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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 | | | | |