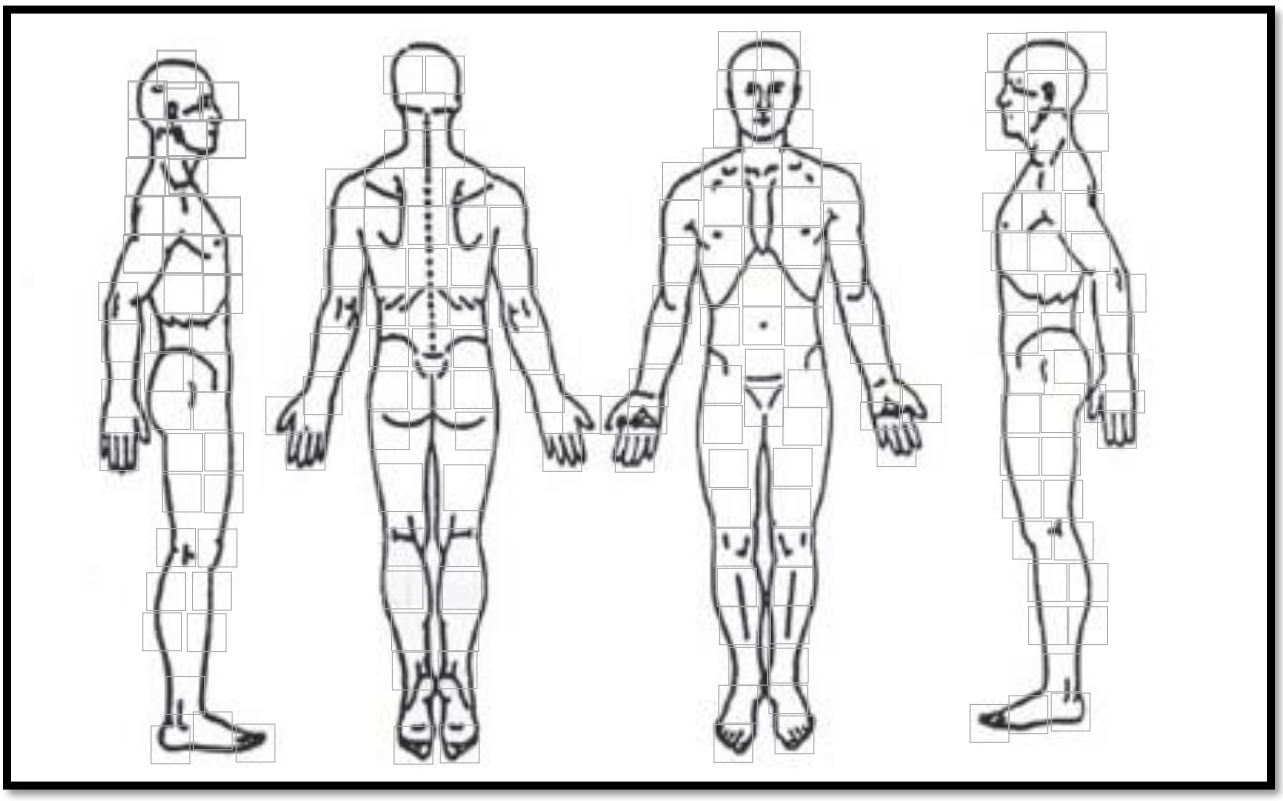
IPRF	INJURY DESCRIPTION REPORT – FORM 45-A	IPRF Claims Fax: (888) 223-1638 Email: claims@iprf.com

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:	Orland Fire Protection District

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

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 (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.