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

WC Form 100 (Effective 07/2019)

Request for Evaluation and Treatment – Work Related Illness or Injury

PLEASE PRINT

Employee Name: _____ **SSN:** **XXX-XX-**_____

Date of Occurrence: _____/_____/20____ **Time:** _____:_____ **AM/PM**

Department: _____ **Phone:** _____

Brief Description Injury/Illness: _____

_____

_____

_____

The above named employee has requested evaluation for treatment of a reported work-related injury. Authorization is granted to ***University Occupational Medicine Clinic (UCOM)/University of Chicago Medical Center Emergency Room*** to evaluate and treat the above-named employee for consideration of a potential claim. Please send a copy of this report, other reports and associated billing statement(s) to:

Office of Risk Management
5801 South Ellis Avenue, Chicago, IL 60637
Email: WCclaim@uchicago.edu

Dept. Supervisor/HR Partner:

_____
Print Name

_____
Signature

Note: University Occupational Medicine Clinic (UCOM), Room D136,
Hours: 7:30 am 4:00 pm Monday - Friday
5841 S. Maryland Ave., Mail Code 7103

At all other times, use the Adult Emergency Room