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ILLINOIS COUNTIES RISK MANAGEMENT TRUST

WORKERS COMPENSATION INJURY REPORT
(TO BE COMPLETED BY INJURED EMPLOYEE)

NAME: _____ SS# _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE NUMBER: _____ DATE OF BIRTH: _____

DATE OF INCIDENT: _____ TIME: _____ AM/PM: _____

ADDRESS/LOCATION OF ACCIDENT: _____

TIME AND DATE YOU NOTIFIED YOUR SUPERVISOR: _____

PERSON YOU NOTIFIED: _____

YOUR POSITION, IF APPLICABLE, OR THE REASON FOR BEING IN THE AREA
OF THE INCIDENT: _____

PART OF BODY: (MULTIPLE PARTS?): _____

FAMILY/TREATING PHYSICIAN AND PHONE NUMBER: _____

DID YOU RECEIVE FIRST AID? _____

PRIOR WORKERS' COMPENSATION CLAIMS OR MAJOR INJURIES? _____

IF SO, EXPLAIN: _____

I UNDERSTAND THAT BY SIGNING THIS STATEMENT, I AM VERIFYING
THAT ALL OF THE ABOVE STATEMENTS ARE TRUE AND CORRECT.

SIGNATURE

DATE

TIME

WITNESS SIGNATURE

This form must be completed by the injured employee within 48 hours of the injury.