

Injury/Accident Investigation Tool Kit

Claims Contacts

If you need guidance or would like to set up supervisory training on how to use these forms, please contact your IPRF Claims Advocate or Loss Control Consultant at (888) 532-6981

Resources

All forms and reports are included in this Tool Kit and available for download on the IPRF website at:

www.iprf.com

How to Use These Important Tools

Accident investigation forms/statements **should be filled out** by the **injured worker, supervisor, and any witnesses** to the accident. The immediate supervisor should conduct the preliminary investigation as soon as possible.

IMPORTANT

Care must be taken to ensure the investigation is fact finding and not fault finding. Obtaining signed statements as soon as possible following an accident ensures that you, the employer, have an accurate account of how the injury occurred. These completed statements are important in helping to correct hazards and prevent the accident from reoccurring.

After I have these forms completed - what do I do with them?

Please send the completed forms to your assigned IPRF Claims Advocate at claims@iprf.com and keep a copy for your files.

What if my injured employee is physically unable to fill out the Employee Accident/Injury (Form 45-C)?

First and foremost, the injured worker's health and wellbeing is the priority. The forms required from the employee should be completed as soon as the injured worker is physically able to complete them.



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IPRF Injury/Accident Guidelines for Members

A simple accident investigation procedure should be followed after every work-related incident, regardless of whether or not the incident becomes a workers' compensation claim. If the IPRF Member has no established procedures, the steps below will assist the immediate supervisor through the investigation process.

Care for the Injured Worker

Responsible Party: Immediate Supervisor

Step #1

Seek Immediate Medical Treatment for the Injured Worker

- Seek immediate medical attention 24/7 by calling **IPRF Telemedicine Services at (844) 789-2567** or by going to the nearest medical facility.
- **For a serious or life-threatening injury, call 911 immediately.**
Call an IPRF Claims Advocate at (888) 532-6981 if the injury is serious or life threatening so they can assist with arranging any special medical care needs.
- **OSHA Reporting Requirements.** Report to OSHA within 8 hours if it's a work-related fatality. Report to OSHA within 24 hours if the injury results in in-patient hospitalization, amputation, or eye loss.

Secure the Injury/Accident Scene

Responsible Party: Immediate Supervisor

Step #2

The Immediate Supervisor/Manager or other higher authority must make the determination if Step #2 is warranted. If not, proceed to Step #3.

The injury/accident area may encompass as little as one piece of equipment in the immediate surrounding area or include an entire room, depending on what was affected during the incident. It should be secured until a higher authority releases the area.

- It is **vital** to prevent any disturbance to the injury/accident scene.
- If a fatality or catastrophic event occurs, the area must be secured until the Illinois Department of Labor or OSHA releases the area.
- Inform all applicable inter-agency supervisors and safety committees.

Begin Injury/Accident Investigation

Responsible Party: Immediate Supervisor

Once medical treatment is rendered, the immediate supervisor will commence the investigation process using the following forms:

Reports/Forms	Submit to IPRF
First Report of Injury (Form 45)	Within 24 hours
Injury Description Report (Form 45-A)	Within 24 hours
Supervisor Investigation Report (Form 45-B)	Within 24 hours
Employee Accident/Injury Report (Form 45-C)	Within 24 hours
Witness Report (Form 45-D)	Within 24 hours (if applicable)
Questionable Claim Report Form (Form 45-E)	Anytime during the claim process

Care must be taken to assure the investigation is fact finding, not fault finding. Obtaining signed statements as soon as possible following an accident ensures an accurate account of how the injury occurred. If possible, photograph the injury/accident site or area for causative factors.

The Illinois Workers' Compensation Act requires an employer to report to the Illinois Workers' Compensation Commission (IWCC) within 30 days all injuries that result in 3 or more lost workdays.

All forms and reports are available for download on the IPRF website (www.iprf.com). Send completed forms to the assigned Claims Advocate at:

IPRF Claims Email
claims@iprf.com

IPRF Claims Fax
(888) 223-1638

Step #3

IPRF Member – Meet with the Injured Worker

Responsible Party: Immediate Supervisor

It is important the Member meet with the injured worker to ensure their well-being, to provide them with a copy of the IL Handbook on Workers' Compensation and Occupational Diseases, and to have the injured worker complete the following accident report forms.

