ILLINOIS PUBLIC RISK FUND
www.iprf.com

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.

Step #1 — Care for the Injured Worker

Responsible Party: Immediate Supervisor

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.

Step #2 — Secure the Injury/Accident Scene

Responsible Party: Immediate Supervisor

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 and 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, then 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.

Step #3

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. Obtain 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	IPRF Claims Fax
claims@iprf.com	**(888) 223-1638**

Step #4

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:

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

RTW

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.

IPRF	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.	Policy/Contract #	Self-Insured?
Illinois Public Risk Fund		**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

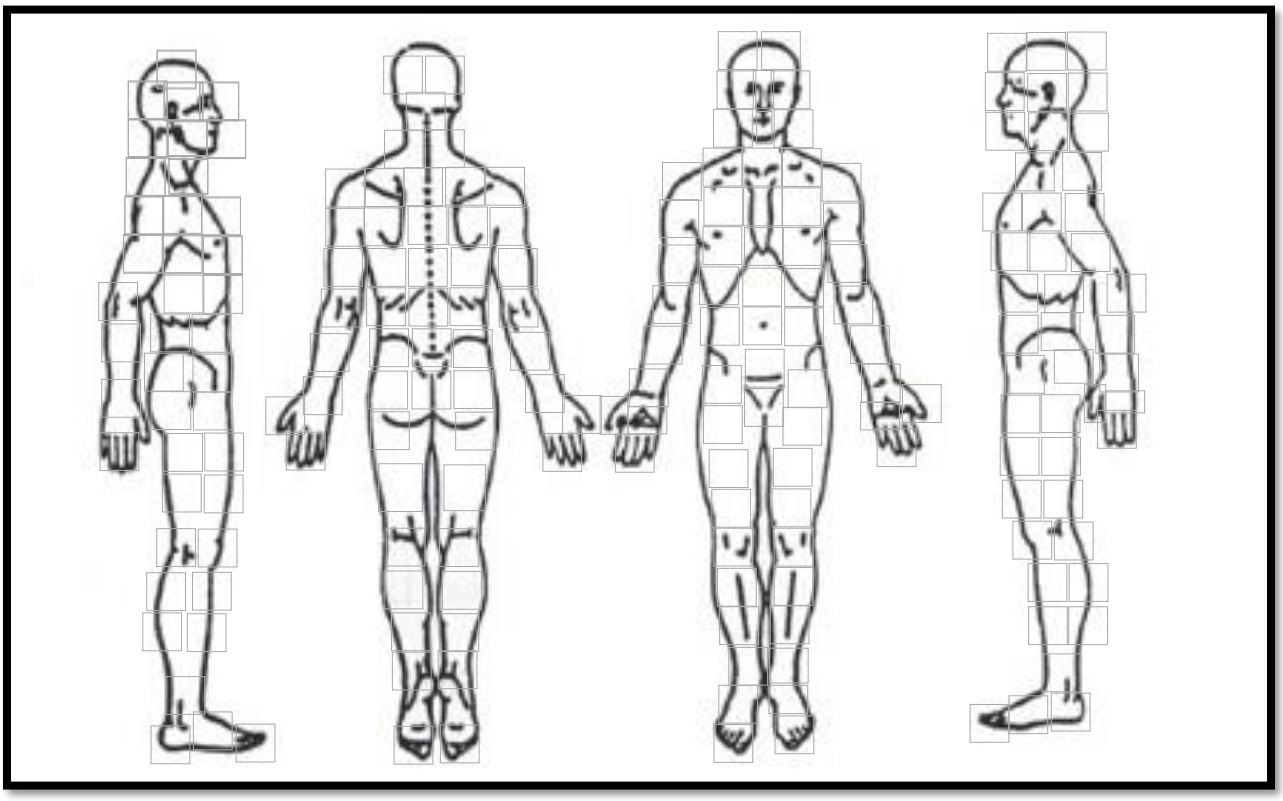
Please send this form to: ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE ROAD SPRINGFIELD, IL 62703-5118. By law, employers must keep accurate records of all work-related injuries and illness (except for certain minor injuries). Employers shall report to the Commission all injuries 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

