



ILLINOIS WORKER'S COMPENSATION – FIRST REPORT OF INJURY (ILLINOIS FORM 45)

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					
Nature of business or service			SIC code		
Name of worker's compensation carrier/admin.			Policy/contract #	Self-insured? Yes No	
Employee's full name			Social security #	Birthdate	
Employee's mailing address				Employee's e-mail address	
Male	Female	Married	Single	# of dependents	Employee's average weekly wage
Job Title or Occupation				Date hired	
Time employee began work		AM PM	Date and time of accident	Last day employee worked	
If the employee died as a result of the accident, give 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 the 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 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			Title and telephone #		

Please send this form to the ILLINOIS INDUSTRIAL COMMISSION 701 S. SECOND STREET SPRINGFIELD, IL 62704 IC45 9/03

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.