CITY OF SYCAMORE

WORKERS' COMPENSATION POLICY

UPDATED
JANUARY, 2016

CITY OF SYCAMOREWORKERS

COMPENSATION POLICY

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INSTRUCTIONS FOR COMPLETING ILLINOIS FORM 45, FIRST REPORT OF INJURY

REPORTING OF CLAIMS:

All injuries/illnesses must be reported to the employee's supervisor by the end of the work shift. **The completed Form 45 must be submitted to Human Resources within 48 hours of the injury/illness.** Prompt reporting will result in immediate investigation and faster claims payment.

HOW TO COMPLETE THE EMPLOYER'S FIRST REPORT OF INJURY:

The First Report of Injury provides an official recording of a Worker's Compensation claim. Be precise in completing the form; relate the accident/injury as described by the claimant. Make no evaluations, assumptions, or subjective remarks on the Form 45. The following instructions apply to the completion of the Form 45, First Report of Injury:

1. Forms must be timely and accurate.
2. Forms should not be completed by the injured employee.
3. In describing the accident, use the following form: "Employee states that "– then describe the accident. Most accidents can be described in one or two sentences and should answer the following questions:
   - **What part of the body was injured?**
     The injury description must include the part of the body, such as cut right ring finger, sprained left ankle, or bruised head. Do NOT use adjectives such as deep, severe, awful, etc. to describe the injury. Also indicate what injury appears to have resulted. A sample injury description may be: "Fall caused bruise to left hip and sprain of the right ankle".
   - **How did the accident happen?**
     The accident description should contain an action verb describing how the injury occurred, such as "fell from," "slipped on," or "crushed by." Also be sure to note if the employee was carrying anything when the accident occurred and note if they were wearing safety gear and/or following safety procedures, such as "the employee was wearing his seatbelt."
   - **What specifically appears to have caused the accident?**
     - If someone hurt their back lifting a box, say that. Don't say "lifting a unit of material" or "hurt back lifting equipment".
     - Avoid jargon or trade names for equipment. If a machine caused the injury, indicate what kind.
     - Explain precisely what the employee was doing, such as "lifting an air conditioner", "pushing a cart", "carrying files" or "bending over to pick up a wrench".
   - **Where did the accident happen?**
     Indicate the geographical location of the accident.

CALL HUMAN RESOURCES WITH ANY QUESTIONS when FILLING OUTFORM

CITY OF SYCAMORE
WORKERS' COMPENSATION POLICY
INFORMATION /FORMS

IF YOU SUFFER FROM A WORK-RELATED INJURY OR ILLNESS, YOU SHOULD TAKE THE FOLLOWING STEPS:

1. Seek immediate medical attention.

The City of Sycamore has retained the services of Physician's Immediate Care, 2496 DeKalb Avenue, Sycamore (815) 754-1122, to assist us with injuries or illnesses sustained on the job. Kishwaukee Corporate Health can treat all minor injuries; serious injuries should be treated in the emergency room at Kishwaukee Hospital.

While the employee may be advised to obtain treatment from a doctor or hospital selected by the employer, by law, an employee may choose any doctor or hospital for treatment. It is the employer's responsibility to pay for all first aid and emergency services, two treating physicians, surgeons, or hospitals of the employee's choice, and any additional medical care providers to whom the employee is referred by the two physicians, surgeons, or hospitals. **NOTE: please inform your medical provider that this is a work injury and to bill the City's Workers' Compensation Insurance Carrier**; **do not use your group medical insurance card for these charges.**

Thereafter, the employee must obtain the employer's/insurance's approval of additional doctors or services. If the medical provider is not approved, the employer is not required to pay for their services and it may ultimately fall to the employee/patient.

If your injury requires that you obtain a prescription medication, **DO NOT USE YOUR BLUE CROSS PRESCRIPTION CARD WHEN FILLING THIS MEDICATION.** You can either:

- Pay for the entire cost of the prescription up front. You will need to turn in to Human Resources both the prescription information label given to you by your pharmacist and the cash register receipt that shows that you paid for the medication. These two items will be sent CCMSI (the agency that processes the City's workers' compensation claims) who, in turn, will send you a check to reimburse you for this expense.
- Use the prescription card that will be sent to the injured employee by CCMSI approximately one week after a claim is filed with them. This card should only be used to fill prescriptions that are associated with the work comp injury.

