FORM 45: **Employer's 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.

A	*45	ILLINOIS UNEMPLOYMENT COMPENSATION NUMBER		DATE OF REPORT	MONTH DAY YEAR	CASE OR FILE NUMBER		
B	EMPLOYER'S NAME		EMPLOYER'S FEIN NUMBER			IS THIS A LOST WORKDAY CASE? ☐ Yes ☐ No		
C	DOING BUSINESS UNDER THE NAME OF				/ CITY, STATE		/ ZIP CODE	
D	MAILING ADDRESS				/ CITY, STATE		/ ZIP CODE	
E	EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS							
F	NATURE OF BUSINESS OR SERVICE		SIC CODE		TOTAL NUMBER OF EMPLOYEES AT THE LOCATION WHERE ILLNESS OR INJURY OCCURRED			
G	NAME OF WORKERS' COMPEN. INSURANCE CARRIER		POLICY NUMBER		SELF INSURED YES ☐ NO ☐		COUNTY WHERE INJURY OCCURRED	
H	EMPLOYEE'S NAME (LAST, FIRST, MIDDLE)				SOCIAL SECURITY NUMBER			
I	HOME ADDRESS				/ CITY, STATE		/ ZIP CODE	
J	MALE ☐ FEMALE ☐	MARRIED ☐	SINGLE ☐	WIDOW(ER) ☐	DIVORCED ☐	BIRTH DATE MONTH DAY YEAR		NUMBER OF DEPENDENT CHILDREN UNDER 18 AT TIME OF INJURY OR ILLNESS
K	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		
L	JOB TITLE OR OCCUPATION				DEPARTMENT NORMALLY ASSIGNED			
M	ADDRESS OF LOCATION WHERE INJURY OR EXPOSURE OCCURRED				/ CITY, STATE		/ ZIP CODE	
N	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 MONTH DAY YEAR			
O	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		
P	NATURE OF THE INJURY							
Q	PART OF THE BODY AFFECTED (BE SPECIFIC)							
R	WHAT TASK WAS EMPLOYEE PERFORMING WHEN ILLNESS OR INJURY OCCURRED?							
S	OBJECT OR SUBSTANCE RESPONSIBLE FOR INJURY OR ILLNESS (SOURCE)							
T	HOW DID ACCIDENT OR ILLNESS OCCUR (TYPE)?							
U	WHAT HAZARDOUS CONDITIONS, METHODS OR LACK OF PROTECTIVE DEVICES CONTRIBUTED?							
V	WHAT UNSAFE ACT BY A PERSON CAUSED OR CONTRIBUTED TO THE INJURY OR ILLNESS?							
W	HAVE MEDICAL SERVICES BEEN RENDERED TO THE EMPLOYEE? ☐ YES ☐ NO		IS OR HAS THE EMPLOYEE BEEN HOSPITALIZED? ☐ YES ☐ NO					
X	NAME AND ADDRESS OF PHYSICIAN				/ CITY, STATE		/ ZIP CODE	
Y	NAME AND ADDRESS OF HOSPITAL				/ CITY, STATE		/ ZIP CODE	
Z	REPORT PREPARED BY: (NAME—PRINT OR TYPE)		SIGNATURE		TITLE AND TELEPHONE NUMBER			

ACCIDENT REPORTING DEPT., ILLINOIS INDUSTRIAL COMMISSION, 100 West Randolph Street, Chicago, Illinois 60601.

NOTE: DISCLOSURE OF THIS INFORMATION TO THE INDUSTRIAL COMMISSION IS MANDATORY UNDER IL. REV. STAT. CH. 48, §138.6. FAILURE TO PROVIDE ANY INFORMATION COULD RESULT IN PROSECUTION. APPROVED BY FORMS MANAGEMENT.