccination:

☐ TB skin Test: 1 Step 2 Step

☐ Tetanus/Diphtheria (TD)

☐ Alcohol Breath Testing / Drug Screen

Special Instructions:

_____

_____

_____

Employers, please fill out this form completely and accurately. No services will be performed unless it is marked, or unless your profile specifically states to do so. This will help us to accurately process all testing in a timely manner.

Please check one of the boxes below:

☐ Bill the company's Worker's Compensation carrier
☐ Credit Card or Company Check has been provided by the company to pay for services rendered
☐ Bill the company directly
☐ Patient's responsibility to pay for services rendered

Employee's Report of Injury

Employee Information

Employee Name: _____

Employee Address: _____

Employee Phone #: _____

Employee Position: _____

Employee Injury Information

Date of Injury: _____

Time of Injury: _____

Where Did Injury Occur: _____

What Part(s) of Body is Injured: _____

What type of Injury (sprain, cut, etc..) _____

Have you ever injured this part of your body before? If so, give an approximate date of injury: _____

Give a brief explanation as to how the injury occurred?

Did anyone witness the injury occur? If so, please list names.

Who did you report the injury to:

What date did you report the injury:

Information About Injury Treatment

List the name of your treating doctor:

List the treating doctor's address:

List the treating doctor's phone number:

List the treatment you are receiving (Pills, physical therapy, etc..)

Employee Signature & Date:

Supervisor Signature & Date:

AUTHORIZATION FOR MEDICAL RECORDS AND REPORTS

Date: .....

TO WHOM IT MAY CONCERN:

1. The undersigned hereby directs and authorizes (a) any physician, nurse or any other medical practitioner who treated, examined and/or attended me, or (b) any hospital, clinic or medical facility at which I have been treated, examined, attended and/or confined, to verbally confer with and to furnish any employee, agent, representative or attorney of Waukegan Public Schools, all information or opinions pertaining to or concerning the past, current or future physical, medical or psychological treatment and/or condition of me including, without limitation, any recommendations regarding further care and my ability to perform job duties. This authorization permits the release of any and all records, documents, papers, opinions or statements, whether written or oral, concerning any examination, diagnosis, treatment, periods or stays of hospitalization or other confinements.

2. I understand that the purpose of this authorization is to allow Waukegan Public Schools to investigate and/or administer claims or potential claims, past, present or future for benefits under the Illinois Workers' Compensation or Occupational Disease Acts. I further understand that this authorization constitutes an express waiver of the patient-physician privilege.

3. A copy of this authorization may be used in place of and with the same force and *effect* as the original. This authorization or any copies thereof shall remain in *effect* unless and until you receive written notice from me revoking your authority to release the above listed information. This authorization is continuing in nature and is to be given full force and *effect* to release any and all foregoing information learned or determined after the date it is signed.

_____ _____

Name of Employee Date of Accident

Signature Date