Workers' Compensation Informational Packet

An employee suffering an accidental injury or exposure on the job should immediately seek medical care if necessary.

The injured employee must file a Workers' Compensation case within 45 days of the date of accident/injury per the Illinois Workers' Compensation Commission. **The injured employee must call Gallagher Bassett immediately following an accident at 1(833)891-1372** as the first step in filing a Workers' Compensation claim.

It is the responsibility of the employee to notify their supervisor, contact HR & Gallagher Bassett, and to follow up with the following paperwork:

- Initial and Scheduled Appointment – Employee Responsibilities (page 2)
- Notice of Benefit Option Form (Page 3)
- Notice of Injury- Completed by injured employee (pages 4-5)
- Medical Authorization- Completed by injured employee (page 6)
- Supervisor Report of Injury- Completed by supervisor (page 7)
- Witness Report- Completed by any witnesses (page 8)
- Initial WC Medical Report- Completed by injured employee's Doctor (page 9-10)

If your physician takes you out of work due to your injury, you must have them complete the Work Status Form. If you are released to return to work from your injury, you must have your provider complete a new Work Status Form.

Work Status Form (If Applicable, Page 17)

All forms should be sent to Human Resources, Attn: Workers' Compensation. Please notify the Workers' Compensation Coordinator when you are involved in a work-related injury or illness at (309) 298-1971 or HR-WorkComp@wiu.edu.

Initial and Scheduled Appointments

-Employee Responsibilities-

Scheduled Medical Appointments

You are required to notify the Workers' Compensation Coordinator of all scheduled medical appointments related to your Workers' Compensation injury. **Immediately following your appointment, you are required to provide work status documentation (Work Status Form or Physician's note) to the Workers' Compensation Coordinator detailing your work status, and restrictions and /or your release to return to work date.**

If for some reason you miss a scheduled appointment, you must notify the Workers' Compensation Coordinator of your missed appointment and the rescheduled appointment date, within two (2) business days. Prior to any return to work, you must present your doctor's Work Status Form as outlined in the procedure below. You CANNOT return to work without a Return-to- Work Authorization from the Workers' Compensation Coordinator.

Returning to Work

Immediately following an appointment where you have been approved to return to work (with restrictions or full duty), you must bring in a Work Status Form, identifying all restrictions or release to full duty, to the Workers' Compensation Coordinator below.

Alyssa Eddington | Sherman Hall 105 | 309-298-1971 | hr-workcomp@wiu.edu
Office hours: Monday – Friday 8 AM – 4:30 PM

Physical Therapy

All physical therapy sessions must be pre-approved through Gallagher Bassett. If you are prescribed therapy for your injury, you must contact the Workers' Compensation Coordinator prior to starting any therapy, and provide a schedule of all therapy sessions to your Workers' Compensation Coordinator. You are NOT required to submit therapy notes following therapy sessions. If for some reason you miss a therapy session you are required to contact the Workers' Compensation Coordinator to advise of the missed appointment and the rescheduled appointment date.

Surgery

All surgeries related to the workers' compensation injury must be approved by Gallagher Bassett prior to attending any appointments related to the Surgery. If your provider recommends surgery for treatment, you must notify your Workers' Compensation Coordinator, and Gallagher Bassett, at your earliest convenience.

Denied Workers Compensation Claim

If the Workers' Compensation Claim is denied, all doctors appointments you have attended during work hours will be changed from Work Comp Time to available benefit time.

My signature below indicates that I have read the above statements and fully understand each of my responsibilities. I also understand that failure to comply with any of these statements, may result in the delay of or denial of payable benefits by Gallagher Bassett.

Employee Name _____ WIU ID#_____

Employee Signature _____ Date_____

Western Illinois University

Workers Compensation Notice of Benefit Option Form

Employee Name: _____ **Date of Incident:** _____

Claim Number: _____ **Supervisors Name:** _____

If you are absent from work due to a work-related injury for working days or more, you must choose to receive either Temporary Total Disability benefits (TTD) from Workers' Compensation according to the rules and regulations of the Illinois Workers' Compensation Act, or be paid using personal accumulative sick and/ or vacation leave benefits. Workers Compensation benefits are not taxed by Federal or State governments.

