ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

Please type or print.

Employer's FEIN	Date of report	Case or File #	Is this a lost workday case?
362821648			Yes / No

Employer's name	Doing business as
SPEED SEJA 802 SCHOOL DISTRICT	

Employer's mailing address
1125 S. DIVISION STRETT, CHICAGO HEIGHTS, IL 60411

Nature of business or service	SIC code

Name of workers' compensation carrier/admin.	Policy/Contract #	Self-insured?
		Yes / No

Employee's full name	Social Security #	Birthdate

Employee's mailing address	Employee's e-mail address

Male / Female	Married / Single	# Dependents	Employee's average weekly wage

Job title or occupation	Date hired

Time employee began work	Date and time of accident	Last day employee worked
AM PM		

If the employee died as a result of the accident, give the date of death.	Did the accident occur on the employer's premises?
	Yes / No

Address of accident

What was the employee doing when the accident occurred?

How did the accident occur?

What was the injury or illness? List the part of body affected and explain how it was affected.

What object or substance, if any, directly harmed the employee?

Name and address of physician/health care professional

If treatment was given away from the worksite, list the name and address of the place it was given.

Was the employee treated in an emergency room?	Was the employee hospitalized overnight as an inpatient?
Yes / No	Yes / No

Report prepared by	Signature	Title and telephone #

Please send this form to the ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE RD. SPRINGFIELD, IL 62703-5118 IC45 6/09

By law, employers must keep accurate records of all work-related injuries and illness (except for certain minor injuries). Employers shall report to the Commission all injuries resulting in the loss of more than three scheduled workdays. Filing this form does not affect liability under the Workers' Compensation Act and is not incriminatory in any sense. This information is confidential.

ICRMT
WC Employee Injury Report
(to be completed by injured employee)

Insured: _____

Your Name: _____ Home Phone: _____

Hire Date: _____ SSN: _____ Date of Birth: _____

Home Address & Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced # Dependents: _____

Date/Time of Incident: _____ Time Shift Began: _____ Date/Time Reported: _____

Address of accident occurrence: _____

Body part and how it was affected: _____

_____

What were you doing when the accident occurred? _____

Reason for being in the area: _____

_____

How did the accident occur ? (use 2nd sheet if necessary): _____

_____

_____

Who else saw the incident? _____

To whom did you report the incident? _____

Have you received first aid? ☐ Yes ☐ No
If yes, check One: ☐ On Premise
☐ Outside medical assistance
☐ Both

Were you treated in the Emergency Room? ☐ Yes ☐ No
Were you hospitalized overnight as an inpatient? ☐ Yes ☐ No
Has your doctor taken you off of work? ☐ Yes ☐ No

When is your next medical appointment? _____

Name, address, phone and fax # (if available) of medical facility where treatment was sought: _____

_____

Date/Time of such treatment: _____

Prior Workers' Compensation Claims? ☐ Yes ☐ No

If yes, please explain (i.e. date, body part, injury specifics):_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I agree the above is true and accurate

Employee's Signature: _____ Date: _____

IPMG
INSURANCE PROGRAM MANAGERS GROUP

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Participant Name:	Address, City, ZIP:	Birth Date:

I hereby authorize my identified health care provider(s) to release and disclose the medical information and other records listed below that may include Protected Health Information about me to Insurance Program Managers Group (IPMG), at 225 Smith Road, St. Charles, IL 60174. "Protected Health Information" or "PHI" includes any information that relates to (1) My past, present or future physical or mental health or condition; or (2) Health care I have received or will receive; or (3) Payment for health care I have received or will receive.

Purpose of Disclosure. All such medical information and PHI may be disclosed by verbal/oral, email, or other form of written communication to IPMG and/or individuals working on its behalf for purpose of informing them of my medical condition and treatment, as reasonably requested for workers' compensation purposes, certification and payment of medical expenses, and discharge planning, ongoing case management, wellness service coordination, and other integrated care management services as disclosed to me by IPMG at the time of this Authorization.

