ILLINOIS FIREFIGHTER'S ASSOCIATION - ACCIDENT INDEMNITY FUND

PO Box 77, Glen Carbon, IL 62034 - 618-882-4783

Report of Accident Only

Fire Department ______________________ County ______________

Injured Member ______________________ Age ______________

Address ____

Telephone ______________________ Social Security # ______________________

Volunteer / Paid ______________________ Occupation or Rank ______________________

Date of Accident ______________________ Time of Accident ______________ a.m. / p.m.

Location at time of Injury: ____

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Describe Accident: ____

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Nature of Injury: ____

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PROBABLE DURATION of TOTAL DISABILITY: ______________________ DAYS

Name & Address: PHYSICIAN (seen immediately after injury) ______________________

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***DATE OF INITIAL EXAM:** Month ________ Day ________ Year ________ Time ________

***First Doctor seen immediately after injury - Must be examined within 24 hours of reported injury**

Fire Department Resident Secretary: ______________________________

Address: ____

Telephone (Day) ______________________ (Evening) ______________________

Date Report Completed: ______________________ Date Mailed ______________________

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Signed - Resident Secretary or Chief

NOTICE: ***Failure to send this Report of Accident by Certified Mail and received within 30 days of the accident causing injury will constitute a waiver of claims against the Illinois Firefighters Association Accident Indemnity Fund.***

Report of Accident form MUST be received at the PO BOX address within 30 days of accident

Date Report Received: ______________________ Claim # ______________________

Notes: ____