Employees must have the *Authorization to Treat* form completed by the attending physician. The completed form must be turned into Human Resources, along with the *First Report of Illness or Injury* and other applicable forms (see item #2). Injured employees must provide their supervisors with written documentation of their medical evaluation and treatment, whether they are released for full or

limited duty, and when any follow-up appointments are scheduled. This documentation is required after each follow-up visit with the medical provider. This documentation will be given to Human Resources, who will forward it on to the insurance carrier.

2. Employees must report all work-related injuries or illnesses immediately – no later than the end of the work shift – to the respective supervisor regardless of the degree of illness or injury.

The **employee's supervisor** must complete Illinois Form 45 – *Employers First Report of Illness or Injury* – both front and backsides. To avoid possible delays, the supervisor must ensure that the employee's name, address, telephone number, Social Security number, and a description of the illness or injury are clearly stated on the form.

The **employee** will need to complete the *Employee's Statement of Work Related Illness or Injury*.

The completed forms must be sent to Human Resources **within 48 hours of the incident** so they can be submitted to CCMSI. All medical bills should be sent to the City of Sycamore, Human Resources Department. Human Resources will forward them on to CCMSI for processing.

The employee must inform the employer promptly of any injury or work-related illness – **even if the injury does not require medical attention**. Any delay in the notice to the employer can delay, or even cause the loss of, the payment of benefits**.** ***Notice to a fellow employee who is not a part of management is not considered notice to the employer.***

NOTE: employees who sustain back or shoulder injuries must undergo a fitness for duty examination before they can return to work.

3. Notify Payroll of any work time lost due to the illness or injury.

If time lost is 3 days or less, the employee should report this on his/her time sheet as regular time, with a notation as to how many regular hours paid were for the workers' comp injury.

Workers' compensation will pay a benefit of 66 2/3 of the employee's gross average weekly wage (for the past 12-month period) beginning with the fourth day of lost time, which is retroactive back to the date of the injury if the employee misses more than 14 days of work. The employee should continue to report this as regular time on his/her time sheet (with a notation that this is work comp related), as he/she will continue to receive his/her regular paycheck (for up to 12 months). *Any payments for wages received by the employee from CCMSI must be signed over to the City of Sycamore.*

4. Keep Human Resources informed about on-going medical treatment.

The treating physician must provide the employee with a written release that will permit the employee to return to his/her normal duties. *The employee will not be allowed to return to work without this written release.*

If the treating physician places the employee on alternate productive duty, the employee must submit a request for this duty to his/her Department Head; a request form is included with this policy. *If there is alternate productive duty available and the employee has been assigned to it,* he/she must obtain a written statement after each follow-up examination with the treating physician detailing the following information:

a. The length of time the employee is to remain on restricted duty;
b. The exact nature of the work that the employee can or cannot perform;
c. The date of the next scheduled reexamination to determine any change in the employee's physical status.

5. Work Comp injuries that require an employee to miss more than one day of work will be applied to an eligible employee's Family and Medical Leave Act (FMLA) time.

The Family and Medical Leave Act is intended to provide job and benefit protection for eligible employees who must take certain types of leave. Employees eligible for FMLA may take up to twelve weeks of unpaid leave during a leave year. While work comp leave is paid leave, the law allows for it to run concurrently with FMLA time. The leave year will be measured backward from the date the employee uses any FMLA leave. Each time the employee takes FMLA leave, the remaining leave entitlement will be the balance of the twelve weeks that has not been used during the immediately preceding twelve months.

If medically necessary, employees may take intermittent leave or leave on a reduced leave schedule.

The City will inform the employee in writing within two days of Human Resources being notified of the injury that the employee's work comp leave will also be designated as FMLA leave.