If your on-the-job injury will result in you missing three (3) or fewer consecutive scheduled work days, you are not eligible to receive Temporary Total Disability (TTD) benefits (i.e. wage replacement). In addition, if your case is deemed to be compensable and the period of disability does not exceed thirteen (13) days, you will not be paid Workers Compensation TTD benefits for the first three (3) workdays of the disability period. Accrued sick leave and vacation are available for these first three days.

Please choose one option below, then sign and date:

I am aware that if I choose to apply for Workers' Compensation Temporary Total Disability (TTD) Benefit payments, payment is not guaranteed. The compensability of my claim is determined by the State of Illinois, Department of Central Management Services, Risk Management Division.

Option 1

____ I choose to receive Workers' Compensation Temporary Total Disability (TTD) Benefits. I understand that while I received TTD benefits, I will be on a leave of absence without pay status with the university. I will not accrue sick or vacation time and I will not be paid for holidays during this period of leave of absence without pay. I also understand that while I am on a Workers' Compensation Leave of Absence using Temporary Total Disability (TTD) Benefits, I will be responsible for paying any payroll deductions normally deducted from a university paycheck.

Option 2

____ I choose to use my university paid accumulative sick leave and/ or vacation benefits for this on-the-job accident. I understand I will not be permitted to receive both paid personal leave benefits and Temporary Total Disability (TTD) simultaneously. I reserve the right to discontinue use of sick and/or vacation benefits and utilize Temporary Total Disability (TTD) benefits with at least an eight (8) day notice before the end of the pay period or understand that this change will take place in the pay period following my request. I must submit a corrected *Notice of Benefit Option Form*, Choosing Option 1 above if I decide to make this change.

Signature of Employee _____ Date _____

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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: ☐ AM ☐ PM	LAST DAY WORKED:
NAME OF AGENCY	ADDRESS OF AGENCY	WORK COUNTY
REPORTED TO SUPERVISOR ☐ Yes ☐ No	NAME OF SUPERVISOR	DATE & TIME REPORTED _____ (am) (pm) _____ (mo) (day) (year)
IF NOT REPORTED ON DATE OF INCIDENT, EXPLAIN:		
HAVE YOU SOUGHTMEDICAL ATTENTION? ☐ Yes ☐ No	NAME, ADDRESS AND PHONE NO. OF DOCTOR:	
ANY SICK, VACATION OR PERSONALDAYS 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 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(ES) TO INJURY ☐ Yes ☐ No	IF YES, NAME(S):	
HAVE YOU SUBMITTED ANY PREVIOUS CLAIMS FOR INJURY/ILLNESS? ☐ Yes ☐ No (IF YES, IDENTIFY EACH ON REVERSE SIDE.)		
DATE THIS FORM COMPLETED _____ (mo) (day) (year)	SIGNATURE OF INJURED EMPLOYEE	
IF INJURED EMPLOYEE UNABLE TO SIGN ABOVE, SIGNATURE OF INDIVIDUAL COMPLETING THIS FORM		

PO Box 2934 • Clinton, IA 52733-2934 • Fax 847-621-7101

Reverse side must be completed if applicable before submission to Gallagher Bassett

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

This is a written request for workers' compensation benefits as a result of the incident described therein.

Please fill out the form truthfully and accurately. Under Section 25.5 of the Illinois Workers' Compensation Act, it is unlawful for any person to intentionally make or cause to be made any false or fraudulent material statement or material representation for the purpose of obtaining any workers' compensation benefit. **I have reviewed, understand and acknowledge the above statement.**

Employee signature (if available to sign) _____ Date _____

Employer Signature _____ Date _____

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AUTHORIZATION TO USE OR DISCLOSE INFORMATION

Employer: State of Illinois **Agency/Facility:** _____
Patient Name: _____ **Claim Number:** _____

Patient Address/Telephone: _____

Patient Social Security No. _____ **Patient Date of Birth:** _____

I, _____, understand that this authorization is voluntary, and that I may refuse to sign this authorization, and that I may revoke this authorization at any time by sending my written revocation to the entity providing the information. I understand that the revocation will not apply to information that has already been released in response to this authorization.

