Complete & return to Superintendent's office

| IPRF | EMPLOYEE INJURY/ACCIDENT REPORT - FORM 45-C | IPRF Claims Fax: (888) 223-1638<br>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 _____