ILLINOIS INDUSTRIAL COMMISSION

100 West Randolph Street, #8-200
Chicago, IL 60601
(312) 814-6611

202 N.E. Madison Avenue, #201
Peoria, IL 61602
(309) 671-3019

200 South Wyman
Rockford, IL 61101
(815) 987-7292

4500 S. Sixth Street, Frontage Road
Springfield, IL 62703
(217) 785-7087

CANNON COCHRANE MANAGEMENT SERVICES, INC. (CCMSI)

910 W. Van Buren Street, #406
Chicago, IL 60607-1609
Phone: (866) 908-9230
FAX: (312) 455-6477

Physician's Immediate Care
2496 DeKalb Avenue
Sycamore, IL 60178
Phone: (815) 754-1122
FAX: (815) 787-3678
Hours: Monday – Friday: 8 am to 8 pm
Saturday and Sunday: 8 am to 5 pm

CITY OF SYCAMORE

Maggie Peck
Human Resources
(815) 895-0786

ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

Please type or print

Employer's FEIN *36-6006121*	**Date of report**	**Case or file #**	**Il this a lost workday case?**	
Employer's name *City of Sycamore*		**Doing business as**		
Employer's mailing address *308 W. State Street*		**City** *Sycamore*	***State*** *IL*	***Zip code*** *60178*
Nature of Business or Service *Municipality*			**SIC Code**	
Name of Workers' Compensation Carrier/Admin. ***IML / CCMSI***		**Policy/Contract #** ***1287D0579***	**Self Insured?** **YES ☑**	
Employee's full name		**Social Security #**	**Birth date**	
Employee's street address		**City**	**State**	**Zip code**
Male ❑ Female ❑	**Married ❑** **Single ❑**	**# Dependents**	**Employee's average weekly wage**	
Job Title or Occupation			**Date hired**	
Time employee began work	**Date and time of accident**		**Last day employee worked**	
If the employee died as a result of the accident, give the date of death		**Did the accident occur on the employer's premises?** **Yes ❑ No ❑**		
Address of accident		**City**	**State**	**Zip code**
What was the employee doing when the accident occurred?				
How did the accident occur?				
What was the injury or illness? List the part of body affected and explain how it was affected.				
What object or substance, if any, directly harmed the employee:				
Name and address of physician/health care professional		**City**	**State**	**Zip code**
If treatment was given away from the worksite, list where it was given		**City**	**State**	**Zip code**
Was the employee treated in an emergency room?		**Was the employee hospitalized overnight as an inpatient?** **Yes ❑ No ❑**		
Report prepared by	**Signature**		**Title and telephone #**	

CITY OF SYCAMORE
AUTHORIZATION TO TREAT

Send bills to:
Human Resources Department
City of Sycamore
308 W. State Street
Sycamore, IL 60178

Workers' Compensation Carrier:
CCMSI
910 West Van Buren Street, Suite 406
Chicago, IL 60607-1609
(866) 908-9230
Policy # 1287D0579

To: Doctor: _____
Hospital: _____
Other: _____

By: _____ Time: _____ A.M/P.M. Date: _____
(Supervisor)

The following employee was injured at work on _____. Please given them the necessary medical attention . *(date)*

For: _____ Date of Birth: _____
(Employee)

Please check one box:
☐ **First Visit** ☐ **Return for Treatment**

Dear Doctor:

Please complete the following and return this form to the employee so that he/she may return the original to the City of Sycamore, Human Resources Department, 308 West State Street, Sycamore, IL 60178.

Please check one:

The employee:

☐ Can return to work
☐ Cannot return to work
☐ Can return to alternate productive duty for ____hours each day.

If the employee cannot return to work, or may only work alternate productive duty, please give approximate date employee can return to full duties: _____

Date employee to return to the doctor: _____

Doctor's comments/diagnosis: _____
_____
_____

Doctor's signature: _____ Date: _____

If you have any questions, please contact:

Maggie Peck, Human Resources
City of Sycamore
308 W. State Street
Sycamore, IL 60178
(815) 895-0786

IMLRMA

EMPLOYEE'S ACCIDENT REPORT

TO THE EMPLOYEE: *This report must be completed by you as soon as possible after your injury. Read the questions carefully and make your answers complete and accurate.*

RETAIN ONE COPY IN ORIGINATING DEPT. – SEND TWO COPIES TO YOUR MUNICIPAL RISK MANAGEMENT COORDINATOR

EMPLOYEE'S PERSONAL INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE NAME:
STREET ADDRESS:		
CITY:	STATE:	ZIP:
HOME PHONE:	CELL PHONE:	WORK PHONE:
DATE OF BIRTH:	GENDER:	SOCIAL SECURITY #:
JOB TITLE:		YEARS ON JOB:
SUPERVISOR:		

