

To: Injured Worker
From: Dea Foster (630-365-8220)
Re: Workers' Compensation Claims

What is workers' compensation? Workers' compensation is a system of benefits paid by employers to workers who experience job-related injuries or diseases.

Who should the injured worker notify? The employee must inform the employer promptly. Ideally, the employee informs their direct supervisor immediately; the supervisor in-turn assists in the process of notifying the employer. Any delay in the notice to the employer can delay the payment of benefits; a delay of more than 45 days may result in the loss of all benefits.

Please complete the “Injured Worker’s Report of Injury” as soon as possible and submit it to the Business Office. Be as specific and detailed as possible with your description of the incident and the injury. Your claim will then be filed with our Workers’ Comp carrier. The IL Workers’ Compensation Commission’s Handbook on Workers’ Compensation and Occupation Diseases can be found at www.iwcc.il.gov/handbook.htm for your reference.

Note: Do not submit any medical bills to our health insurance carrier. All bills pertaining to the claim should be sent to our office and will be forwarded to our Workers’ Compensation carrier.

INJURED WORKER'S REPORT OF INJURY

EMPLOYER INFORMATION:

Employer: Kaneland Community Unit School District #302 Phone: 630-365-5111

Address: 47W326 Keslinger Road, Maple Park, Illinois 60151-9720

School: _____

Principal: _____

INJURED WORKER INFORMATION:

Name: _____

Address: _____ City _____ Zip _____

Phone: _____ Social Security #: _____

Marital Status: _____ Single _____ Married _____ Date of Birth _____

Dependent(s) Names & Ages: _____

Occupation: _____

Date of Hire: _____ Other Employment: _____

INJURY:

Date: _____ Time: _____ Location: _____

Witness(es) Name & Address: _____

Witness(es) Name & Address: _____

Task You Were Performing at the Time of the Injury: _____

Body Part(s) Injured (be specific): _____

Last Day Worked: _____ Return to Work Date or Expected Return to Work Date: _____

Have Medical Services Been Rendered (If Yes, List Physician /Hospital Name& Address): _____

Cause/Describe How Accident Happened. (Include details to answer who, what, when, where and how): _____

Date: _____, 20__ Signature of **Employee**: _____

Date: _____, 20__ Signature of Supervisor: _____

RETURN THIS FORM TO KANELAND BUSINESS OFFICE ATTN: DEA FOSTER