

**LEONARD LAW GROUP, LLC.
300 SOUTH ASHLAND AVENUE – SUITE 101
CHICAGO, ILLINOIS 60607
Tel. (312) 226-8273
Fax. (312) 226-8274**

WORKERS COMPENSATION PACKET

CLIENT INFORMATION

Name _____ M / F

Street _____ City _____ State _____

Zip Code _____ DOB _____ Social Security No. _____

Home Phone _____ Cell Phone _____

Email Address _____ Marital Status M S W

Name and Age of Children Under 18

Current Attorney _____

Who Referred You To LLG _____

EMPLOYMENT INFORMATION

Employer _____

Employer's Phone Number _____

Street _____ City _____ State _____ Zip _____

Union _____ Business Agent _____ Steward _____

Type of Trade _____ Hourly Pay/Salary _____

Work Schedule _____ Working Full Duty _____

ACCIDENT INFORMATION

Accident Date _____ Location (City) _____

Employer Notified _____ Date Employer Notified _____

Employer Contact Notified _____

Accident Witnesses _____

Description of Bodily Injuries _____

Description of Accident _____

Prior Injuries to Same Body Parts _____

If Yes, When _____

Type of Prior Treatment Received _____

Did you file a Comp Claim for the Prior Injury _____

INSURANCE INFORMATION

Workers' Compensation Insurance Co. _____

Street _____ City _____ State ____ Zip _____

Claims Adjuster _____ Phone No. _____

Claim No. _____ Receiving TTD _____ Weekly TTD Rate _____

Nurse _____ Phone No. _____

Are Medical Bills Being Paid _____

MEDICAL CHRONOLOGY

PETITIONER'S CHOICE

1. Emergency Room

Treatment _____

2. Family Doctor/Primary Care

Treatment _____

3. Orthopedist/Specialist

Treatment _____

4. Neurologist/Neurosurgeon

Treatment _____

5. Therapist

Treatment _____

COMPANY'S CHOICE

1. Emergency Room

Treatment _____

2. Orthopedist Specialist

Treatment _____

3. Neurologist / Neurosurgeon

Treatment _____

4. Therapist

Treatment _____

LOST TIME FROM WORK

Dates authorized off work _____

Are you on light duty work status and not offered work _____

Date of Next Doctor Visit _____ Return to Work Date _____

THIRD PARTY CASE

Did a third party contribute (not a co-employee) to your accident

General Contractor on Site _____

Sub Contractor(s) on Site _____

Project Location _____

Description of Accident _____

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 Case # _____
 v. (Office use only)

 Employer/Respondent 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

 Street address

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

 City, State, Zip code

 Firm name

 Telephone number E-mail address

**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. 50 % of any amount received in excess of the written offer, if any, or 20 % (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. \$ 100 (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. 20 % (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. 20 % (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 _____. It is further agreed by and between the parties that this agreement is not intended to apply to appeals beyond the Industrial Commission. A further agreement will be executed at the time of such appeal.

X

Signature of client

Signature of attorney

Name of client (please print)

Name of attorney and IC code # (please print)

Street address

Name of law firm

City, State, Zip code

Firm's address

LEONARD LAW GROUP, LLC.
300 SOUTH ASHLAND - SUITE 101
CHICAGO, ILLINOIS 60607
(312) 226-8273

WORKERS' COMPENSATION RETAINER AGREEMENT

I HEREBY AGREE TO RETAIN *LEONARD LAW GROUP, LLC.*, AS MY ATTORNEY(S) TO REPRESENT ME ON MY WORKERS' COMPENSATION CLAIM OR ANY OTHER CLAIMS THAT I MAY HAVE BASED ON THE INFORMATION I GAVE HIM/THEM FOR ANY ACCIDENT, ILLNESS OR DEATH WHICH TOOK PLACE ON OR ABOUT _____, 20__.

I FURTHER AGREE TO PAY AND/OR REIMBURSE MY ATTORNEYS FOR ALL REASONABLE EXPENSES INCURRED IN REPRESENTING MY INTERESTS RELATIVE TO THE ABOVE WORKERS' COMPENSATION CLAIM.

IT IS FURTHER AGREED THAT NO SETTLEMENT WILL BE MADE WITHOUT THE CONSENT OF THE CLIENT AND THERE WILL BE NO CHARGE FOR LEGAL SERVICES RENDERED UNLESS RECOVERY IS MADE.

