

City of O'Fallon, Illinois

Ergo Insight
WC Employee Injury Report
(to be completed by injured employee)

Your Name: _____ Home Phone: _____

Hire Date: _____ SSN: _____ Date of Birth: _____

Home Address: _____

Marital Status: Single Married Divorced # Dependents: _____

Date/Time of Incident: _____ Time Shift Began: _____ Date/Time Reported: _____

Address of accident occurrence: _____

Body part and how it was affected: _____

What were you doing when the accident occurred? _____

Reason for being in the area: _____

How did the accident occur ? (use 2nd sheet if necessary): _____

Who else saw the incident? _____

To whom did you report the incident? _____

Have you received first aid? Yes No
If yes, check One: On Premise Outside medical assistance Both
Were you treated in the Emergency Room? Yes No
Were you hospitalized overnight as an inpatient? Yes No
Has your doctor taken you off of work? Yes No

When is your next medical appointment? _____

Name, address, phone and fax # (if available) of medical facility where treatment was sought: _____

Date/Time of such treatment: _____

Prior Workers' Compensation Claims? Yes No

If yes, please explain using 2nd sheet if necessary (i.e. date, body part, injury specifics): _____

I agree the above is true and accurate

Employee's Signature: _____ Date: _____

**WORKERS' COMPENSATION INJURY MEDICAL AUTHORIZATION
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
AND COMMUNICATION RELEASE**

By this Authorization for Release of Records and Waiver of Patient/Physician Privilege, and pursuant to my request for benefits under the Illinois Workers' Compensation Act for accidental injuries occurring on _____, I hereby authorize any of my treating physicians, medical care providers, health insurance carriers and any of their agents, and my employer, its insurers, claims administrators, rehabilitation and medical management consultants, attorneys, and any other agents of my employer to communicate with each other orally, in writing, via electronic communication, or by any other means as to my: diagnosis; prognosis; causal connection; past, present and future medical care and treatment; my work injury work duties, and ability to work, past, present, and future. I understand that this information may be used and disclosed to carry out treatment, payment, or for other health care operations.

I also authorize my employer and any of its representatives and agents to provide, and my medical providers to review, any additional materials.

I hereby authorize CITY OF O'FALLON, ILLINOIS or its representatives to contact my treating physician or medical care provider to clarify what, if any, physical restrictions exist, their duration and the appropriateness of modified work, or to clarify the diagnosis, care and treatment, or prognosis, as well as the causal connection of the medical condition in relation to the initial accident.

A photocopy, facsimile, e-mail or other electronic copy of this authorization shall be valid as the original.

Under the provisions of the Health Insurance Portability and Accountability Act with regard to the medical information that may or will be disclosed by this Authorization, I understand the following:

- a. I have the right to request restrictions regarding CITY OF O'FALLON'S use or disclosure of my medical records and/or information.**
- b. If CITY OF O'FALLON does agree to the restrictions I request, their agreement is binding upon only CITY OF O'FALLON, but that CITY OF O'FALLON is not required to agree to those restrictions.**
- c. This information may be used and disclosed to evaluate my claim for benefits, carry out treatment, issue payments, or to address other health care related issues related to my claim for benefits.**
- d. There is the potential for my Personal Health Information (PHI) to be re-disclosed by the recipient of this information, and thus will no longer be protected by the privacy rule.**

By signing and dating this document below, I signify that I agree to these terms. I understand that I am not required to sign this authorization form to receive health care benefits, including, but not limited to, enrollment in a group health plan, treatment or payment of any claims. This release shall remain valid for the length of my claim. I have the right to revoke this authorization in writing by notifying CITY OF O'FALLON at its current address. I understand that any use or disclosure made under this authorization prior to any such revocation will not be affected by a revocation. I may see and copy the information described on this form if I ask for it in writing.

Name (Please print)

Address (Street, City/Town, and zip code)

Signature

Date

City of O'Fallon, Illinois

Ergo Insight
WC Supervisor Report
(to be completed by supervisor of injured employee)

Injured Employee Name: _____ SSN: _____

Employee Home Phone: _____ Employee's approximate weekly wage: _____

Supervisor's Name and Title: _____

Date/Time of Accident: _____ Date/Time Employee Reported: _____

Medical Expenses so far (if known): _____

Did/will employee lose time from work as a result of this accident? Yes No

If yes, please list dates/timeframes missed due to this accident: _____

If lost time: Did or will the lost time exceed 3 consecutive scheduled work shifts? Yes No

Is there a possibility of accommodating a modified duty position during any recovery period? Yes No

If no, reason why: _____

Was medical treatment performed outside of the employer's facility? Yes No

If yes, was this medical provider (select all that apply): Occupational Health Provider
 Chosen by employee
 Other

Did the employee see more than one physician for this accident? Yes No

What object or substance, if any, directly harmed the employee? _____

Did the accident occur on the employer's premises? Yes No

Please review the employee's report of injury. Do you agree with the employee's details of this accident? Yes No

If no, please explain thoroughly (use 2nd sheet if necessary): _____

What did the employee tell you regarding what happened for the incident to occur? _____

What was the sequence of events that led up to the accident? What material, equipment and tools were involved? _____

What were the environmental conditions at the accident site? _____

What was done immediately after the accident? _____

Specify body parts injured in this accident: _____

Injury Type (i.e. sprain, fracture, etc.): _____

Accident Location: _____

Loss Causation: _____

What conditions or actions contributed to the accident? _____

What system design and implementation problems contributed to the accident occurrence? _____

What actions will be taken to reduce unsafe conditions and actions? _____

What actions will be taken to strengthen system design and implementation? _____

Would you like Method Management to contact you for further risk management assistance? Yes No

Do you believe an outside/3rd party is responsible for this accident occurring? Yes No

If yes, please indicate the responsible party's name, address and phone number if known: _____

I agree the above is true and accurate

Supervisor Name: _____ Supervisor Phone: _____

Supervisor's Signature: _____ Date: _____

City of O'Fallon, Illinois

Ergo Insight
WC Witness Report
(to be completed by accident witness)

Injured Employee Name: _____

Your Name: _____ Your Phone Number: _____

Your Address: _____

Your relationship with injured employee (check one): Co-worker Other

Date/Time of Incident: _____ Today's Date/Time: _____

What was the employee doing at the time of the accident? _____

What was the sequence of events that led up to the accident? _____

What was done immediately after the incident? _____

What were the environmental conditions at the accident site? _____

What materials, equipment and tools were involved? _____

I agree the above is true and accurate

Witness Name (please print): _____

Witness' Signature: _____ Date: _____