This authorization shall remain in effect until the workers' compensation claim is fully resolved unless a different date is specified here _____ (Date).

☐ Medical Information ☐ Mental Health / Psychiatric Information

I hereby authorize any physician, psychologist, psychiatrist, dentist, hospital or other medical provider to furnish all records, reports, histories, diagnostic tests and evaluation, physician and nurses' notes and therapy notes to Gallagher Bassett/Employing State Agency and its legal representative, for purposes of processing and administration of the workers' compensation claim identified herein.

I understand that the recipient may not lawfully further use or disclose the information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If an authorization is requested by a person / organization listed above for the use or disclosure of protected health information, the person / organization listed above must provide me with a copy of the signed authorization. I understand I have a right to receive a copy of this authorization.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic Information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

A carbon, photo static, or thermo fax copy of this true release shall be as valid as the original.

_____ _____
Signature of Patient, Parent or Legal Guardian *Date*

_____ _____
If signed by other than patient, indicate relationship *Witness to Signature*

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SUPERVISOR'S REPORT OF INJURY OR ILLNESS

Claim Number _____

This form must be completed thoroughly by employee's supervisor within 24 hours after an accident

PART I – GENERAL INFORMATION

Employee Name	Title		Social Security No.
Address	City/State	Zip	Home Phone
Agency	Location		Work Phone

Job Description and/or Assigned Duties of Employee (be specific):

Number of Years in current job title: _____

Previous job title: _____ Number of years previous title: _____

Activity at time of accident/incident: _____

Date of Accident/Incident	Hour: ◯ AM ◯ PM	Exact Location		
Did you witness? ■ Yes ☐ No	How was notice received? ☐ Written ☐ Oral	Date Received	Time Received	From Whom Notice Received

PART II – DETAILS OF ACCIDENT

Description of Accident/Incident:

Did a third party cause or contribute to the accident? ◯ Yes ◯ No

If yes, explain and provide name, address and phone number of negligent party (use reverse side if necessary):

Description of Injury – Part(s) of Body Injured:

Name(s) of Witness(es) (if none, so state):

PART III – CAUSE OF ACCIDENT

Describe any unsafe acts or conditions which contribute to the accident/incident:

PART IV – CORRECTIVE ACTION TAKEN

Was the condition above corrected (how)?	Reported to higher authority (Name & Title)?
Name and Title of Supervisor	Did the incident result in any disciplinary action? ◯ Yes ◯ No

_____ Signature of Supervisor/Phone Number

_____ Report Date

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Claim Number _____

WORKERS' COMPENSATION WITNESS REPORT

Injured Employee Name	Work Location	
Your Name	Do you work for the State of Illinois? ☐ Yes ☐ No	Work Phone
Home Address (Street)	(City/State/Zip)	Home Phone

Did you see the accident? ☐ Yes ☐ No	Date you witnessed? Time ☐ AM ☐ PM	Did you know employee before the accident? ☐ Yes ☐ No

What did you see or hear? – Be specific (use back side if necessary)

Exact location of what you saw or heard

Name(s) and Address(es) of any other witness(es)

I CERTIFY THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

_____ Date Completed

_____ Signature of Witness

Name and Title of Individual Making Report (print)

_____ Print Name

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Dear Medical Provider:

The Illinois Worker's Compensation and Occupational Diseases Act provides that the employer is obligated to pay all medical, hospital and surgical charges incurred in connection with an accidental injury and/or disease which arises out of and in the course of employment. This obligation is "limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury or disease."

The Act further provides that "Every hospital, physician, surgeon or other person rendering treatment or services in accordance with the provisions of this Section shall upon written request furnish full and complete reports thereof to, and permit their records to be copied by, the employer***."

The Act also provides that "in the event the (Illinois Workers' Compensation) Commission shall find that a doctor selected by the employee is rendering improper or inadequate care, the Commission may order the employee to select another doctor certified or qualified in the medical field for which treatment is required. If the employee refuses to make such change the Commission may relieve the employer of his obligation to pay the doctor's charges from the date of refusal to the date of compliance."