INCIDENT INFORMATION

DATE OF INJURY:	TIME OF INJURY: A.M. ❑ P.M. ❑	DID YOU IMMEDIATELY REPORT YOUR INJURY TO YOUR SUPERVISOR? YES ❑ NO ❑
IF YES, *WHEN ?* (indicate date and time)		

IF YOU DID NOT IMMEDIATELY REPORT YOUR INJURY TO YOUR SUPERVISOR, PLEASE STATE REASON:

LOCATION WHERE INJURY OCCURRED:

DESCRIBE WHAT HAPPENED TO CAUSE YOUR INJURY:

WHAT IS THE NATURE OF YOUR INJURY? (*specifically, what parts of your body have been injured*)

WITNESSES (PEOPLE PRESENT AT THE TIME OF INJURY OR INCIDENT): YES ❑ NO ❑

NAME:	PHONE:
NAME:	PHONE:
NAME:	PHONE:

HAVE YOU PREVIOUSLY HAD A SIMILAR INJURY AND/OR AN INJURY TO THE SAME BODY PART(S)? PLEASE EXPLAIN.

ADDITIONAL COMMENTS:

EMPLOYEES SIGNATURE:	DATE:
SUPERVISOR'S SIGNATURE:	
RISK MANAGEMENT COORDINATOR SIGNATURE:	
DATE OF MEETING:	

RETAIN ONE COPY IN ORIGINATING DEPT. – SEND TWO COPIES TO YOUR MUNICIPAL RISK MANAGEMENT COORDINATOR

SUPERVISORS ACCIDENT INVESTIGATION

The unsafe acts of people, and the unsafe conditions that cause accidents, can be corrected only when they are known specifically. It is your responsibility to **identify** them and **correct** them. This report and investigation **should be completed within 24 hours of the accident**. The employee involved and his/her supervisor should cooperate to complete **all** the information requested. Please use additional paper as necessary.

Name Of Municipality CITY OF SYCAMORE		Department	
Exact Location		Date Of Occurrence	Time ☐ A.M. ☐ P.M. / Date Reported

INJURY OR ILLNESS		PROPERTY DAMAGE	OTHER INCIDENT	
Employee/Insured Name		Property Damaged	Person Reporting Incident	
Occupation	Part Of Body Affected?	Owned By	Occupation	Cost (If Applicable)
Nature Of Injury-Illness		Nature Of Damage	Nature Of Incident	
Object-Equipment-Substance Inflicting Injury /Illness		Object-Equipment-Substance Inflicting Damage	Object-Equipment-Substance Related	
Person With Most Control Of Object Etc.		Person With Most Control Of Object Etc.	Person With Most Control Of Object Etc.	

DESCRIPTION

Describe Clearly How The Incident Occurred

Witnesses – Phone Numbers

ANALYSIS

What Acts/Failure To Act And/Or Conditions Contributed Most Directly To This Incident?

What Are The Basic Or Fundamental Reasons For The Existence Of These Acts And/Or Conditions?

EVALUATION	LOSS SEVERITY POTENTIAL	PROBABLE RECURRENCE RATE
	☐ Major ☐ Serious ☐ Minor	☐ Frequent ☐ Occasional ☐ Rare

PREVENTION

What Action Has Or Will Be Taken To Prevent Recurrence? Number All Items In Sequence

Action Completed ☐ Yes ☐ No

Investigated By	Date	Reviewed By	Date
Phone #		Phone #	

CITY OF SYCAMORE JOB SAFETY ANALYSIS	**JOB:**	**Personal Protective Equipment Required:**	**DATE:**	**New:** ☐ **REVISED:** ☐
	Title of Person Performing Job:	**Supervisor:**	**Analysis Performed By:**	
	Cause of Injury:	**Department:**	**Reviewed By:**	
Sequence of Basic Job Steps:	**Potential Hazards:**	**Recommended Actions or Procedures:**		

TO BE COMPLETED BY SUPERVISOR and returned to HUMAN RESOURCES.

BACK INJURY FORM

The supervisor is to complete this form while interviewing the employee, and return it to Human Resources to become part of the workers compensation claim.

