

(A)

ILLINOIS COUNTIES RISK MANAGEMENT TRUST

**WORKERS COMPENSATION INCIDENT REPORT
(TO BE COMPLETED BY SUPERVISOR)**

DATE COMPLETED: _____

INJURED EMPLOYEE'S NAME: _____

DATE OF BIRTH: _____ DATE OF HIRE: _____

ADDRESS/LOCATION OF ACCIDENT: _____

DATE OF INCIDENT: _____ TIME OF INCIDENT: _____

TYPE OF INJURY: _____

LIST NAMES OF WITNESSES AT THE SCENE OF THE INCIDENT: _____

DESCRIBE IN DETAIL WHAT HAPPENED: _____

**This form must be completed by the supervisor immediately upon
learning of the incident**

revised 11/13/00