ANTHONY J. PERAICA & ASSOCIATES, LTD.
5130 S. ARCHER AVENUE
CHICAGO, IL 60632
(773)735-1700

Today's Date: ______________________

INFORMATION FOR FILING CLAIMS UNDER THE ILLINOIS WORKERMEN'S COMPENSATION ACT

His or Her Name: ____

Home Address:

(Street address)____

(City, State, Zip)____

Telephone No.: ______________________ Fax No.: ______________________

Cell Phone No.: ______________________ Work No.: ______________________

E-mail Address: ______________________

Age (at time of Injury): ______________________ Birth Date: ______________________

Social Security No.: ______________________

Currently Married: Yes No Spouse's Name: _____________________________

List All Children Under 18 Years of Age at the Time of Accident:

Name	Age	Male	Female
1.			
2.			
3.			
4.			

Name & Address of Relative/Friend: ____

Phone Number of Relative/Friend: ____

Name of Employer at time of injury: ____

Employer's Address:

(street address)____

(City, State, Zip)____

How long Employed: ______________________

Still working for this Employer: Yes No

Gross Weekly Wage: ______________________

Hourly rate of pay: ______________________

Hours per week: ______________________

Were you given any pre or post-employment exams, tests, or drug screen? Yes No

Explain: ____

____

Date of Injury (Day or week & date): _________________________ Time: ____________

When did you return to work: ____

Location of Accident (city & state): ____

Name of workman's Compensation Insurance

Carrier: ____

Part of Body Injured (Indicate right or left where applicable):

____

Will you need an interpreter to appear with you in court? Yes No Language: ___________

Have you received any written offers from workers' compensation insurance company?

Yes   No

If a written offer was made, how much and at what percentage of the body part? Please provide a copy of letter to the office.

____

Are you or have you been represented by another attorney in this proceeding?

Yes: _______ No: ________   Name & address of attorney: ________________________

ACCIDENT: Describe how the accident happened and what part or parts of your body were injured:

____

____

____

____

____

To whom did you report your accident? What was his/her position with the employer (foreman, nurse, personnel or others)?

____

When: ____

Did you lose any time from work because of this injury? Yes   No

If yes, how much? ____

Is Total Temporary Disability rate correct? Yes   No   Explore

Is Total Disability owed? Yes   No   Explore

Treatment: Give the names & addresses of the Doctors you have seen for this injury.

Name Address Phone No. Company Doctor

____ Yes No

____ Yes No

____ Yes No

____ Yes No

Did you go to any hospitals because of this injury? Yes No

Name of Hospital Address Emergency Room Only?

____ Yes No

____ Yes No

____ Yes No

____ Yes No

More than one stay? Yes No

If yes, please explain: ____

____

____

Do you have any broken bones from this accident? Yes No

Where? ____

What did the doctor(s) say was wrong with you? ___________________________________

Were you placed on light duty? Yes No

What type of light duty and how long?

____

____

What was the nature of your treatment?

Surgery: ____

X-rays: ____

Cast: ____

Brace: ____

Physiotherapy: ____

Other: ____

____

What type of home treatment do you provide for yourself?

____

____

Do you have any complaints of disability to any part of your body, scarring, or both?

Yes No

Where? ____

Are you released from active medical care? Yes No

If not, from which doctor are you still receiving active treatment?

____

____

Have you had any injury prior to or since this accident? Yes   No

If yes, please explain:

____

____

____

Were you taking any medication-prescription or otherwise within 24 hours prior to the accident? Yes   No

If so, what?

____

____

Bills: Did you pay any medical bills or do you owe any bills because of this accident?

Yes   No   If yes, explain: ____

____

____

Did you have any other source of income at the time of the accident? Yes   No

If so, what source?

____

If so, did the employment with whom you were injured know of the concurrent employment and if so, when?

____

Is there a possible third party action? Yes   No

Is there a possible Wage Loss Differential Claim?   Yes   No   Possible

Who referred you to this office? ____

Were you given an Industrial Commission Information Handbook by your employer?
Yes No

Have you ever filed a previous Workers' Compensation Claim in Illinois? Yes No

If yes, please provide case number: ______________________________

That the information provided on this questionnaire is true and accurate to the best of my knowledge.

______________________________ ______________________________
Signature Date

Attach copies of following (if available): Driver's License, Social Security Card, Business cards from all treating doctors, pharmacies, and health care providers visited.

Additional Notes:

____

____

____

____

____

____

____

____

____

____

ILLINOIS WORKERS' COMPENSATION COMMISSION
ATTORNEY REPRESENTATION AGREEMENT

____ Case # ______ WC ________________

Employee/Petitioner

v.

