THE UNIVERSITY OF CHICAGO | Finance and Administration Division
Office of Risk Management

Effective 07/2019
Questions about this form?
Contact Risk Management
Email: WCclaim@uchicago.edu

Employee's Statement of Injury or Illness – Workers' Compensation

PLEASE PRINT **Today's Date: ___ /___ /20___**

Employee Name: _______________________________________ SSN: xxx-xx-_________ Date of Birth: ___ /___ /____

Employee Home Address: ____________________________________ City, ST, Zip: _______________________________

Home Phone Number: ___________________________ Emergency Contact & Number: ___________________________

Department: _____________________________ Position: __________________ Supervisor: _______________________

Date of Occurrence: ___/___/20___ Time: ___:___ AM/PM

Accident Location & Address: ____

Did you report the accident, injury, illness? YES / NO Date Reported: ___/___/20__

How did you report it? In Person / By Phone / By E-mail / Via UCAIR Other: _____________________________________

To whom did you report it? ___________________________________ Title: _____________________________________

What were you doing when the accident, injury, illness occurred? ____

____

____

What tools or equipment were you using at the time? ____

____

____

Describe the accident and injury/illness: ____

____

____

Select the area(s) where there is an injury; the type of injury; and, indicate right, left, front or back:

	Eye	Face Head	Shoulder	Chest Ribs	Arm	Wrist	Hand	Fingers	Back	Leg	Knee	Foot Toes
Burn												
Bruise												
Cut												
Gash												
Rash												
Scrape												
Scratch												
Sprain/ Strain												
Fracture												

Signature: ____ **Date: ____________________________**