EMPLOYEE'S INJURY REPORT

Claim No. _____

WCTI
WORKERS' COMPENSATION TRUST OF ILLINOIS

To enable the Company to give your case prompt attention in accordance with the compensation law, please complete this form in full and return it immediately in the enclosed envelope which does not require a postage stamp.

NAME OF EMPLOYER	HOW LONG HAVE YOU WORKED FOR THIS EMPLOYER?		
OCCUPATION WHEN INJURED	WERE YOU DOING YOUR REGULAR WORK?		
	WAGES WHEN INJURED (Per day, per week)		WORK DAYS PER WEEK
WERE YOU A TEMPORARY OR STEADY EMPLOYEE?	AGE	ARE YOU MARRIED?	NO. OF CHILDREN AND AGE OF EACH
IF UNDER 21 YEARS, GIVE NAME AND ADDRESS OF YOUR PARENT OR GUARDIAN			

DATE AND TIME OF INJURY	DATE AND TIME YOU WERE FORCED TO LEAVE WORK BECAUSE OF YOUR INJURY	
PLACE WHERE INJURY WAS SUSTAINED (No., Street, City or Town)		WERE YOU ON EMPLOYER'S PREMISES?
WAS INJURY CAUSED BY ANOTHER PERSON?	NAME OF OTHER PERSON	
WHO IS HE EMPLOYED BY?		
NAMES AND ADDRESSES OF EYE WITNESSES		

WHEN DID YOU FIRST REPORT YOUR INJURY?	TO WHOM DID YOU FIRST REPORT YOUR INJURY?
NAME OF YOUR DOCTOR	DOCTOR'S ADDRESS
HAVE YOU RETURNED TO WORK?	IF SO, WHAT DATE?

DESCRIBE YOUR INJURY AND HOW ACCIDENT HAPPENED

DATE OF THIS REPORT	SIGNATURE
EMAIL ADDRESS	PRINTED NAME
ADDRESS (No., Street, City or Town)	TELEPHONE NUMBER