* *

NAME: _____ Date Soreness was first noticed: _____

DEPT: _____ Job Title: _____

1) Did the pain develop gradually or suddenly? _____
2) Is this a recurring problem that comes and goes? _Y or N_

SUDDEN ONSET:

1) What were you doing when the pain was first felt? _____

   _____

2) Have you done this before? __Y or N__ How often? _____
3) When you felt the pain, were you performing this function the way you usually do, or in a different manner? _____
4) Did anything unusual / unexpected happen while performing this function? _Y or N_ IF NO, how do you think the pain was caused?

   _____

   _____

GRADUAL ONSET:

1) When did you first notice pain coming on? _____
2) What had you been doing that you feel caused this pain to develop?

   _____

3) How long, or how many times did you do perform this function on the date of injury?
4) Have you ever performed this function before? _Y or N_ IF YES, how often and how long ago? _____
5) Were you performing this function the way you usually do? Y or N IF NO, what did you do differently? _____
6) Except for the pain that developed, do you remember anything unusual / unexpected that happened while performing this function? _____

_____

IF NOT, what do you think caused this pain to occur? _____

_____

RECURRING:

1) What kind of activity seems to bring on this pain? _____

_____

2) How often does this problem occur? _____

3) Have you discussed this problem with your physician(s)? __Y or N____

4) Do you have any suggestions on how the City can help you avoid this problem / pain in the future? (EXPLAIN: _____

_____

_____

EMPLOYEE'S COMMENTS: _____

_____

_____

SUPERVISOR'S SIGNATURE: _____

DATE: _____

CITY OF SYCAMORE
BLOODBORNE PATHOGENS
EXPOSURE REPORT PROCEDURES

ANY INCIDENT OF EXPOSURE WHERE BLOODBORNE PATHOGENS ARE IN QUESTION, THE FOLLOWING PROCEDURES MUST BE FOLLOWED:

1. Seek immediate medical attention.

The exposed employee must complete an Exposure Report Form as soon as possible (these forms are available in each City Department and at Kishwaukee Hospital). A copy of this form and the cover sheet will be given to the ER Charge Nurse at the treating hospital. A copy should also be given to Human Resources

At the hospital, blood work will performed on the exposed employee. Depending on the results of this testing, the exposed employee may be required to return to the hospital for follow-up testing after 6 weeks, 12 weeks, and 6 months.

Test results from the source individual

2. NOTIFY HUMAN RESOURCES OF THE EXPOSURE WITHIN 48 HOURS OF ITS OCCURRENCE.

THE EXPOSED EMPLOYEE AND THEIR SUPERVISOR MUST COMPLETE A WORKERS' COMPENSATION INJURY REPORT FORM AS SOON AS POSSIBLE.

THE ORIGINAL OF THIS FORM SHOULD BE SENT TO HUMAN RESOURCES.

Please check one box:

☐ **First Visit** ☐ **Return for Treatment**

Dear Physician:

The following form is to be completed and returned to the injured employee so that he/she may return the original to the City of Sycamore, Human Resources Department, 308 W. State Street, Sycamore, IL 60178, FAX 815-895-1760.

Please check one: The employee:

- ☐ Can return to work
- ☐ Cannot return to work
- ☐ Can return to alternate productive duty for ____hours each day.

If the employee cannot return to work, or may only work alternate productive duty, please give approximate date employee can return to full duties: _____

If the employee may work alternate productive duty, please indicate all restrictions s/he may have:

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____

Date employee to return to the doctor: _____

Physician's comments/diagnosis:

_____
_____
_____
_____

Physician's signature: _____ Date: _____

If you have any questions, please contact:

Maggie Peck, Human Resources
City of Sycamore
308 West State Street
Sycamore, IL 60178
(815) 895-0786

CITY OF SYCAMORE

REQUEST FOR

ALTERNATE PRODUCTIVE DUTY

Alternate Productive Duty privileges shall be afforded to employees who have been deemed temporarily disabled by their treating physician due to a non-duty or duty-related illness or injury. Temporary disability is defined as the lack of ability to perform all aspects of the employee's job for a specific period of time that is generally less than one calendar year. Employees shall continue to enjoy their contractual rights, and remain at the same level of salary and benefits.

