

**SUPERVISOR'S INVESTIGATION REPORT – FORM 45-B**IPRF Claims Fax: 888-223-1638
Email: IPRFclaims@ccmsi.com**SUPERVISOR'S INVESTIGATION REPORT (FORM 45-B)****(To be completed by the Supervisor ONLY)**

Forward completed Form to Human Recourses

THIS FORM MUST BE COMPLETED AND RETURNED WITHIN 24-HOURS OR LESS AFTER THE ACCIDENT/INJURY. THERE ARE NO EXCEPTIONS TO THIS RULE.

IPRF Member Agency Name: _____

Location where accident occurred	Employer's Prop: Yes	No	Date of accident/illness
	Job Site: Yes	No	

Who was injured?	Employee	Time of accident	A.M.
	Non-Employee		P.M.

Years of service to date	Job title	Full-time	Volunteer
		Part-time	

What property/equipment was damaged?	Property/equipment owned by:
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What was the employee doing when injury/illness occurred? What tool was being used? What type of operation?

Describe clearly how the injury/illness occur? List all objects and substances involved.

Nature and extent of injury? (Soft tissue injury i.e. sprain, strain or hard injury i.e. broken bone, wounds)

PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS

<input type="checkbox"/>	Failure to lockout	<input type="checkbox"/>	Improper maintenance	<input type="checkbox"/>	Poor housekeeping
<input type="checkbox"/>	Failure to secure	<input type="checkbox"/>	Improper protective equipment	<input type="checkbox"/>	Poor ventilation
<input type="checkbox"/>	Horseplay	<input type="checkbox"/>	Inoperative safety device	<input type="checkbox"/>	Unsafe arrangement or process
<input type="checkbox"/>	Improper dress	<input type="checkbox"/>	Lack of training or skill	<input type="checkbox"/>	Unsafe equipment
<input type="checkbox"/>	Improper guarding	<input type="checkbox"/>	Operating without authority	<input type="checkbox"/>	Unsafe position
<input type="checkbox"/>	Improper instruction	<input type="checkbox"/>	Physical or mental impairment	<input type="checkbox"/>	Other

Was employee trained in the appropriate use of personal protective equipment (PPE)?	Yes	No
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Was employee cautioned for failure to use PPE and proper safety procedures?	Yes	No
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Did employee promptly report injury/illness?	Yes	No
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Supervisor's corrective action to ensure this type of accident does not recur:

Supervisor's Name_____
Signature_____
Date_____
Cell Phone #_____
E-mail Address