ILLINOIS FORM 45: EN	IPLOYER'S FIRST	KEPO	<u> </u>	F INJUKY	Please type or	print.	
Employer's FEIN	Date of report	Ca	Case or File #		Is this a lost workday case?		
					Yes	No	
Employer's name			Doing business as				
Employer's mailing address					Employer's emai	address	
Employer's maining additions					Zimpioy di di dinai	. addi ooo	
Notice of hospitals are an in-					CIC		
Nature of business or service					SIC code		
		1					
Name of workers' compensation carrier/admin.			olicy/Cor	ntract #	Self-insured?		
					Yes	No	
Employee's full name					Birthdate		
Employee's mailing address					Employee's e-ma	ail address	
						uuu. 000	
Gender	Marital status	#	Depende	ents	Employee's aver	age weekly wage	
Male Female	Married Single	!					
Job title or occupation					Date hired		
Time employee began work					Last day employ	Last day employee worked	
If the employee died as a result of the	l ne accident, give the date of o	death.	Did the	e accident occur o	<u> </u>	emises?	
Address of accident				Yes N	0		
Address of accident							
What was the employee doing when	the accident occurred?						
How did the accident occur?							
What was the injury or illness? List t	he part of body affected and	explain l	now it wa	as affected.			
What object or substance, if any, dir	ectly harmed the employee?						
, ,,							
Name and address of physician/heal	th care professional						
marile and address of physician/flear	ur care professional						
If treatment was given away from the	e worksite, list the name and	address	of the p	lace it was given.			
Was the employee treated in an emergency room?			Was the employee hospitalized overnight as an inpatient?				
Yes No			Yes No				
Report prepared by	Signature	Title an	d telepho		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