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: Why do I have to complete 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 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: The original signed Injury/Illness Report should be mailed to the Claims Management office. To expedite handling of your claim, the Injury/Illness Report can be faxed or emailed to our office.

Please remember to submit a copy of your Injury/Illness Report to your campus' safety contact:

UIC reports – Rich Anderson, safe@uic.edu, 223 PSB, MC-645
UIS reports – Bob Lael, rlael2@uis.edu, HRB 30
UIUC reports – Tom Anderson, tjanders@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 choose up to 2 doctors on your own. However, if your claim is accepted as covered under Workers' Compensation and you are seen in one of the Occupational Medicine Departments listed below, all reasonable charges (including referrals) involving the treatment of the on-the-job injury or illness will be paid.

UIC - **University Health Services;** Weekdays 7:00 am – 4:00 pm; Wednesdays 7:00 am – 3:00 pm; 835 S. Wolcott Avenue, # E144; Chicago, IL 60612; (312) 996-7420; *After hours and weekends:* **University of Illinois Hospital Emergency Department;** 1740 W. Taylor Street; Chicago, IL 60612; (312) 996-7298

Peoria/Rockford – reference Injury Brochure: http://www.obfs.uillinois.edu/risk/workers_compensation/injury_brochures/

UIS - **Midwest Occupational Health Associates (MOHA);** Weekdays 8:00 am – 5:00 pm; 775 Engineering Avenue; Springfield, IL 62703; (217) 522-4300; *After hours and weekends:* **Memorial Medical Center Emergency Department** 701 N. 1st Street; Springfi eld, IL 62781; (217) 788-3000

UIUC – **SAFEWORKS OF ILLINOIS;** Weekdays 8:00 am – 5:00 pm; 1806 N. Market Street; Champaign, Illinois 61820; (217) 356-6150; *After hours and weekends:* **Provena Covenant Hospital Emergency Department;** 1400 W. Park Street; Urbana, IL 61801; (217) 337-2131

Carle Occupational Medicine; Weekdays 8:00 am – 5:00 pm; 810 W. Anthony Drive; Urbana, IL 61801; (217) 383-3077; *After hours and weekends:* **Carle Hospital Emergency Department;** 602 W. University Avenue; Urbana, IL 61801; (217) 383-3313

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
http://www.obfs.uillinois.edu/risk/workers_compensation/

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UNIVERSITY OF ILLINOIS

First Report of Injury/Illness

(To be completed within 24 hours of incident by employee)

EMPLOYEE INFORMATION **(* Federal Government/University Required Information)**

Name____ UIN #__________________

Street____ 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________
(cirle 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. 11/09)

UNIVERSITY OF ILLINOIS

First Report of Injury/Illness

(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 □
Ankle □R □L
Arm □R □L
Back □
Chest □
Ear □R □L
Elbow □R □L
Eye □R □L
Face □
Finger □
Foot □R □L
Groin □
Hand □R □L
Head □
Hip □R □L
Knee □R □L
Leg □R □L
Lungs □
Neck □
Shoulder □R □L
Toes □
Wrist □
Other__________

Type of Injury: **(Check all that apply)**

Absorption □
Amputation □
Bruise □
Burn □
Foreign body□
Fracture □
Inflammation □
Ingestion □
Inhalation □
Irritation □
Laceration □
Over-exertion □
Over-exposure □
Puncture □
Strain / Sprain □
Other__________

Type of event: **(Check all that apply)**

Body Motion / Body Position □
Caught in / under / between □
Electrical contact □
Explosion □
Fall from elevation □
Fall on same level □
Repetitive motion □
Slip / twist □
Slip / trip / fall □
Struck by / struck against □
Temperature extreme □
Vehicular Accident □
Unknown □
Other_____________

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
- □ Safety features of devices bypassed
- □ Unbalanced or poor position or motion
- □ Other: _____________________

Preventive Action Supervisor will:

- □ Develop / revise safety procedures
- □ Maintain good housekeeping
- □ Maintain tools / equipment
- □ Post safety signs
- □ Perform job hazard analysis
- □ Provide protective 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

(Rev. 11/09)