IPRF	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: _____

IPRF	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 ☐ Job Site: Yes ☐ No ☐		Date of accident/illness:				
Who was injured?	Employee ☐ Non-Employee ☐		Time of accident:	A.M. ☐ 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

☐	Failure to lockout	☐	Improper maintenance	☐	Poor housekeeping
☐	Failure to secure	☐	Improper protective equipment	☐	Poor ventilation
☐	Horseplay	☐	Inoperative safety device	☐	Unsafe arrangement or process
☐	Improper dress	☐	Lack of training or skill	☐	Unsafe equipment
☐	Improper guarding	☐	Operating without authority	☐	Unsafe position
☐	Improper instruction	☐	Physical or mental impairment	☐	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	

IPRF	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 *(Emergency Room, Clinic, Personal Physician):*					
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**

IPRF	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

IPRF	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

IPRF	**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 (HIPPA) 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.

Workers' Compensation
Work Status Report

Date of Treatment:		Visit Type:		Initial		Follow Up

Role of Medical Provider (check all that apply):

Primary Care Doctor		Treating Doctor		Referral/Consulting Doctor		IME Doctor		PA		APRN		Other (please specify)	

PART I: GENERAL INFORMATION

1. Injured Employee's Name:	5. Clinic/Facility Name:			**For Transmission Purposes Only**	Date Being Sent:
2. Date of Injury:	6. Clinic/Facility/Doctor Phone & Fax:			**Please Fax or Email this report to:** [Contact Information for Member Agency Contact for WC Claims]	
3. SS# (last four):	7. Clinic/Facility/Doctor Street Address:				
4. Doctor's Name:	City	State	Zip		

PART II: WORK STATUS INFORMATION

8. The injured employee's medical condition resulting from the worker's compensation injury **(check and complete all that apply)**:

	(a) will allow the employee to return to work as of	Date:	without restrictions.		
	(b) will allow the employee to return to work as of	Date:	with restrictions (identify in Part III), which are expected to last until:	Date:	
	(c) has prevented and still prevents the employee from returning to work as of:	Date:	and is expected to continue through:	Date:	

The following describes how this injury prevents the employee from returning to work:

PART III: ACTIVITY RESTRICTIONS (complete all that apply if box 8(b) is checked)

9. Posture Restrictions:

Max Hrs Per Day	1	2	4	6	8	Other
Standing						
Sitting						
Kneeling/Squatting						
Bending/Stooping						
Pushing/Pulling						
Twisting						
Other						

10. Motion Restrictions:

Max Hrs Per Day	1	2	4	6	8	Other
Walking						
Climbing Stairs/ladders						
Grasping/Squeezing						
Wrist flexion/extension						
Reaching						
Overhead Reaching						
Keyboarding						
Other						

11. Restrictions Specific To:

	Left hand/Wrist		Left leg
	Right hand/wrist		Right leg
	Left arm		Back
	Right arm		Left foot/ankle
	Neck		Right foot/ankle

Other:

12. Lift/Carry Restrictions:

	May not lift/carry objects more than:	lbs	For more than		Hours per day	
	May not perform any lifting or carrying					

13. Miscellaneous Restrictions:

	Max hours per day of work:			No driving/operating heavy equipment		Must use crutches at all times	
	Sit/stretch breaks of:		Per:	Can only drive automatic transmission		Dressing changes necessary at work	
	Must wear splint/cast at work			No skin contact with:		No running	
	No working at heights or on ladders			No working in extreme hot/cold environments			

14. Medication Restrictions:		Must take prescription medications		Advised to take over the counter meds		Meds may cause drowsiness
15. Other Restrictions:	Other:					

PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

16. Work Injury Diagnosis

Information:

17. Expected Follow-Up Services **(check and complete all that apply):**

	Evaluation by the treating doctor on:	Date:	Time:		
	Referral to/consult with:	Name:	Specialty:		
	Physical therapy/medicine:		Times per week for		weeks
	None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.				

Employee Signature

Health Care Practitioner's Signature

Date