

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 EMAIL ACCIDENT REPORT TO IRMA PROMPTLY – CLAIMS@IRMARISK.ORG
OR SUBMIT VIA FAX - (708) 562-0900

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 OF ACCIDENT	
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'S STATUS ☐ FULL TIME ☐ PART TIME ☐ SEASONAL ☐ CONTRACT ☐ VOLUNTEER ☐ MISC.			SOCIAL SECURITY NUMBER
TIME IN JOB ☐ IN TRAINING ☐ UNDER 6 MONTHS ☐ 6 MONTHS TO 1 YEAR ☐ 1 TO 5 YEARS ☐ OVER 5 YEAR			
DATE OF HIRE	AVERAGE NUMBER OF HOURS WORKED PER WEEK		HOURLY RATE
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) 562-0900			