____

Employer/Respondent

I, ____ , "client," retain __________________________________ ,

"attorney," to prosecute and/or settle any disputed claims for benefits under the Illinois Workers' Compensation Act or

Occupational Diseases Act against ____ , "employer," for injuries arising

out of and in the course of employment of ____ on _________________ .

If the client has received a written offer from the employer or its agent to pay a specific amount of compensation for any permanent disability caused by these injuries, the client has given the attorney a copy. The client and attorney each have a copy of that agreement, signed by both of them.

In return for representation before the Commission, the client agrees to pay the attorney a sum of money equal to:

A. 1. _____ % of any amount received in excess of the written offer, if any, or ______ % (not to exceed 20%) of the total amount received for compensation for permanent disability caused by the accident, whichever is less; provided, however, if the compensation received for permanent disability does not exceed the written offer, the attorney shall receive no fee for permanent disability; or

2. $ ________ (not to exceed $100) if the respondent does not dispute its liability, the proper amount is paid timely, the client does not receive more than that specified by law, and the accident resulted in any of the following: death of the employee; amputation of one or more fingers, toes, or body parts; removal of a testicle; enucleation or 100% loss of vision in an eye; fracture of one or more vertebra, spinous or transverse process, or facial bones; fracture of a skull; removal of a kidney, spleen, or lung; and

B. _____ % (not to exceed 20%) of any compensation for temporary total disability that the employer refused to pay in a timely manner or in the proper amount; and

C. _____ % (not to exceed 20%) of all disputed medical bills; and

D. In addition to the above, all costs and expenses of advocating the above claims.

No settlement shall be made without the consent of the client. There will be no charge unless recovery is made.

If the client terminates this agreement before recovery, the client will pay the attorney a reasonable fee, as determined by the Workers' Compensation Commission, from the subsequent recovery (not to exceed the amounts listed in A-C above) plus any unpaid expenses related to advocating the claim up to the date the agreement ended.

This agreement is governed by the Illinois Workers' Compensation Act, Section 16a, particularly in regard to the limitation of attorneys' fees in death, permanent total disability, and permanent partial disability cases.

The attorney states that he or she has explained each provision of this agreement to the client. The client states that he or she has read and understands this agreement, and has received a copy of this agreement on ____________________ .

______________________________	______________________________
Signature of client	Signature of attorney
______________________________	______________________________
Name of client (please print)	Name of attorney and IC code number (please print)
______________________________	______________________________
Street address	Name of law firm
______________________________	______________________________
City State Zip code	Firm's address

ADDENDUM TO FEE AGREEMENT AND DISCLOSURE

___________________________________,	)	
	)	
Petitioner	)	
	)	
v.	)	Date of Accident:
	)	
	)	____________________, 20__
___________________________________,	)	
	)	
Respondent.	)	

This document is intended by the parties to be a supplement to the Workers' Compensation Attorney Representation Agreement executed by the parties in this matter on the ____ day of __________, 20__. It is intended by the parties to express their intention regarding attorneys' fees to be shared among co-counsel.

The undersigned attorney retains the authority to hire other counsel in preparation, prosecution, and trial of this matter.

In the event that the undersigned attorney retains a co-counsel in the matter herein, attorney hereby makes the disclosure that the attorney fees will be shared with co-counsel on a 50/50 split.

The client hereby consents to the hiring of co-counsel and to the fee-sharing of the attorney fees.

Dated: _______________, 20__

____
Client

____
Attorney

ILLINOIS WORKERS' COMPENSATION COMMISSION
APPEARANCE OF REPRESENTATIVE

Please see the other side of this form.

____ Case # _____ WC ____________

Employee/Petitioner

v.

____

Employer/Respondent

I hereby enter my appearance as counsel ___ co-counsel ___ for the petitioner ___ respondent ___ .

____

Signature of attorney

____

Attorney's name and IC attorney code # [1] (please print)

____

Telephone number E-mail address

____

Name of respondent's insurance/service company (please print)

____

Firm's name

____

Street address

____

City, State, Zip code

ATTENTION, ATTORNEY. A co-counsel appearance must be accompanied by a copy of the original *Attorney Representation Agreement* with the co-counsel's signature. Please indicate where the Commission should send notices:

___ Name and address listed above

____

____

____

PROOF OF SERVICE

If the person who signed the *Proof of Service* is not an attorney, this form must be notarized.

I, ______________________________ , affirm that I delivered _____ mailed with proper postage _____

in the city of ______________________________ a copy of this form

at __________ on ______________ to each party at the address(es) listed below.

____

Signature of person completing *Proof of Service*

Signed and sworn to before me on ________________

____

Notary Public

[1] The Commission assigns code numbers to attorneys who regularly appear before it. To obtain or look up a code number, contact the Information Unit in the Chicago office or any of the downstate offices at the telephone numbers listed below.

