ORTHOPEDICS OF ILLINOIS
The Bone, Joint, & Sports Medicine Center

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American Board of Orthopedic Surgery
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Employee Work Injury Report Confirmation

Part I. Employee Information:

Name:			
Social Security #		Date of Birth	
Injury Description		Date of Injury	

Part II. The status of this claim is:

- ☐ Employer acknowledges claim as a work-related injury and assumes financial responsibility for the medical charges associated with the injury.
- ☐ Employer denies claim as a work-related injury and does not assume financial responsibility for the medical charges associated with the injury.
- ☐ Employee's claim is being reviewed.

_____
Signature of employer representative Date

_____
Print Name Telephone Number

Part III. Worker's Compensation Carrier Information
(please complete so that we can submit claims and release records and reports)

Carrier Name: _____

_____
Address Policy Number Claim Number

Address: _____

Telephone: _____ Fax: _____

This form is to be completed by the patient's employer and returned by ___/___/___ to:

Ortho IL Worker's Compensation Eligibility
2200 Ft. Jesse Rd., Ste. 250
Normal, IL 61761, or fax to 309-863-5923