SCHOOL EMPLOYEES LOSS FUND (SELF)

Accident Investigation/Incident Cover Sheet

To: ______________________ **From:** ______________________

Date: ______________________ **Pages:** ______________________

Re: ______________________

School District Name:	
School Name:	**School Type Code:**
Department (Check One):	**School Type (Check One):**
☐ 001 MECHANICAL	☐ 001 HIGH SCHOOLS
☐ 002 OTHER	☐ 002 JR. HIGH / MIDDLE SCHOOLS
☐ 003 ADMINISTRATIVE STAFF	☐ 003 ELEM / PRIMARY SCHOOLS
☐ 004 SCHOOL PRINCIPAL / SUPERINTENDANT / DIRECTOR	☐ 004 PRE SCHOOLS
☐ 005 TEACHERS & ATHLETIC COACHES	☐ 005 SPECIAL ED SCHOOLS
☐ 006 AIDS – TEACHERS, PE, BUS, CLINIC, SPECIAL ED	☐ 006 ADMINISTRATIVE OFFICES GARAGE / TRANSPORTATION
☐ 007 BOOKKEEPER – SECRETARY – FTE CLERK	☐ 007 FACILITIES
☐ 008 BUS DRIVER	☐ 008 MAINTENANCE / STORAGE / WAREHOUSE FACILITIES
☐ 009 MAINTENANCE / CUSTODIAL	
☐ 010 DRIVERS – FOOD SERVICE / WAREHOUSE	
☐ 011 LUNCHROOM	
☐ 012 CETA	
☐ 013 SCHOOL HEATH WORKER	
☐ 014 O.P.S. (TEMPORARY EMPLOYEE)	
☐ 015 NURSE	

Select Occupation Code (Check One):	
	☐ 7380 Bus Drivers
	☐ 8868 Teachers, Teachers Aids Admin. Staff, Clerical, Cafeteria and Lunchroom Supervisors
	☐ 9101 Custodial, Maintenance, and All Other Employees

Comments:

The documents accompanying this facsimile transmission contain confidential information, which may also be legally privileged and which is intended to be read or used only by the individual or entity named above. If the reader of the facsimile is not the intended recipient, you are hereby notified that you are in possession of confidential and privileged information. Any disclosure, dissemination, distribution, copying or the taking of any action in reliance of the contents of this information is strictly prohibited. If you have received this facsimile in error, please immediately notify the sender by telephone and return the original to the sender by mail.

Re-disclosure of this information is prohibited without the express written consent of the party to whom it pertains.

ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

Please type or print.

Employer's FEIN	Date of report	Case or File #	Is this a lost workday case? Yes / No
Employer's name		Doing business as	
Employer's mailing address			
Nature of business or service		SIC code	
Name of workers' compensation carrier/admin.	Policy/Contract #		Self-insured? Yes / No
Employee's full name		Social Security #	Birthdate
Employee's mailing address			Employee's e-mail address
Male / Female	Married / Single	# Dependents	Employee's average weekly wage
Job title or occupation			Date hired
Time employee began work AM PM	Date and time of accident		Last day employee worked
If the employee died as a result of the accident, give the date of death.		Did the accident occur on the employer's premises? Yes / No	
Address of accident			
What was the employee doing when the accident occurred?			
How did the accident occur?			
What was the injury or illness? List the part of body affected and explain how it was affected.			
What object or substance, if any, directly harmed the employee?			
Name and address of physician/health care professional			
If treatment was given away from the worksite, list the name and address of the place it was given.			
Was the employee treated in an emergency room? Yes / No		Was the employee hospitalized overnight as an inpatient? Yes / No	
Report prepared by	Signature	Title and telephone #	

Please send this form to the ILLINOIS INDUSTRIAL COMMISSION 701 S. SECOND STREET SPRINGFIELD, IL 62704. IC45 9/03

By law, employers must keep accurate records of all work-related injuries and illness (except for certain minor injuries). Employers shall report to the Commission all injuries resulting in the loss of more than three scheduled workdays. Filing this form does not affect liability under the Workers' Compensation Act and is not incriminatory in any sense. This information is confidential.

SCHOOL EMPLOYEES LOSS FUND (SELF)

Employee's Report of Injury

Information About You

District Name & # ______________________________

Employee Name: ______________________________

Address: ______________________________

Phone #: ______________________________

Marital Status: S ☐ M ☐ D ☐ W ☐ Sex: M ☐ F ☐

Children under 18 (sex and age): ______________________________

Height: ____________ Weight: ____________ Average Weekly Wage: ____________

Length of Employment: ____________ Days & Hours Worked: ____________

Other Employment: ______________________________

Information About the Accident

Date of Accident: ____________ Time: ____________

Place of Accident: ______________________________

____

What were you doing before the accident? ______________________________

____

What happened? ______________________________

____

____

Witnesses Name , if any: ______________________________

____

Who did you report the injury to? ______________________________

____

What date did you report it? ______________________________

____

SCHOOL EMPLOYEES LOSS FUND (SELF)

Information About the Injury

What part of your body was injured? ______________________________

Any other part or parts injured? ______________________________

What kind of injury (strain, cut, broken bone)? ______________________________

____

Exact location of pain(s): ______________________________

____

Information About the Treatment

What doctor is treating you (name, address, phone #)? ______________________________

____

Who is your family doctor? ______________________________

What clinic is treating you? ______________________________

What hospital is treating you? ______________________________

What treatment are you getting (medication, physical therapy, rest, etc.)? ______________________________

____

Has the doctor told you to be off work? ______________________________

____

General Information

Have you ever injured the same part of your body before? ______________________________

Explain: ______________________________

Have you ever injured any other part of your body before? ______________________________

Explain: ______________________________

Do you have any serious illness (Diabetes, High Blood Pressure, etc.)? ______________________________

Explain: ______________________________

Have you understood the questions you have answered? ______________________________

Signed: ______________________________

Date:

Return this form to your Supervisor

School Employees Loss Fund (SELF)

Supervisor's Investigation Report

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 and name them and to suggest the remedy in this report.

