

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			Employer's email address	
Nature of business or service			SIC code	
Name of workers' compensation carrier/admin.		Policy/Contract #	Self-insured? Yes No	
Employee's full name			Birthdate	
Employee's mailing address			Employee's e-mail address	
Gender Male Female	Marital status 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 #	Email address	

Please send this form to: ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE RD SPRINGFIELD, IL 62703
 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 way. This information is confidential. IC45 8/12