

ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

Please type or print.

Employer's Illinois Unemployment Compensation #		Date of report		Case or File #	
Employer's name			Is this a lost workday case? ___ Yes ___ No		
Doing business under the name of					
Mailing address		City		State	Zip code
Employer location, if different from mailing address					
Nature of business or service				SIC code	
Name of workers' compensation carrier/admin.		Policy/Contract #	Self-insured? ___ Yes ___ No		County of accident site
Employee's name (last, middle, first)			Social Security #		
Employee's street address		City		State	Zip code
___ Male ___ Female	___ Married ___ Single		Birthdate	# Dependents	
Date & time of accident		Employee's average weekly wage		Last day employee worked	
Job title or occupation					
Address of accident		City		State	Zip code
Did the employee die as a result of the accident? ___ Yes ___ No		If yes, give the date of death			
Did the accident occur on the employer's premises? ___ Yes ___ No		This accident resulted in ___ Occupational injury ___ Occupational disease			
Nature of the injury					
Part of body affected (be specific)					
What task was the employee performing when the accident occurred?					
Object or substance responsible for accident, if any (source)					
How did accident occur?					
What hazardous conditions, if any, contributed to the accident?					
What unsafe act, if any, contributed to the accident?					
Have medical services been rendered to the employee? ___ Yes ___ No			Has the employee been hospitalized? ___ Yes ___ No		
Name and address of physician		City		State	Zip code
Name and address of hospital		City		State	Zip code
Report prepared by		Signature		Title and telephone #	

Please send this form to the ILLINOIS INDUSTRIAL COMMISSION 701 S. SECOND STREET SPRINGFIELD, IL 62704 . IC45 1/00
 By law, employers shall maintain 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.