EMPLOYEE'S ACCIDENT REPORT

(TO BE FILLED OUT BY EMPLOYEE) (PRINT NEATLY OR TYPE)

Report Date: _____ Accident Date: _____ Time of Accident: _____

Name: _____ DOB _____

Home Address: _____ City: _____ State: _____ Zip: _____

Employee #: _____ Job Title: _____

Department No. and Name: _____ Supervisor: _____

Address/Specific Location of Accident: _____

Scheduled Days off ☐S ☐M ☐T ☐W ☐Th ☐F ☐S **(check days off)**

Complete Description of How the Accident Occurred: (Provide Details. Complete Reverse Side if Necessary):

Describe all parts of body injured:

Have you injured these body parts previously? _____ If so, when and how?

Did you receive medical treatment for those parts of your body? Yes ☐ No ☐ If yes, name of doctor(s), hospital and addresses.

Was the accident witnessed?_____ If yes, list all witnesses (Full name, title, relationship, if any, to witness)

Are you presently employed at another job?

If yes, list name and address of other employer.

Name and address of primary care physician.

I have read the above and the same is true and correct.

Signature: _____ Date: _____

Phone No.: (*work*) _____ (*home*) _____ (*cell*) _____

Personal Email: _____

Cook County Department of Risk Management Workers' Compensation Division
161 N. Clark St., Suite 2400B, Chicago, IL 60601
work.comp@cookcountyil.gov