The following specific information to be disclosed:

[ ] All medical and billing records or any other information maintained by you (including records prepared by others that are in your possession) regarding the above listed Participant;

or only the following:

[ ] Health Treatment [ ] Dental Treatment [ ] Vision Treatment

[ ] Other _____

[ ] Records related to the following treatment: _____

[ ] Related to the following time period(s): _____ to _____

I understand that the records to be disclosed pursuant to this Authorization may contain records or information relating to treatment or participation in the following: Initials

- Federally assisted drug or alcohol abuse programs _____
- HIV Testing or HIV or AIDS Status _____
- Diagnosis and Treatment of Mental or Psychological Health _____
- Genetic testing information and/or records _____

I understand that such information is subject to special protections pursuant to state and federal laws. By my initials, I authorize the use or disclosure of such records if they are otherwise included within the scope of this Authorization

I understand that IPMG shall be authorized to use and disclose my PHI in the manner provided under applicable law, including the Health Insurance Portability and Accountability Act (HIPAA), as described in its Notice of Privacy Rights. I have the right to revoke this Authorization in writing, except to the extent the provider has taken action in reliance upon this Authorization. I also understand a photocopy or facsimile of this Authorization shall be considered as effective and valid as the original. I understand that I may see and copy the information described on this form if I ask for it, and that I may obtain a copy of this form after I sign it. I understand that this Authorization is voluntary and that I may refuse to sign this Authorization. My refusal to sign will not affect my ability to seek and receive treatment, payment for submitted claims or maintain other eligibility for any other coverage provided under my employer's employee benefit plan(s).

I understand that my Protected Health Information may also be used or disclosed for purposes of responding to the lawsuit or claim brought by me or involving me. I understand that my PHI may be made available to various parties also involved with or defending such legal action by me or involving me, and that the information, once disclosed, might no longer be subject to certain state or federal privacy protections once released.

With respect to PHI or other information provided for or by my group health plan for health benefit purposes only, this Authorization expires on the earlier of _____, 202__ or the following event: , but such expiration will not be effective as to records already released in reliance on the Authorization.

_____ _____

Signature of Participant or Personal Representative Date

Personal Representative Section

If a Personal Representative executes this form, that Personal Representative warrants that he or she has authority to sign this form on the basis of:

* Legal Authority (Power of Attorney, etc.) Please attach documentary evidence.
* Parent, Guardian or other individual acting in loco parentis
* Written Designation by the Patient or Participant

ICRMT
WC Supervisor Report
(to be completed by supervisor of injured employee)

Injured Employee Name: _____ SSN: _____

Insured: _____

Employee Home Phone: _____ Employee's approximate weekly wage: _____

Supervisor's Name and Title: _____

Date/Time of Accident: _____ Date/Time Employee Reported: _____

Medical Expenses so far (if known): _____ ☐ ☐ _____

Did/will employee lose time from work as a result of this accident? Yes No

If yes, please list dates/timeframes missed due to this accident: _____

If lost time: Did or will the lost time exceed 3 consecutive scheduled work shifts? ☐ Yes ☐ No
Is there a possibility of accommodating a modified duty position during any recovery period? ☐ Yes ☐ No

If no, reason why: _____

Was medical treatment performed outside of the employer's facility? ☐ Yes ☐ No

If yes, was this medical provider (select all that apply): ☐ Occupational Health Provider
☐ Chosen by employee
☐ Other

Did the employee see more than one physician for this accident? ☐ Yes ☐ No

What object or substance, if any, directly harmed the employee? _____

_____

Did the accident occur on the employer's premises? ☐ Yes ☐ No

Please review the employee's report of injury. Do you agree with the employee's details of this accident? ☐ Yes ☐ No

If no, please explain thoroughly (use 2nd sheet if necessary): _____

_____

_____

What did the employee tell you regarding what happened for the incident to occur? _____

_____

_____

What was the sequence of events that led up to the accident? What material, equipment and tools were involved? _____

_____

What were the environmental conditions at the accident site? _____

What was done immediately after the accident? _____

Specify body parts injured in this accident: _____

Injury Type (i.e. sprain, fracture, etc.): _____

Accident Location: _____

Loss Causation: _____

What conditions or actions contributed to the accident? _____

What system design and implementation problems contributed to the accident occurrence? _____

What actions will be taken to reduce unsafe conditions and actions? _____

What actions will be taken to strengthen system design and implementation? _____

Would you like Risk Management to contact you for further risk management assistance? ☐ Yes ☐ No