In accordance with the above provisions, you are requested to complete the attached medical report. Your timely furnishing of this report will work to the benefit of the injured employee in that it will enable Gallagher Bassett to make prompt decisions regarding the compensability of the injury and issuance of appropriate disability payments to the employee. Your detailed completion of this report is also necessary for us to process your itemized bill for payment.

Should any clarification of this report or copies of other medical records be required, we will specifically request same. Thank you in advance for your cooperation.

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Mail To: PO Box 2934
Clinton, IA 52733-2934
Fax: 847-621-7101
ATTN: State of Illinois

INITIAL WORKERS' COMPENSATION MEDICAL REPORT Claim No. _____

The Illinois Workers' Compensation and Occupational Diseases Act provides that the employer is obligated to pay all first aid, medical and surgical services reasonably necessary to cure or relieve from the effects of occupationally-related injury or disease. Every hospital and doctor shall, upon written request, furnish complete records and permit their records to be copied by the employer and/or the employee.

Your detailed completion of this report is also necessary to enable our office to process your itemized bill for payment.

A. Employee's Name _____ Date of Report _____

Agency/Facility _____

Date of Accident _____ Date Examined _____ Height _____ Weight _____

☐ Family Doctor ☐ Specialist ☐ Chiropractor ☐ Other Number of years of Relationship _____

B. History (Description of Accident) _____

_____

History of previous injuries and illnesses _____

_____

Name(s) of other physician(s) who served on case _____

C. Diagnosis (ICD-9-CM Code(s)) _____

Describe nature and extent of injuries _____

_____

D. Treatment (Proposed or completed, surgical, dressing(s), etc.) _____

_____

Medications _____ (Given/Prescribed) _____

X-Ray Results (Attach copy of report) _____

E. Prognosis _____

_____

Estimated date or return to work with restrictions _____ Identify Restrictions _____

Estimated date of return to work without restrictions _____

F. Final Report (Complete the following if treatment is no longer being rendered to this employee by the undersigned physician)

Date patient discharged from treatment _____ Case transferred to _____

Name of Doctor _____
(please print or type)
Address _____

_____

Phone _____

DOCTOR'S SIGNATURE _____ Date _____

WESTERN ILLINOIS UNIVERSITY
RELEASE FROM WORK / RETURN TO WORK
Work Status Form

PATIENT'S NAME:_____ JOB TITLE:_____

DATE OF INJURY/ILLNESS:_____ DATE(S) TREATED:_____

PHYSICIAN'S EVALUATION: (please complete all sections; if non-applicable please document N/A)

_____ **Off work, beginning** _____

_____ *Estimated* date of return to work_____

_____ Patient referred to _____

_____ Patient's next appointment date with provider _____

_____ **Return to work on** _____

_____ With no restrictions

_____ With the following restrictions until_____

____ No work requiring jerking or jamming of the_____

____ No pushing, pulling or lifting with the _____ more than_____ lbs pressures.

____ No repeated stooping, bending or lifting over_____ lbs.

____ Keep wound area bandaged, clean, dry and protected.

____ No prolonged walking/or standing.

____ No prolonged kneeling.

____ No climbing vertical ladders or working at heights.

____ Must wear support immobilize.

____ Sit down work only.

____ May not operate motor vehicle or work with moving machinery.

____ One hand work only, using _____ right _____ left hand.

____ Other restrictions and/or limitations_____

Additional Instructions_____

_____

PHYSICIAN_____ Phone_____ FAX_____

ADDRESS_____

PHYSICIAN'S SIGNATURE:_____ DATE:_____

A determination will be made by WIU regarding the feasibility of the employee to return to work with restrictions.
PLEASE RETURN THIS FORM AS SOON AS POSSIBLE. THANK YOU!

HUMAN RESOURCES PHONE: 309/298-1971 FAX: 309/298-2300

Qualifying leave will automatically be counted toward the twelve weeks allowed per fiscal year under the Family Medical Leave Act (FMLA) for eligible employees.