Reports/Forms	Submit to IPRF
Injury Description Report (Form 45-A)	Within 24 hours
Employee Accident/Injury Report (Form 45-C)	Within 24 hours
Medical Authorization Form (Form 45-F)	Within 24 hours, if treatment obtained.

All forms and reports are available for download on the IPRF website (www.iprf.com). Send completed forms to the assigned Claims Advocate at:

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claims@iprf.com

IPRF Claims Fax
(888) 223-1638

Step #4

Return to Work (RTW)/Release to Full Duty

An injured worker who seeks any sort of medical care/treatment for a work-related injury must obtain a Return to Work (RTW) or Release to Full Duty order from the treating physician. The Member must forward all documentation and RTW orders to the assigned IPRF Claims Advocate.

**EMPLOYER'S FIRST REPORT OF INJURY – FORM 45**IPRF Claims Fax: (888) 223-1638
Email: claims@iprf.com**ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY**

Employer's FEIN	Date of report	Case or File #	Is this a lost workday case?
Employer's name		Doing business as	
Employer's mailing address			Employer's email address
Nature of business or service			SIC code
Name of workers' compensation carrier/admin. Illinois Public Risk Fund		Policy/Contract #	Self-Insured? No
Employee's full name			Birthdate
Employee's mailing address			Employee's e-mail address
Gender	Marital Status	# 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?	
Address of accident			
What was the employee doing when the accident occurred?			
How did the accident occur?			
What was the injury or illness? List the part of the 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.			
If treatment was given away from the worksite, list the name and address of the place it was given.			
Was the employee treated in the emergency room?		Was the employee hospitalized overnight as an inpatient?	
Report prepared by	Signature	Title and telephone #	Email address
Please send this form to: ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE ROAD SPRINGFIELD, IL 62703-5118. By law, employers must keep accurate records of all work-related injuries and illness (except for certain minor injuries). Employers shall report to the Commission all injuries resulting in the loss of more than three scheduled workdays. Filing this form does not affect liability under the Workers' Compensation Act and is not incriminatory in any sense. This information is confidential. IC45 8/12			



