TRISTAR®

WORKERS' COMPENSATION EMPLOYEE'S NOTICE OF INJURY (COMPLETE ALL ITEMS)

EMPLOYEE'S NAME: (last) (first)		
EMPLOYEE'S ADDRESS: (no.) (street)		
(city) (state) (zip)		TELEPHONE: Home: _____ Work: _____
SOCIAL SECURITY NO.	DATE OF BIRTH (mo) (day) (year)	SEX: ☐ Female ☐ Male
MARITAL STATUS: ☐ Married ☐ Single ☐ Widow(er) ☐ Divorced		NUMBER OF DEPENDENT CHILDREN UNDER 18 AT DATE OF INJURY _____
DATE OF INJURY OR ILLNESS (mo) (day) (year)	TIME: ☐ AM ☐ PM	LAST DAY WORKED:
NAME OF AGENCY	ADDRESS OF AGENCY	WORK COUNTY
REPORTED TO SUPERVISOR ☐ Yes ☐ No	NAME OF SUPERVISOR	DATE & TIME _____ _____ REPORTED (am) (pm) (mo) (day) (year)
IF NOT REPORTED ON DATE OF INCIDENT, EXPLAIN:		
HAVE YOU SOUGHTMEDICAL ATTENTION? ☐ Yes ☐ No	NAME, ADDRESS AND PHONE NO. OF DOCTOR:	
ANY SICK, VACATION OR PERSONALDAYS USED FOR THIS INJURY? ☐ Yes ☐ No	NUMBER AND TYPE	
HAS ANY INSURANCE COMPANY PAID FOR TREATMENT AS A RESULT OF THIS INJURY? ☐ Yes ☐ No	NAME AND POLICY NO.	
WHAT DUTY WERE YOU PERFORMING AT TIME OF INJURY? (BE SPECIFIC)		
PLACE WHERE INJURY OCCURRED (BE SPECIFIC)		
DETAIL HOW INJURY OCCURRED (USE REVERSE SIDE IF NECESSARY)		
DID A THIRD PARTY CAUSE OR CONTRIBUTE TO ACCIDENT? ☐ Yes ☐ No		
IF YES, EXPLAIN AND PROVIDE ADDRESS AND PHONE # OF NEGLIGENT PARTY (USE REVERSE SIDE IF NECESSARY):		
DESCRIBE INJURY (INDICATE PART(S) OF BODY AFFECTED)		
ANY WITNESS(ES) TO INJURY ☐ Yes ☐ No	IF YES, NAME(S):	
HAVE YOU SUBMITTED ANY PREVIOUS CLAIMS FOR INJURY/ILLNESS? ☐ Yes ☐ No (IF YES, IDENTIFY EACH ON REVERSE SIDE.)		
DATE THIS FORM COMPLETED _____ (mo) (day) (year)	SIGNATURE OF INJURED EMPLOYEE	
IF INJURED EMPLOYEE UNABLE TO SIGN ABOVE, SIGNATURE OF INDIVIDUAL COMPLETING THIS FORM		

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Reverse side must be completed if applicable before submission to Tristar

ADDITIONAL DETAILS HOW INJURY OCCURRED:

PREVIOUS INJURIES OR ILLNESSES

DATE(S) OF INJURY/ILLNESS	DESCRIBE INJURY/ILLNESS	WAS THIS WORKERS' COMPENSATION (YES OR NO)	NAME AND ADDRESS OF DOCTOR	IF YES, AMOUNT OF SETTLEMENT

ADDITIONAL DETAILS CONCERNING THIRD PARTY NEGLIGENCE

This is a written request for workers' compensation benefits as a result of the incident described therein.

Please fill out the form truthfully and accurately. Under Section 25.5 of the Illinois Workers' Compensation Act, it is unlawful for any person to intentionally make or cause to be made any false or fraudulent material statement or material representation for the purpose of obtaining any workers' compensation benefit. I have reviewed, understand and acknowledge the above statement.

Employee signature (if available to sign) _____ Date _____

Employer Signature _____ Date _____

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