THE UNIVERSITY OF CHICAGO | Human Resources

WC Form 100

Request for Evaluation and Treatment - Work Related Illness or Injury

PLEASE PRINT

Employee Name: _____ Date, Time of Injury/Illness: _____

SSN: _____ Department: _____ Phone: _____

Brief Description Injury/Illness: _____

Authorization is granted to ***University Occupational Medicine Clinic (UCOM)/UCMC Emergency Room*** to evaluate and treat the above-named employee. Please send a copy of this report, other reports and associated billing statement(s) to:

Leave Administration - 6054 S. Drexel Avenue Chicago, IL 60637
Email: leaveadministration@uchicago.edu

Dept. Supervisor/HR Administrator: _____
PRINT NAME SIGNATURE

Note: University Occupational Medicine Clinic (UCOM), Room D136 (behind the Adult ER) at 5841 S. Maryland Ave., Mail Code 7103 Hours: 7:30 am to 3:30 pm Mon - Fri.

At all other times, use the Adult Emergency Room at Mitchell Hospital.

UCOM/ER Report (or attach report)

Date, Time of Exam:

Subjective:

Objective:

Impression:

Plan:

Return to Work/Restrictions:

By: _____