EMPLOYEE: _____

DEPARTMENT: _____

REASON FOR REQUEST: _____

DURATION OF REQUEST: _____

PLEASE LIST THE ALTERNATE PRODUCTIVE DUTIES THE EMPLOYEE WILL BE PERFORMING DURING THIS TIME:

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Department Head Date

_____ _____

City Manager's Approval Date

_____ _____

Approval of Treating Physician Date

CITY OF SYCAMORE
OCCUPATIONAL ACCIDENT/ILLNESS
TIME REPORT

For purposes of calculating Temporary Total Disability (TTD) payments from our Workers Compensation carrier, City supervisors are required to complete this form for each week an employee experiences time lost from work or is assigned Alternate Productive Duty (APD) as a result of an on-the-job accident or illness. This form must be submitted to Human Resources each Monday following the week in which the loss has occurred.

NOTE: Employees who have returned to work on Alternate Productive Duty (APD) shall not exceed those limitations prescribed by their physician.

****

Employee: _____

Date of Accident/Illness: _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Date							
Hours Missed due to Work Comp Injury							
APD Hours Worked							

_____ _____

Supervisor's Signature **Date**

WORK INJURY CARE IN DEKALB/SYCAMORE

Physicians Immediate Care
2496 DeKalb Avenue
(Across from Kishwaukee Community Hospital)
Sycamore, IL 60178
815.754.1122

Daytime, evening and weekend hours
Monday-Friday: 8:00 a.m.–8:00 p.m.
Saturday-Sunday: 8:00 a.m.–5:00 p.m.

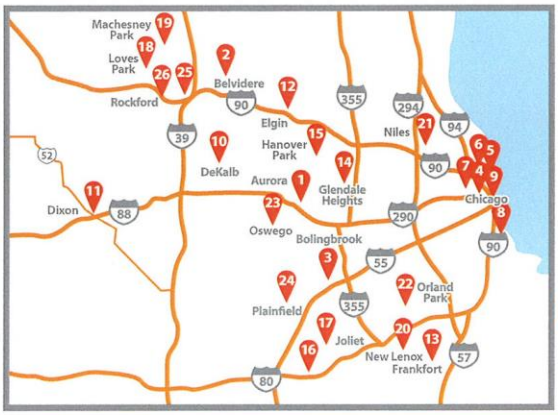
www.visitphysicians.com

physicians immediate care™

CURING WORRY™

3/14

OUR LOCATIONS



1. Aurora (PT)
2853 Kirk Road
P: 630.423.3030 | F: 630.800.1201
Mon-Fri: 7:30 am-8:00 pm
Sat-Sun: 8:00 am-4:00 pm

2. Belvidere (PT)
1663 Belvidere Road
P: 815.544.0040 | F: 815.544.0048
Mon-Fri: 7:30 am-8:00 pm
Sat-Sun: 7:30 am-4:00 pm

3. Bolingbrook (PT)
391 S. Bolingbrook Drive
P: 630.226.1006 | F: 630.226.9003
Mon-Fri: 7:30 am-10:00 pm
Sat-Sun: 7:30 am-4:00 pm

4. Chicago - Bucktown
1702 N. Milwaukee Avenue
P: 773.770.4056 | F: 773.227.7219
Mon.-Fri.: 8:00 a.m.-8:00 p.m.
Sat.-Sun.: 8:00 a.m.-4:00 p.m.

5. Chicago - Edgewater
6140 N. Broadway
P: 773.435.9028 | F: 773.564.9206
Mon-Fri: 8:00 a.m.-8:00 p.m.
Sat-Sun: 8:00 a.m.-4:00 p.m.

