ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

Please type or print.

Employer's name Employer's mailing address Employer's mailing address Nature of business or service Name of workers' compensation carrier/admin. Policy/Contract # Self-insured? Yes / No Employee's full name Social Security # Birthdate Employee's e-mail address Employee's e-mail address Employee's average weekly wage Male / Female Married / Single # Dependents Employee's average weekly wage Date hired Time employee began work Date and time of accident Last day employee worked Did the accident occur on the employer's premises? Yes / No							
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Yes / No Yes / No							
Yes / No Yes / No	Was the employee treated in an emergence	rv room?		Was the employ	ee hospitalized o	vernight as an in	natient?
Report prepared by Signature Title and telephone #	•			Yes /	No	Title and televi	no #
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Please send this form to the ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE RD. SPRINGFIELD, IL 62703 –5118 IC45 6/09 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.