Do you believe an outside/3rd party is responsible for this accident occurring? ☐ Yes ☐ No

If yes, please indicate the responsible party's name, address and phone number if known: _____

I agree the above is true and accurate

Supervisor Name: _____ Supervisor Phone: _____

Supervisor's Signature: _____ Date: _____

ICRMT
WC Witness Report
(to be completed by accident witness)

Insured: _____

Injured Employee Name: _____

Your Name: _____ Your Phone Number: _____

Your Address: _____ ☐ ☐

Your relationship with injured employee (check one): Co-worker Other

Date/Time of Incident: _____ Today's Date/Time: _____

What was the employee doing at the time of the accident? _____

_____

What was the sequence of events that led up to the accident? _____

_____

_____

What was done immediately after the incident? _____

_____

_____

What were the environmental conditions at the accident site? _____

_____

What materials, equipment and tools were involved? _____

_____

I agree the above is true and accurate

Witness Name (please print): _____

Witness' Signature: _____ Date: _____

Advocate Occupational Health

EMPLOYER AUTHORIZATION

Please complete the form and requested services. Employer accepts financial responsibility for authorized visits. Send a copy with your employee to the appointment.

CLIENT INFORMATION			
Employee Name		Job Title/Description	
Employer	SPEED SEJA 802 SCHOOL DISTRICT	Phone	
Contact Person/Authorized By	BMURILLO@SPEED802.ORG AND/OR LASHANDA.SHUMPERT@SPEED802.ORG		
Reason for Visit			
Appointment Date		Time	

INJURY TREATMENT	
Injury Description	Date of Injury
☐ Drug Screen Required - *Select Option Below*	☐ Breath Alcohol Test Required

- Employees should not go to the Emergency Department or Urgent Care unless the injury is life threatening or it is after business hours.

AUTHORIZED TESTS OR TREATMENT

MEDICAL EXAMINATION

PHYSICAL EXAM
- ☐ Pre-Employment Exam
- ☐ Annual Exam
- ☐ Return to Duty

DOT PHYSICAL
- ☐ Pre-Employment Exam
- ☐ Recertification Exam

DOT PHYSICAL W/IL SCHOOL BUS PHYSICAL
- ☐ Pre-Employment Exam
- ☐ Recertification Exam/Annual

ILLINOIS SCHOOL BUS PHYSICAL
- ☐ Pre-Employment
- ☐ Exam/Annual

RESPIRATOR CLEARANCE / FIT TESTING
- ☐ Respirator Questionnaire Review (ONLY)
- ☐ Physical Exam
- ☐ Pulmonary Function Test (PFT)
- ☐ Fit Testing

OTHER MEDICAL EXAMS
- ☐ HAZMAT/Medical Surveillance
- ☐ Coast Guard
- ☐ Other:_____

LAB OR MEDICAL TESTING
- ☐ Audiogram
- ☐ Vision Type:_____
- ☐ TB Test: ☐ 1 Step ☐ 2 Step ☐ Quant
- ☐ Back Lift Test: ☐ 50 lbs ☐ 75 lbs ☐ 100 lbs

PLEASE SPECIFY:
- ☐ Vaccine(s)_____
- ☐ Lab(s)_____
- ☐ Other:_____

DRUG OR ALCOHOL

REASON FOR DRUG / ALCOHOL TEST
- ☐ Pre-employment
- ☐ Annual
- ☐ Random
- ☐ Post-Accident
- ☐ Reasonable Suspicion/Cause
- ☐ Return to Duty
- ☐ Follow-Up

BREATH ALCOHOL TEST
☐ DOT ☐ NON-DOT

TYPE OF DRUG SCREEN
☐ DOT Drug Test

TEST COLLECTION ONLY
☐ DOT ☐ Non-DOT ☐ Hair

RAPID DRUG TEST
- ☐ 5 Panel ☐ 10 Panel
- ☐ Other:_____

NON DOT DRUG TEST
- ☐ 5 Panel ☐ 10 Panel
- ☐ Other:_____

Special Instructions: _____

Authorization Signature: Brenda Murillo, 708.481-0535