INTERGOVERNMENTAL RISK MANAGEMENT AGENCY
Four Westbrook Corporate Center, Suite 940
Westchester, IL 60154
(708) 562-0300

IRMA

PLEASE FAX ACCIDENT REPORT TO IRMA PROMPTLY - 708-562-0900
IRMA NON-WORKERS COMPENSATION ACCIDENT REPORT FORM

Please complete the sections of the report that are applicable. Please print in ink. The individual having responsibility for reporting the accident should complete the report **by the close of the work shift**. The claimant should not complete this form.

The supervisor/department head of the employee who filled out the form should complete section VIII. The report shall then be forwarded to your claims coordinator **by the end of the work shift or within 24 hours**. This completed form shall then be forwarded to IRMA the **same day** the claims coordinator receives it.

I. MEMBER INFORMATION

NAME OF IRMA MEMBER (MUNICIPALITY)	CONTACT PERSON NAME AND PHONE NUMBER	DEPARTMENT
City of Crystal Lake	**Nick Hammonds, Management Analyst (815) 356 - 3675**	City Manager's Office

DATE OF LOSS	TIME OF LOSS	WAS EMPLOYEE INJURED
5/24/20 and 5/	____ A.M. ____ P.M.	YES ____ NO X

LOCATION OF LOSS	EMPLOYEE NAME/DRIVER IF AUTO

POLICE OR FIRE DEPT. REPORT #	STREET/SIDEWALK CONDITIONS:	WEATHER CONDITONS:
	___DRY ___OTHER ___WET ____SNOW/ICE	___CLEAR/CLOUDY ___RAIN ___SNOW ___ OTHER

II. MEMBER PROPERTY DAMAGE

ITEMS DAMAGED:	AGE OF ITEM (S) DAMAGED:	VIN NUMBER:	ESTIMATE OF DAMAGE $:

MAKE OF OUR VEHICLE/MOBILE EQUIPMENT:	YEAR:	MODEL:	LICENSE NUMBER (S):

III. MEMBER DESCRIPTION OF ACCIDENT

IS OTHER PARTY MAKING A CLAIM? ___ YES ___ NO PLEASE EXPLAIN:

IV. CLAIMANT ACCIDENT / INJURY INFORMATION

NAME	SEX	AGE/D.O.B.

BUSINESS PHONE	HOME PHONE	ADDRESS

NATURE OF INJURY/PART OF BODY	WHAT WAS INJURED PERSON DOING?
_____ FATALITY	

WHERE TAKEN? (Name of hospital/clinic, address, phone number)

V. CLAIMANT AUTOMOBILE INFORMATION

OWNER OF OTHER VEHICLE	AGE	ADDRESS	CITY	STATE	ZIP	PHONE
DRIVER, IF OTHER THAN OWNER	AGE	ADDRESS	CITY	STATE	ZIP	PHONE

MAKE OF VEH.	YEAR	MODEL	LICENSE NO.	VIN NO.	AREA OF DAMAGE	ESTIMATE OF DAMAGE $

IS VEHICLE INSURED?	COMPANY/AGENCY NAME, POLICY NO. & PHONE NO.	WHERE VEHICLE CAN BE SEEN
____YES ____NO		

VI. CLAIMANT NON-AUTO PROPERTY DAMAGE (i.e. fence, building, etc.)

OWNER OF PROPERTY	ADDRESS	CITY	STATE	ZIP	PHONE

DESCRIBE DAMAGED PROPERTY	LOCATION OF PROPERTY

IS PROPERTY INSURED? ____YES ____NO	COMPANY/AGENCY NAME, POLICY NO. & PHONE NO.

VII. WITNESS INFORMATION

NAME	AGE/D.O.B.	ADDRESS	BUS PHONE	HOME PHONE
NAME	AGE/D.O.B.	ADDRESS	BUS PHONE	HOME PHONE

VIII. ADDITIONAL COMMENTS

Conditions (Describe any conditions or defects contributing to the accident)

Describe any unsafe acts or procedures contributing to the accident.

What precautions could have been taken to avoid accident (if any?)

Remedy (As a supervisor, what action have you taken or do you propose taking to help prevent a similar accident?)

Comments:

X_____
SUPERVISOR/DEPT. MANAGER SIGNATURE & DATE

X_____
CLAIMS COORDINATOR SIGNATURE & DATE

PLEASE FAX ACCIDENT REPORT TO IRMA PROMPTLY.
PLEASE SEND ANY SUPPORTING MATERIAL, SUCH AS AVAILABLE REPORTS, NEWSPAPER ACCOUNTS, PICTURES, REPAIR ESTIMATES AND/OR BILLS, AS SOON AS POSSIBLE.
POLICE REPORTS / AMBULANCE REPORTS / ESTIMATES OF REPAIR
NOTE: IF MEMBER PROPERTY IS DAMAGED BY A CLAIMANT VEHICLE, PLEASE FILE A STATE OF ILLINOIS ACCIDENT FORM WITH THE SECRETARY OF STATE.