

# 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?<br>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?<br>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  |                  | 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?<br>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?<br>Yes / No  |                  | Was the employee hospitalized overnight as an inpatient?<br>Yes / No |  |  |
| Report prepared by  |                  | Signature  |  | Title and telephone #                    |

Please send this form to the ILLINOIS WORKERS' COMPENSATION COMMISSION 701 S. SECOND STREET SPRINGFIELD, IL 62704. IC45 12/04

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.