6. Chicago - Lincoln/Peterson
5961 N. Lincoln Avenue
P: 312.702.3923 | F: 773.942.6036
Mon-Fri: 8:00 am-8:00 pm
Sat-Sun: 8:00 am-4:00 pm

7. Chicago - Six Corners (PT)
4211 N. Cicero Avenue
P: 773.794.1000 | F: 773.794.9986
Mon-Fri: 7:30 am-8:00 pm
Sat-Sun: 7:30 am-4:00 pm

8. Chicago - South Loop
811B S. State Street
P: 312.566.9510 | F: 312.566.9511
Mon-Fri: 8:00 am-8:00 pm
Sat-Sun: 8:00 am-4:00 pm

9. Chicago - West Loop
600 W. Adams Street
P: 312.506.0900 | F: 312.876.0939
Mon-Fri: 7:30 am-8:00 pm
Sat: 8 am-5 pm | Sun: 8 am-4 pm

10. DeKalb/Sycamore (PT)
2496 DeKalb Avenue
P: 815.754.1122 | F: 815.787.3678
Mon-Fri: 8:00 am-8:00 pm
Sat-Sun: 8:00 am-5:00 pm

11. Dixon
1672 South Galena Avenue
P: 815.564.2663 | F: 815.677.9899
Mon.-Fri.: 7:30 a.m.-8:00 p.m.
Sat.-Sun.: 8:00 a.m.-4:00 p.m.

12. Elgin (PT)
2490 Bushwood Drive, Unit F
P: 224.293.5200 | F: 847.428.2432
Mon-Fri: 7:30 am-8:00 pm
Sat-Sun: 7:30 am-4:00 pm

13. Frankfort
21035 La Grange Road
P: 815.534.1026 | F: 815.534.4042
Mon-Fri: 8:00 a.m.–8:00 p.m.
Sat-Sun: 8:00 a.m.–4:00 p.m.

14. Glendale Heights
335 E. Army Trail Road
P: 630.735.1400 | F: 847.285.1635
Mon-Fri: 7:30 am-8:00 pm
Sat-Sun: 8:00 am-4:00 pm

15. Hanover Park
7425 Barrington Road
P: 630.823.0392 | F: 630.855.6349
Mon-Fri: 8:00 am-8:00 pm
Sat-Sun: 8:00 am-4:00 pm

16. Joliet - Houbolt (PT)
1360 Houbolt Road
P: 815.823.8800 | F: 815.729.2178
Mon-Fri: 7:00 am-8:00 pm
Sat-Sun: 7:30 am-4:00 pm

17. Joliet - Larkin
800 Larkin Avenue
P: 815.741.4300 | F: 815.725.0600
Mon-Fri: 8:00 am-8:00 pm
Sat-Sun: 8:00 am-4:00 pm

18. Loves Park (PT)
1000 E. Riverside Boulevard
P: 815.633.4300 | F: 815.633.2961
Mon-Fri: 7:30 am-8:00 pm
Sat-Sun: 7:30 am-4:00 pm

19. Machesney Park
11475 N. 2nd Street
P: 815.654.8000 | F: 815.654.9433
Mon-Fri: 7:30 am-8:00 pm
Sat-Sun: 7:30 am-4:00 pm

20. New Lenox
621 E. Lincoln Highway
P: 815.907.5955 | F: 815.462.3725
Mon-Fri: 7:30 am-8:00 pm
Sat-Sun: 8:00 am-4:00 pm

21. Niles
8630 W. Golf Road
P: 847.299.0009 | F: 847.299.0006
Mon-Fri: 7:30 am-8:00 pm
Sat-Sun: 8:00 am-4:00 pm

22. Orland Park
9570 W. 159th Street
P: 708.675.7070 | F: 708.675.7074
Mon-Fri: 7:30 am-8:00 pm
Sat-Sun: 8:00 am-4:00 pm

23. Oswego
2322 Route 34
P: 630.383.7042 | F: 630.554.8099
Mon-Fri: 8:00 am-8:00 pm
Sat-Sun: 8:00 am-4:00 pm

24. Plainfield
13641 S. Route 59
P: 815.556.2942 | F: 815.733.6222
Mon-Fri: 7:30 am-8:00 pm
Sat-Sun: 8:00 am-4:00 pm

25. Rockford - East State
6595 E. State Street
P: 815.226.1300 | F: 815.226.1301
Mon-Fri: 7:00 am-10:00 pm
Sat-Sun: 7:30 am-8:00 pm

26. Rockford - S. Alpine (PT)
3475 S. Alpine Road
P: 815.874.8000 | F: 815.874.7525
Mon-Fri: 7:30 am-8:00 pm
Sat-Sun: 7:30 am-4:00 pm

(PT) = Physical therapy.
Call for hours and address.

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