

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

Please send this form to the ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. SPRINGFIELD, IL 62703-5118 IC45 5/09

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.