IPRF	EMPLOYEE INJURY/ACCIDENT REPORT (FORM 45-C)	IPRF Claims Fax: 888-223-1638 Email: IPRFclaims@ccmsi.com

EMPLOYEE INJURY/ACCIDENT REPORT (FORM 45-C)

(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 the location of Treatment:					
Treating Doctors Name:					
Type of Treatment Performed:					
Have you been Treated for this condition before?	**No:** ☐	**Yes:** ☐			
If yes, please explain:					

_____ _____

Employee Signature: *Date:*

_____ _____

Supervisor Signature who administered this form to the employee: *Date:*

IPRF	MEDICAL AUTHORIZATION RELEASE – FORM 45-F	IPRF Claims Fax: 888-223-1638 Email: IPRFclaims@ccmsi.com

IPRF MEDICAL AUTHORIZATION RELEASE (FORM 45-F)

RE: Name: _____ Date: _____

SS#: _____ Claim#: _____

DOB: _____

YOUR ARE HERE BY AUTHORIZED TO RELEASE TO

ILLINOIS PUBLIC RISK FUND
CLAIMS ADMINISTRATION
3333 Warrenville Rd., Suite 550
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.