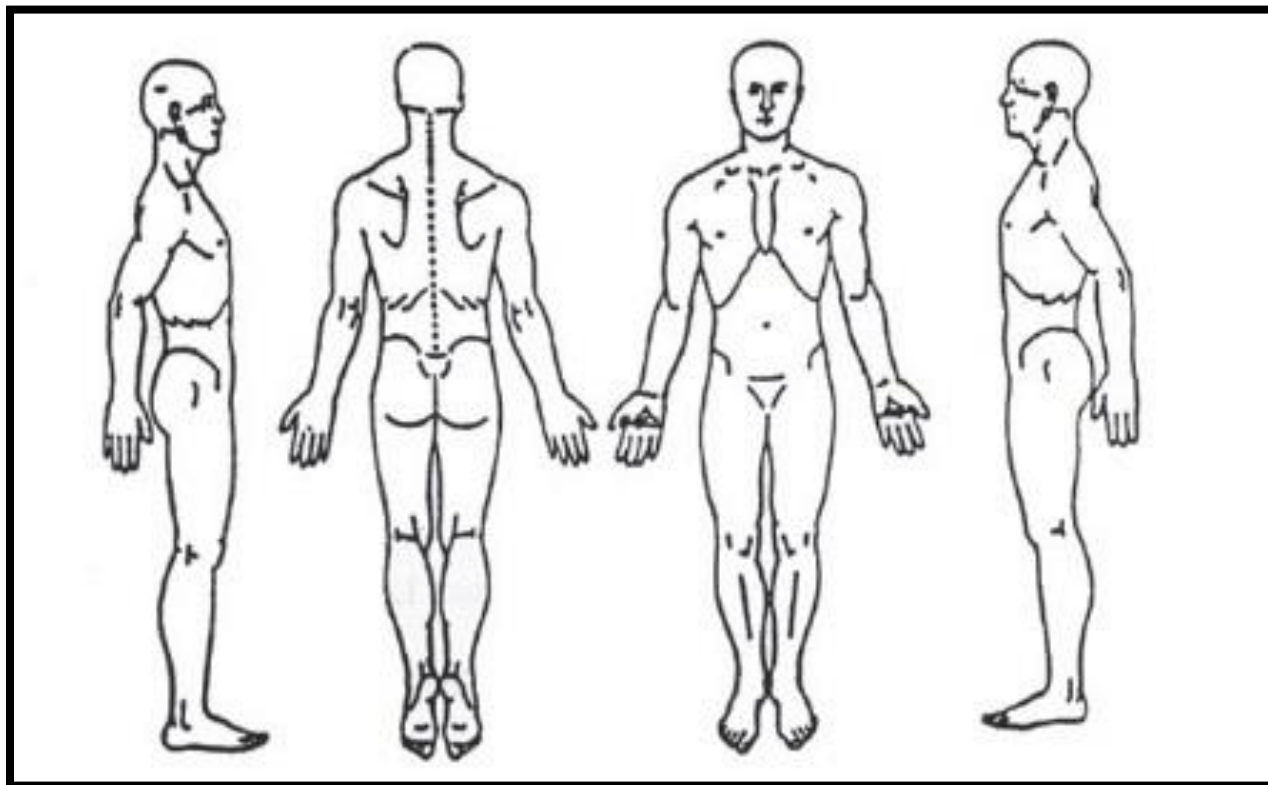
INJURY DESCRIPTION REPORT – FORM 45-A

IPRF Claims Fax: (888) 223-1638
Email: claims@iprf.com

To be completed by the employee

Injured Employee Name: _____ Date: _____

Please indicate the part(s) of body injured by checking or circling the appropriate body diagram outline below.



Additional Comments:

Person Completing Form: _____ Date: _____

**SUPERVISOR INVESTIGATION REPORT – FORM 45-B**IPRF Claims Fax: (888) 223-1638
Email: claims@iprf.com**To be completed by the Supervisor ONLY**

Forward completed form to Human Resources

THIS FORM MUST BE COMPLETED AND RETURNED WITHIN 24-HOURS AFTER THE ACCIDENT/INJURY.

IPRF Member Agency Name:							
Location where accident occurred:		Employer's Prop: Yes No		Date of accident/illness:			
		Job Site: Yes No					
Who was injured?		Employee		Time of accident:		A.M.	
		Non-Employee				P.M.	
Date of Hire:	Job title:		Full-time Part-time		Volunteer		
What property/equipment was involved in the accident?		Property/equipment owned by:					
What was the employee doing when injury/illness occurred? What tool or equipment was being used? What type of operation?							
Describe clearly how the injury/illness occurred? (List all objects and substances involved)							
Nature and extent of injury? (i.e. sprain, strain, fracture, laceration)							
PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS							
<input type="checkbox"/>	Failure to lockout	<input type="checkbox"/>	Improper maintenance	<input type="checkbox"/>	Poor housekeeping		
<input type="checkbox"/>	Failure to secure	<input type="checkbox"/>	Improper protective equipment	<input type="checkbox"/>	Poor ventilation		
<input type="checkbox"/>	Horseplay	<input type="checkbox"/>	Inoperative safety device	<input type="checkbox"/>	Unsafe arrangement or process		
<input type="checkbox"/>	Improper dress	<input type="checkbox"/>	Lack of training or skill	<input type="checkbox"/>	Unsafe equipment		
<input type="checkbox"/>	Improper guarding	<input type="checkbox"/>	Operating without authority	<input type="checkbox"/>	Unsafe position		
<input type="checkbox"/>	Improper instruction	<input type="checkbox"/>	Physical or mental impairment	<input type="checkbox"/>	Other		
Was employee trained in the appropriate use of personal protective equipment (PPE)?				Yes	No		
Was employee reprimanded for failure to use PPE and proper safety procedures?				Yes	No		
Did employee promptly report injury/illness?				Yes	No		
Corrective action completed to ensure this type of accident does not reoccur?							

