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:*