



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				City		State	Zip code
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 street address				City		State	Zip code
Male / Female	Married / Single		# Dependents		Employee's average weekly wage		
Job title or occupation					Date hired		
Time employee began work AM / PM		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				City		State	Zip code
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				City		State	Zip code
If treatment was given away from the worksite, list where it was given.				City		State	Zip code
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 INDUSTRIAL COMMISSION 701 S. SECOND STREET SPRINGFIELD, IL 62704. IC45 1/02

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.