ILLINOIS
DEPARTMENT OF CENTRAL
MANAGEMENT SERVICES

Division of Risk Management
Claims Section

WORKERS' COMPENSATION EMPLOYEE'S NOTICE OF INJURY (COMPLETE ALL ITEMS)

EMPLOYEE'S NAME (last) (first)

EMPLOYEE'S ADDRESS (no.) (street)

(city) (state) (zip) | TELEPHONE Home ______________________ Work ______________________

SOCIAL SECURITY NO. | DATE OF BIRTH (mo) (day) (year) | SEX: ☐ Female ☐ Male

MARITAL STATUS: ☐ Married ☐ Single ☐ Widow(er) ☐ Divorced | NUMBER OF DEPENDENT CHILDREN UNDER 18 AT DATE OF INJURY __________

DATE OF INJURY OR ILLNESS (mo) (day) (year) | TIME A.M. P.M. | LAST DAY WORKED

NAME OF AGENCY | ADDRESS OF AGENCY | WORK COUNTY

REPORTED TO SUPERVISOR ☐ Yes ☐ No | NAME OF SUPERVISOR | DATE & TIME REPORTED a.m. p.m. (mo) (day) (year)

IF NOT REPORTED ON DATE OF INCIDENT, EXPLAIN

HAVE YOU SOUGHT MEDICAL ATTENTION ☐ Yes ☐ No | NAME, ADDRESS PHONE NO. OF DOCTOR

ANY SICK, VACATION OR PERSONAL DAYS USED FOR THIS INJURY? ☐ Yes ☐ No | NUMBER AND TYPE

HAS ANY INSURANCE COMPANY PAID FOR TREATMENT AS A RESULT OF THIS INJURY ☐ Yes ☐ No | NAME AND POLICY NO.

WHAT DUTY WERE YOU PERFORMING AT TIME OF INJURY? (BE SPECIFIC)

PLACE WHERE INJURY OCCURRED (BE SPECIFIC)

DETAIL HOW INJURY OCCURRED (USE REVERSE SIDE IF NECESSARY)

DID A NEGLIGENT THIRD PARTY CAUSE OR CONTRIBUTE TO ACCIDENT? ☐ Yes ☐ No

IF YES, EXPLAIN AND PROVIDE, ADDRESS, AND PHONE # OF NEGLIGENT PARTY:
(USE REVERSE SIDE IF NECESSARY)

DESCRIBE INJURY (INDICATE PART(S) OF BODY AFFECTED)

ANY WITNESS(S) TO INJURY ☐ Yes ☐ No | IF YES, NAME(S)

HAVE YOU SUBMITTED ANY PREVIOUS CLAIMS FOR INJURY / ILLNESS?
(IF YES, IDENTIFY EACH ON REVERSE SIDE) ☐ Yes ☐ No

DATE THIS FORM COMPLETED ______________________________ (mo) (day) (year)

SIGNATURE OF INJURED EMPLOYEE ____

IF INJURED EMPLOYEE UNABLE TO SIGN ABOVE,
SIGNATURE OF INDIVIDUAL COMPLETING THIS FORM

Reverse side must be completed if applicable before submission to CMS

ADDITIONAL DETAILS HOW INJURY OCCURRED

PREVIOUS INJURIES OR ILLNESSES

DATE(S) OF INJURY / ILLNESS	DESCRIBE INJURY / ILLNESS	WAS THIS WORKERS' COMPENSATION YES OR NO	NAME AND ADDRESS OF DOCTOR	IF YES, AMOUNT OF SETTLEMENT

ADDITIONAL DETAILS CONCERNING THIRD PARTY NEGLIGENCE