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			
Nature of business or service			SIC code
Name of workers' compensation carrier/admin.		Policy/Contract #	Self-insured?
Employee's full name		Social Security #	Birthdate
Employee's mailing address			Employee's e-mail address
		# 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 #

Please send this form to: **ILLINOIS WORKERS' COMPENSATION COMMISSION 701 S. SECOND ST. SPRINGFIELD, IL 62704**

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 12/04