

**FORM 45: Employers First Report of Injury or Illness**

PLEASE TYPE OR PRINT

Filing of this report does not affect your liability under the Workers' Compensation Act and is not incriminatory in any sense.

<b>A</b>	*45	ILLINOIS UNEMPLOYMENT COMPENSATION NUMBER		DATE OF REPORT	MONTH DAY YEAR	CASE OR FILE NO.	
<b>B</b>	EMPLOYER'S NAME						IS THIS A LOST WORKDAY CASE? ' YES ' NO
<b>C</b>	DOING BUSINESS UNDER THE NAME OF			/ CITY, STATE		/ ZIP CODE	
<b>D</b>	MAIL ADDRESS			/ CITY, STATE		/ ZIP CODE	
<b>E</b>	EMPLOYER LOCATION IF DIFFERENT FROM MAIL ADDRESS						
<b>F</b>	NATURE OF BUSINESS OR SERVICE			SIC CODE	TOTAL NUMBER OF EMPLOYEES AT LOCATION WHERE INJURY OCCURRED		
<b>G</b>	NAME OF WORKERS' COMPENSATION. INSURANCE CARRIER			POLICY NUMBER		SELF INSURED ' YES ' NO	COUNTY WHERE INJURY OCCURRED
<b>H</b>	EMPLOYEE'S NAME (LAST, FIRST, MIDDLE)					SOCIAL SECURITY NO.	
<b>I</b>	HOME ADDRESS			/ HOME PHONE ( ) / WORK PHONE ( )		/ CITY, STATE / ZIP CODE	
<b>J</b>	MALE ' ' FEMALE ' ' MARRIED ' ' SINGLE ' ' WIDOWED ' ' DIVORCED ' ' BIRTH DATE MONTH DAY YEAR	NUMBER OF DEPENDANT CHILDREN UNDER 18 AT TIME OF INJURY OR ILLNESS					
<b>K</b>	DATE AND TIME OF THE INJURY OR EXPOSURE MONTH DAY YEAR ____ A.M. ____ P.M.		EMPLOYEE'S AVERAGE WEEKLY EARNINGS		LAST DAY EMPLOYEE WORKED MONTH DAY YEAR		
<b>L</b>	JOB TITLE OR OCCUPATION			DEPT. NORMALLY ASSIGNED			
<b>M</b>	ADDRESS OF LOCATION WHERE INJURY OCCURRED				CITY, STATE		ZIP CODE
<b>N</b>	DID EMPLOYEE DIE AS A RESULT OF THE INJURY OR ILLNESS? ' YES ' NO			IF EMPLOYEE DIED AS A RESULT OF THE INJURY OR ILLNESS, GIVE DATE OF DEATH			
<b>O</b>	WAS THE INJURY OR EXPOSURE ON THE EMPLOYER'S PREMISES? ' YES ' NO		DID THIS INCIDENT RESULT IN: ' OCCUPATIONAL INJURY ' OCCUPATIONAL DISEASE			WAS EMPLOYEE GIVEN INDUSTRIAL COMMISSION HANDBOOK? ' YES ' NO	
<b>P</b>	NATURE OF THE INJURY:						FULL TIME ' PART TIME (less than 30 hrs/wk) ' SEASONAL EMPLOYEE ' FULL TIME ' PART TIME
<b>Q</b>	PART OF THE BODY AFFECTED (BE SPECIFIC):						
<b>R</b>	WHAT TASK WAS EMPLOYEE PERFORMING WHEN ILLNESS OR INJURY OCCURRED:						
<b>S</b>	OBJECT OR SUBSTANCE RESPONSIBLE FOR INJURY OR ILLNESS (SOURCE)						
<b>T</b>	HOW DID ACCIDENT OR ILLNESS OCCUR (TYPE)?						
<b>U</b>	WHAT HAZARDOUS CONDITIONS, METHODS OR LACK OF PROTECTIVE DEVICES CONTRIBUTED?						
<b>V</b>	WHAT UNSAFE ACT BY A PERSON CAUSED OR CONTRIBUTED TO THE INJURY OR ILLNESS?						
<b>W</b>	HAVE MEDICAL SERVICES BEEN RENDERED TO THE EMPLOYEE? ' YES ' NO			IS OR HAS THE EMPLOYEE BEEN HOSPITALIZED? ' YES ' NO			
<b>X</b>	NAME AND ADDRESS OF PHYSICIAN:						
<b>Y</b>	NAME AND ADDRESS OF HOSPITAL:						
<b>Z</b>	REPORT PREPARED BY:(NAME - PRINT OR TYPE):			SIGNATURE			TITLE & TELEPHONE NUMBER

ACCIDENT REPORTING DEPT., ILLINOIS INDUSTRIAL COMMISSION, 100 W. RANDOLPH STREET, CHICAGO, ILLINOIS 60601

NOTE: DISCLOSURE OF THIS INFORMATION TO TH4 INDUSTRIAL COMMISSION IS MANDATORY UNDER IL. REV. STAT. CH. 48 ' 1386 FAILURE TO PROVIDE ANY INFORMATION COULD RESULT IN PROSECUTION. APPROVED BY FORMS MANAGEMENT

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