

**EMPLOYEE INJURY/ACCIDENT REPORT (FORM 45-C)**IPRF Claims Fax: 888-223-1638
Email: IPRFclaims@ccmsi.com**EMPLOYEE INJURY/ACCIDENT REPORT (FORM 45-C)**
(To be completed by the Injured Employee ONLY)

Name:		SSN:	
Home Address:		DOB:	
City:	State:	Zip:	
Cell Phone:	Email Address:		
Date of Injury:	Time of Injury:		
Location of Injury:			
Supervisor Name:			
Describe What Happened?			
Describe Injury:			
Any Witnesses to the Accident/Injury?	No:	Yes:	
If Yes, Please Provide Names:			
Did You Refuse Treatment?	No:	Yes:	
If Yes, Why?			
Place of Treatment (Emergency Room, Clinic, Personal Physician):			
Address of the location of Treatment:			
Treating Doctors Name:			
Type of Treatment Performed:			
Have you been Treated for this condition before?	No:	Yes:	
If yes, please explain:			

*Employee Signature:*_____
*Date:*_____
*Supervisor Signature who administered this form to the employee:*_____
Date: