

Please type or print.

ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY Fax or Email to: 312-930-6138 dekalb@sandnergroup.com

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				Dept. #		SIC code	
Name of workers' compensation carrier/admin.				Policy/Contract #		Self-insured? Yes No	
Employee's full name				Social Security #		Birthdate	
Employee's mailing address						Employee's phone #	
Male Female		Married Single		# Dependents		Employee's average weekly wage	
Job title or occupation						Date hired	
Time employee began work			Date and time of accident			Last day employee worked	
If the employee died as a result of the accident, give the 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 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 the 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			Signature			Title and telephone #	