DeKalb County Government

**FORWARD TO FINANCE OFFICE**

*Please type or print.*

## ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

| | | | |
|---|---|---|---|
| Employer's FEIN **36-6006548** | Date of report | Case or File # Office Use Only | Is this a lost workday case? ☐ Yes ☐ No |
| Employer's name DeKalb County Government | | Doing business as: DeKalb County Government | |
| Employer's mailing address DeKalb County Finance Office - 200 N. Main Street, Sycamore, IL 60178 | | | |
| Nature of business or service **T: 815-895-7124 OR F: 815-895-7129** | Dept. # | SIC code Office Use Only | |
| Name of workers' compensation carrier/admin. **IPMG** | Policy/Contract # | Self-insured? ☒ Yes ☐ No | |
| Employee's full name | Social Security # | Birthdate | |
| Employee's mailing address<br>Employee's email address: | | Employee's phone #<br>Work:<br>Cell: | |
| ☐ Male ☐ Female | ☐ Married ☐ Single | # Dependents | Employee's average weekly wage |
| Job title or occupation | | | Date hired |
| Time employee began work : AM | Date and time of accident : AM | | 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<br>Name:<br>Title: | Signature | Telephone Number: | |

**PRINT**