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| --- | --- |
| **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? |
|  |  |  |   |
|  Employer's name |  Doing business as |
|  |  |
|  Employer's mailing address  |  Employer’s email address |
|  |  |
|  Nature of business or service |  SIC code |
|  |  |
|  Name of workers' compensation carrier/admin. |  Policy/Contract # |  Self-insured? |
|  |  **dsfsdf** |  |
|  Employee's full name  |  Birthdate |
|  |  |
|  Employee's mailing address |  Employee's e-mail address |
|  |  |
|  Gender |  Marital status |  # 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? |
|  |   |
|  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?  |  Was the employee hospitalized overnight as an inpatient? |
|   |   |
|  Report prepared by |  Signature |  Title and telephone #  |  Email address  |
|  |  |  |  |
| Please send this form to: ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE ROAD SPRINGFIELD, IL 62703-5118  |
| 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. IC45 8/12 |