REJECTION OF APPEARANCE

Date ___________________________

To: ____

____

____

Your appearance has been rejected for the following reason(s):

_____ No case number is listed.

_____ The wrong case number is listed.

_____ You did not attach the *Attorney Representation Agreement*. This is required for a petitioner's counsel.

_____ You did not provide a copy of the original *Attorney Representation Agreement* with your signature. This is required for a petitioner's co-counsel.

_____ Proof of service was not provided.

_____ You did not indicate where notices should be sent.

_____ Another attorney is listed as counsel, and he or she has not withdrawn or been dismissed.

_____ Other: ____

____

____

If you have questions, please contact any Commission office. Return the corrected form to:

DATA ENTRY UNIT
ILLINOIS WORKERS' COMPENSATION COMMISSION
100 W. RANDOLPH STREET #8-200
CHICAGO, IL 60601

ILLINOIS WORKERS' COMPENSATION COMMISSION
APPLICATION FOR ADJUSTMENT OF CLAIM (APPLICATION FOR BENEFITS)

ATTENTION. Please type or print. Answer all questions. File three copies of this form.

Workers' Compensation Act ___ Occupational Diseases Act ___ Fatal case? No ___ Yes ___ Date of death __________

____
Employee/Petitioner

v.

____
Employer/Respondent

Case #
(Office use only)

Location of accident ________________________
or last exposure City, State

____
Injured employee's name [1] Street address City, State, Zip code

____
Employer's name Street address City, State, Zip code

Employee information: Social Security # _________________ Male ____ Female ____ Married ____ Single ____

Dependents under age 18 ______ Birthdate _____________ Average weekly wage $ ______________

Date of accident [2] _____________________ The employer was notified of the accident orally ____ in writing ____.

How did the accident occur? ____

What part of the body was affected? ____

What is the nature of the injury? ___________________________ Return-to-work date [3] ________________

Is a *Petition for an Immediate Hearing* attached? Yes ____ No ____

Is the injured employee currently receiving temporary total disability benefits? Yes ____ No ____

If a prior application was ever filed for this employee, list the case number and its status ______________________________

ATTENTION, PETITIONER. This is a legal document. Be sure all blanks are completed correctly and you understand the statements before you sign this. Refer to the Commission's *Handbook on Workers' Compensation and Occupational Diseases* [4] for more information.

____
Signature of petitioner

____
Date

APPEARANCE OF PETITIONER'S ATTORNEY

Please attach a copy of the *Attorney Representation Agreement*.

____
Signature of attorney

____
Attorney's name and IC code # [5] (please print)

____
Firm name

____
Street address

____
City, State, Zip code

____
Telephone number

____
E-mail address

Disclosure of this information to the Commission is done voluntarily under 820 ILCS 305/6(b).

PROOF OF SERVICE

If the person who signed the *Proof of Service* is not an attorney, this form must be notarized.
If you prefer, you may submit the front of this application form with the *Proof of Service* on a separate page.

I, ________________________________ , affirm that I delivered _____ mailed with proper postage _____

in the city of _________________________________ a copy of this form

at _________ on _______________ to the respondent listed on this application and to each

additional party, if any, at the address listed below.

____
Signature of person completing *Proof of Service*

Signed and sworn to before me on ________________

____
Notary Public

[1] In most cases, the injured employee files this application and is referred to as the petitioner. If the injury was fatal, or if the worker is a minor or incapacitated, another person (as allowed by law) may file. In those cases, the person filing the application is the petitioner, and the worker is referred to as the injured employee. Please complete information related to age, etc., for the injured employee.

[2] This may be the date of the accident, last exposure, disability, or death.

[3] If the employee has not returned to work, leave this space blank.

[4] The Commission publishes a handbook that explains the workers' compensation system. If you would like a copy, please call any of the Commission offices listed on the other side of this form.

[5] The Commission assigns code numbers to attorneys who regularly practice before it. To obtain or look up a code number, contact the Information Unit in Chicago or any of the downstate offices at the telephone numbers listed on this form.

ILLINOIS WORKERS' COMPENSATION COMMISSION
STIPULATION TO SUBSTITUTE ATTORNEYS

ATTENTION, PETITIONER: please attach a copy of the *Attorney Representation Agreement*.

____ Case # _____ WC _______________

Employee/Petitioner

v.

____

Employer/Respondent

I, ______________________________________ , want the attorney, ____________________________________ , to appear on my behalf in this case.

____
Signature of petitioner or respondent

I hereby withdraw as the attorney for the above party.

____
Signature of attorney

____
Name of attorney and IC attorney code # (please print)

____
Name of law firm

I hereby enter my appearance as the attorney for the above party.

____
Signature of attorney

____
Name of attorney and IC attorney code # (please print)

____
Street address

____
City, State, Zip code

____
Date