I HEREBY GIVE AND GRANT TO *LEONARD LAW GROUP, LLC.*, FULL POWER AND AUTHORITY TO DO AND PERFORM ALL AND EVERY ACT AND THING WHATSOEVER INCLUDING EXECUTING DRAFTS AND RELEASES NECESSARY TO BE DONE IN CONNECTION WITH THIS CASE AS FULLY, TO ALL INTENTS AND PURPOSES AS I MIGHT OR COULD DO IF PERSONALLY PRESENT, HEREBY RATIFYING AND CONFIRMING ALL THE SAID ATTORNEY(S) SHALL LAWFULLY DO OR CAUSE TO BE DONE BY VIRTUE HEREOF.

I/WE AGREE TO PAY *LEONARD LAW GROUP, LLC.*, 20% OF ANY PPD ADVANCES OR DISPUTED COMPENSATION OF TTD BENEFITS THAT THE EMPLOYER REFUSED TO PAY IN A TIMELY MANNER OR IN THE PROPER AMOUNT.

I/WE AGREE TO PAY *LEONARD LAW GROUP, LLC.*, AS COMPENSATION FOR THEIR SERVICES OUT OF MY MONEY REALIZED FROM SAID CLAIMS A SUM EQUAL TO 20% OF THE GROSS AMOUNT BY SETTLEMENT OR AWARD BY THE ILLINOIS WORKERS' COMPENSATION COMMISSION.

IF AN APPEAL OF THIS CASE IS TAKEN TO THE CIRCUIT COURT OR APPELLATE COURT, THEN THE ATTORNEYS' FEES SHALL BE EQUAL TO 33 1/3% OF THE GROSS AMOUNT RECOVERED.

X

[REDACTED]

X

[REDACTED]

LEONARD LAW GROUP, LLC .

DATE

AUTHORIZATION TO RELEASE PATIENT INFORMATION

SECTION I

Patient's Name: _____ Birthdate: _____
Street Address: _____ Social Security #: _____
City, State, Zip: _____ **Date of Accident:** _____

SECTION II

The undersigned hereby authorizes and requests the Administrative Director of Medical Records and/or his or her designee of:

to disclose and furnish this requested information to the person or facility listed below. The potential for this information to be re-disclosed by this person or facility exists and will not be protected by applicable federal and state laws governing the use and release of my health information:

**LEONARD LAW GROUP, LLC.
300 SOUTH ASHLAND, SUITE 101
CHICAGO, IL 60607**

SECTION III

1. Dates of Service: From ALL To PRESENT
2. Purpose of disclosure (please specify): Workers' Compensation
3. Revocation/Expiration. This authorization is valid until 09/30/2010 (Include Month, Day, Year) Without expressed written revocation, this authorization expires 90 calendar days after it is signed.
4. Information Requested Includes:

<input checked="" type="checkbox"/> Physician Progress Notes	<input checked="" type="checkbox"/> Operative Reports	<input checked="" type="checkbox"/> Nursing Notes
<input checked="" type="checkbox"/> Discharge Summary	<input checked="" type="checkbox"/> Lab/Pathology Results	<input checked="" type="checkbox"/> Outpatient Records
<input checked="" type="checkbox"/> Radiology Reports	<input checked="" type="checkbox"/> Therapy Records	<input checked="" type="checkbox"/> Billing Records
<input checked="" type="checkbox"/> Emergency Room Records		
<input checked="" type="checkbox"/> Hospitalization Records	<input checked="" type="checkbox"/> Immunization Records	
<input checked="" type="checkbox"/> Other _____	ITEMIZED BILLS	
5. By checking the boxes below, you authorize the release of the following information:

<input checked="" type="checkbox"/> Psychiatric/mental illness (Parent/Guardian co-signature is required for the release of psychiatric information of patients ages 12-17 years old.)		
<input checked="" type="checkbox"/> AIDS/related illness	<input checked="" type="checkbox"/> HIV Test Results	<input checked="" type="checkbox"/> Genetic Testing
<input checked="" type="checkbox"/> Alcohol/Drug Treatment		

SECTION IV

X _____ X _____
Patient Signature (Parent/Guardian/Authorized Signature) Date

Authority to sign, if not the Patient (if other than patient, state relationship; if personal representative, describe your authority to act for this patient.)

RECORDS TO BE **MAILED** **PICKED UP**

AUTHORIZATION TO RELEASE PATIENT INFORMATION

SECTION I

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City, State, Zip: _____ **Date of Accident:** _____

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