Supervisor's Name_____
Signature_____
Date_____
Phone #_____
E-mail Address

**EMPLOYEE INJURY/ACCIDENT REPORT - FORM 45-C**IPRF Claims Fax: (888) 223-1638
Email: claims@iprf.com**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 (<i>Emergency Room, Clinic, Personal Physician</i>):			
Address of treatment facility:			
Treating doctor's name:			
Type of treatment performed:			
Have you been treated for this condition before?	No:	Yes:	
If yes, please explain:			

Employee Signature_____
Date_____
Supervisor Signature_____
Date

**WITNESS REPORT – FORM 45-D**

IPRF Claims Fax: (888) 223-1638
Email: claims@iprf.com

To be completed by the witness ONLY

IPRF Member Agency Name:

Name of injured employee:

Name of witness:

Location where incident occurred:

Date of incident:

Time of incident:

What were you (the witness) doing at the time of incident?

How and when did you become aware of the incident?

What did you hear at the time of the incident?

Describe what you saw at the time of the incident:

Who else was present?

Please relate any additional information you have pertaining to the incident:

Witness Signature

Date

Forward the completed form to the Claims Advocate

**QUESTIONABLE/PROBLEM CLAIM REPORT – FORM 45-E**

IPRF Claims Fax: (888) 2238
Email: claims@iprf.com

Please complete this form and attach to the First Report of Injury when you suspect a questionable or problem claim.
Please date and sign the bottom of this form.

Reason for questions about this claim:

Late report of accident (over 45 days)

Report was submitted to:

Supervisor

Employer

Other

Use space below

Other (Explanation):

Employee has a history of disciplinary problems

Unwitnessed accident

Not in the course of employment

Not at work the day of accident

Retained an attorney immediately

Off premises injury

Late report of accident (over 45 days)

Please give details of any secondary employment (employer name, phone and contact):

Signature

Date

Phone Number

Title

**MEDICAL AUTHORIZATION RELEASE – FORM 45-F**IPRF Claims Fax: (888) 223-1638
Email: claims@iprf.com

RE: Name: _____ Date: _____
SSN#: _____ Claim#: _____
DOB: _____

YOUR ARE HERE BY AUTHORIZED TO RELEASE TO

**ILLINOIS PUBLIC RISK FUND
CLAIMS ADMINISTRATION**
3333 Warrenville Rd., Suite 650
Lisle, IL 60532 – 4552
Fax: (888) 223 – 1638

Or any representative acting on its behalf, including my employer, and to permit them to examine and/or copy:

Any and all hospital records, medical records, psychological records, x-ray films and their reports, all test of any type and character and their reports, statements of charges and any and all records of medical care, history, condition, treatment, diagnosis, prognosis, etiology or expense in your possession or control pertaining to the undersigned. (Illinois Mental Health and Development Disabilities Confidentiality Act – REF. 740 ILCS 1101 et seq; and Illinois Workers Compensation Act 820 ILCS 3058(a)).

You are also authorized to discuss with them my injuries, physical condition, treatment and care and to furnish them with a written report regarding same.

The purpose for releasing this information is:

- (A) To facilitate the evaluation of my claim for workers' compensation benefits (REF: 50 IL Admin Code, CH IL 7110.70).
- (B) To permit said disclosed information to be admitted into evidence at a hearing on my claim for said benefits pursuant to the appropriate rules of practice before the Illinois Workers Compensation Commission.

A photostatic copy of this authorization shall be as valid as the original. This authorization is valid for the duration of the claim.

You are hereby released from any and all liability or responsibility, which could or might result because of the disclosure of any information pursuant to this authorization.

Date

Signature

Print Name

Note: this authorization for disclosure is intended to comply with the provision of the health insurance portability and accountability act of 1996 (HIPAA) and the acts "Privacy Rule" relating to the authorization Disclosure of Protected Health Information (PHI) to employers, and ministers, insurers, and other persons involved in state workers compensation systems in accordance with 45 C.F.R. 164.512.

IPRF 52 Week Wage Statement Form

Employer:

Employee

Date of Injury:

Completed by:

Claim No:

Date of Hire:

Date:

If your payroll system can provide a report, please submit in lieu of completing this form. This is an interactive form.

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