PRIVILEGED AND CONFIDENTIAL INSURED-INSURER PRIVILEGE

INTERGOVERNMENTAL RISK MANAGEMENT AGENCY
Four Westbrook Corporate Center, Suite 940
Westchester, IL 60154
(708) 562-0300

SUPERVISOR'S INVESTIGATION REPORT

PLEASE MAIL OR FAX (708) 562-0400 ACCIDENT REPORT FORM TO IRMA WITHIN 5 WORKING DAYS

This report shall be completed in ink by the supervisor of the injured, **no later than the end of the injured person's work shift.** The report shall then be forwarded to your claims coordinator **within 24 hours**, along with the completed form IC45.

Any additional information, including a completed wage statement (if applicable), should follow as soon as possible. This completed form shall then be forwarded to IRMA the **same day** the claims coordinator receives it.

The unsafe acts of persons and the unsafe conditions that cause accidents can be corrected only when they are known specifically, It is your responsibility to find them, name them and to state the remedy for them in this report.

NAME OF IRMA MEMBER (MUNICIPALITY)	DATE & TIME: / / ☐ AM ☐ PM

DATE INJURED PERSON REPORTED ACCIDENT AND TO WHOM

LOCATION OF ACCIDENT (The name or number of building, store, dept., floor, etc.)

NAME OF INJURED EMPLOYEE / PHONE NUMBER	INJURED EMPLOYEE'S DEPARTMENT	INJURED EMPLOYEE'S JOB

INJURED PERSON STATUS
☐ FULL TIME ☐ PART TIME ☐ SEASONAL ☐ CONTRACT ☐ VOLUNTEER ☐ MISC.

TIME IN JOB
☐ IN TRAINING ☐ UNDER 6 MONTHS ☐ 6 MONTHS TO 1 YEAR ☐ 1 TO 5 YEARS ☐ OVER 5 YEARS

DATE OF HIRE / /	AVERAGE NUMBER OF HOURS WORKED PER WEEK:		SS#

DESCRIBE THE INJURY:

DESCRIBE THE ACCIDENT (State what the injured was doing and the circumstances leading to the accident)

WAS EMPLOYEE REQUESTED TO GO TO A MEDICAL MANAGEMENT NETWORK FACILITY FOR TREATMENT? ☐ YES ☐ NO	IF RESTRICTED, IS LIGHT DUTY AVAILABLE? ☐ YES ☐ NO
IS EMPLOYEE STILL TREATING WITH A MEDICAL MANAGEMENT NETWORK FACILITY? ☐ YES ☐ NO	IF NO, NAME & ADDRESS OF TREATING DOCTOR:

DID/WILL INJURED PERSON MISS **MORE THAN 3 WORKDAYS** DUE TO THIS ACCIDENT?
☐ YES ☐ NO ☐ UNKNOWN

# OF WORK DAYS INJURED PERSON MISSED :	DATE STARTED LOSING TIME: ☐ / ☐ / ☐

ANY WITNESSES TO THIS INJURY/ACCIDENT? ☐ YES ☐ NO
IF YES, WITNESS NAME _____ TITLE/JOB DESCRIPTION _____ PHONE #_____
WITNESS NAME _____ TITLE/JOB DESCRIPTION _____ PHONE #_____

HOW COULD THE INJURY/ILLNESS HAVE BEEN PREVENTED?

REMEDY (As a supervisor, what action have you taken or do you propose taking to prevent a repeat accident?)

SUPERVISOR	REVIEWED AND APPROVED BY CLAIMS COORDINATOR	DATE REPORT PREPARED / /

EMAIL ACCIDENT REPORT TO IRMA PROMPTLY – CLAIMS@IRMARISK.ORG OR SUBMIT VIA FAX – (708) 562-0400