County of DuPage

Employee Statement of Injury / Illness

To be completed by the Employee as soon as possible following a work-related injury / illness.

I understand it is unlawful to willfully make a false statement for the purposes of obtaining benefits.

Answer All Questions Failure to complete this form in full may result in a delay of benefits.

1. **Employee Name _____ Home Phone # (_____)_____**

2. **Employee ID # _____ Birth date _____ Date of Hire _____ Time on Present Job _____**

3. **Employee Department and Job Title _____**

4. **Date of Incident _____ Time of Incident _____**

5. **Location of Incident Room# _____ Hallway_____Station_____Bath_____Toilet_____Shower_____**

   Wheelchair _____ Other_____

6. **Circle body part affected on page 2 and indicate P, T, N, B, or S as defined on picture:**

7. **Describe in detail the work being performed at time of incident – how the injury / illness occurred. Explain below:**
   If using during transfer check: Gait Belt ❑ Draw Sheet ❑ EZ Lift ❑

   Resident was: Cooperative ❑ Aggressive ❑ Combative ❑ Refused Care ❑

8. **Did the injury / illness occur because of a specific incident or did it develop gradually? ❑ Specific Incident ❑ Gradually**

   If pain developed gradually, on what date did you first notice pain? _____

9. **Did any unusual circumstance contribute to your injury / illness? ❑ Yes ❑ No**

   If yes, please explain (i.e. equipment failure, weather conditions, wet floor, etc.)

10. **Did you discuss your injury / illness with other employees? ❑ Yes ❑ No**

    If yes, with whom and when?

11. **Did anyone witness your injury / illness? ❑ Yes ❑ No**

    If yes, list name(s) of witnesses

12. **Did you call Nurse Triage 877-764-3574 to report it? ❑ Yes ❑ No**

13. **Complete the online Preferred Provider Program Participation Election Form at www.dupage.org/HR/PPPAcknowledge/**

14. **Did you receive First Aid or Self -Treat? ❑ Yes ❑ No**

15. **If you received professional medical treatment for your injury / illness by a provider outside of the County WC PPP**

    list the doctor's name, phone number and address.

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PAIN DIAGRAM

NAME:_____TODAY'S DATE:_____

PLEASE COMPLETE THE FOLLOWING "*PAIN DIAGRAM*" BY USING LETTERS AT THE LEFT TO INDICATE ON THE DIAGRAM YOUR AREAS OF PAIN:

PAIN (P)
TINGLING (T)
NUMBNESS (N)
BURNING (B)
STIFFNESS (S)

SIGNATURE:_____