District Name and Number:		School or building name:
Location of accident: *(stairs, hall, office, outside, etc.)*		Date and hour of accident:
Name of injured person:	Injured employee's department:	Injured employee's job or position:
Describe the injury:		
Describe the accident *(State what the injured employee was doing and the circumstances leading to the accident.)*		
Unsafe condition *(Describe as oily floor, poor light, lack of guards on belts and gears, broken steps, etc.)*		
Unsafe act--Unsafe work procedure (*Describe using known facts, or a specific items contributing to the accident, etc.)*		
Suggested Improvement *(As a supervisor, what do you propose that might prevent a repeat accident.)*		
Supervisor	Reviewed and approved by	Date report prepared
(attached any additional information or pictures)		

School Employees Loss Fund (SELF)

Supervisor's Investigation Report (cont'd)

Each accident regardless of whether it results in a personal injury, property damage, or a near miss should be investigated to determine the actual cause and to take proper action to prevent recurrence.

The accident should be investigated by the supervisor of the injured employee. The investigation should be conducted as soon as possible to get the most accurate information. **Your purpose is to obtain facts and prevent recurrence – not place blame.**

Steps to Follow

1. If available, obtain notice of event. (IL Form 45)
2. Go to the scene immediately.
3. Find out what happened, obtain witness names.
4. Determine accident CAUSES.
5. Develop and implement corrective action to prevent repeat accident.
6. Complete all sections of the form.
7. Report to management.
8. Send completed forms to the SELF claims administrators, Sedgwick at fax 614-601-9515

This Guide is to stimulate questioning in determining the DIRECT and INDIRECT accident causes.

Questions To Ask	**If The Causes Appear To Be**	
	Conditions	**Actions**
WHY	– did it exist? – had no one noticed and corrected it?	– was it being done? – was it being done this way? – was it (job or detail) necessary?
WHAT	– caused it to exist? – caused it to be involved?	– was its purpose? – other way could it be done? – details could be eliminated? – instructions were not followed?
WHERE	– was it? – was its source? – else does it exist? – can I find out?	– should it be done? – else is it being done?
WHEN	– did it occur? – do similar conditions occur?	– should it be done?
WHO	– was responsible for it? – can give me answers? – should take corrective action?	– is best qualified to do it? – can give me answers? – can show me what was being done?
HOW	– should it be corrected? – can it be avoided in the future?	– is the best way to do it? – can it (job or detail) be improved?

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Witness Statement

District Name and Number: ______________________ Claim #: __________

Date of accident: ______________ About what time? ______________

Where did it happen? ______________________

Did you see it? ________ If not, how soon after did you arrive? ______________

Where were you when accident occurred? ______________________

____

Was weather a factor? ________ If yes, describe conditions: ______________

____

Condition of accident area ______________________

What precautions had been taken? ______________________

____

Did any defects contribute to the accident? ______________________

If yes, name and describe ______________________

____

Did the injured party(s) actions contribute to the accident? ________ If yes, how?

____

____

Name of injured ______________________

Give name and address of other witnesses ______________________

____

Describe how accident occurred? ______________________

____

Did you hear anyone admit fault? ________ Who? ______________

In your opinion, who was to blame? ______________________

Why? ______________________

____

Are you a personal friend or relative of the injured party? ________ If yes, state relationship:

____

Date: ______________________

Name: ______________ Signature: ______________

Home Address: ______________ Phone: ______________

Business Address: ______________ Phone: ______________

SCHOOL EMPLOYEES LOSS FUND (SELF)

HIPAA Privacy Authorization

For Disclosure of Protected Health Information
Relevant to Pending Claims

Patient's Name: ______________________________

Address: ______________________________ Date of Birth: ______________

1. I make this Authorization for the purpose of copying records in connection with a claim to which I am a party.

2. This Authorization is directed to and applies to protected health information maintained by:
(Hospital, Physician, Medical Provider, etc.)

____

____

____

____

3. I hereby authorize the above, its director, administrative and clinical staff or assignees, medical information services and billing departments to release any and all medical records and information from my date of birth to the present unless specified otherwise, relating to my care and treatment including x-rays, photographs, electronic and digital files and any other records, unless I expressly direct or specify otherwise. I understand that medical information may include records, if any, relating to treatment for alcohol and drug abuse protected under the regulations in 42 C.F.R. Part 2, psychiatric/psychological services and social work records and any information regarding communicable diseases and infections, tuberculosis, venereal diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or ARC.

4. This information is to be released for copying purposes to: ______________________________
______________________________ or their agent, ______________________________

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the Federal Privacy Rules.

6. This authorization shall be in force and in effect until the conclusion of the pending claim unless otherwise specified.

7. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and send it to the hospital, doctor or other custodian of medical information. I understand that the revocation will not apply to information that has already been released in response to this authorization.

8. I understand that authorizing the release of this health information is voluntary and that I need not sign this form in order to ensure health care treatment, eligibility for benefits, payment or health plan enrollment.

9. A copy of this authorization is as valid as the original.

All Pertinent Sections Of This Form Must Be Completed Before Signing

______________________________	X ______________________________
Date	Signature of Patient or Personal Representative
______________________________	______________________________
Description of Personal Representative's Authority or Relationship	Print Name of Patient or Personal Representative

S-FORMS\SELF Forms\SELF_Med Auth