ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

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 workers' 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	# 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 #

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.

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.state.wi.us/wc/
e-mail: DWDDWC@dwd.state.wi.us

An employer subject to the provisions of ch. 102, Wis. Stats., shall, within one day after the death of an employee due to a compensable injury, report the death to the Department of Workforce Development (DWD) and to the employer's insurance carrier, if insured. In cases of permanent disability or where temporary disability results beyond the 3-day waiting period, an insured employer shall also notify its insurance carrier of a compensable injury or illness within 7 days after the injury or beginning of a disability from occupational disease related to the employee's compensable injury.
Insurance carriers and self-insured employers must report all compensable claims to DWD on this form, the EDI system, or the internet format within 14 days of the date of injury.

The provision of your social security number is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)]. (**Please read the instructions on reverse for completing this form**)

EMPLOYEE

Employee Name (First, Middle, Last) | Social Security Number | Sex ☐ M ☐ F | Employee Home Telephone No. ( )

Employee Street Address | City | State | Zip Code | Occupation

Birthdate Mo. Day Year | Date of Hire | County and State where accident or exposure occurred

EMPLOYER

Employer Name | WI Unemployment Insurance Account No. | Self-Insured? Yes ☐ No ☐ | Nature of Business (specific product)

Employer Mailing Address | City | State | Zip Code | Employer FEIN

Name of Worker's Compensation Insurance Co. or Self-Insured Employer | Insurer FEIN

Name and Address of Third Party Administrator (TPA) used by the Insurance Company or Self-Insured Employer | TPA FEIN

WAGE INFORMATION

Wage at Time of Injury $ | Specify per hr., wk., mo., yr., etc | In Addition to Wages, Meals ☐ Board ☐ Lodging ☐ Check Box(es) if Employee Received: ☐ Tips | No. of Meals/wk. _____ No. of Days/wk _____ Avg. Weekly Amt. $

Is worker paid for overtime? Yes ☐ No ☐ If yes, after how many hours of work per week?

For the 52 week period prior to the week the injury occurred, report below the number of weeks worked in the same kind of work, and the total wages, salary, commission and bonus or premium earned for such weeks.

No. of Wks: | Gross Amount Excluding Tips: $ | If Piece-Work, No. of Hrs. Excluding Overtime:

Start Time | Hrs. Per Day | Hrs. Per Wk. | Days Per Wk.

Employee's Usual Work Schedule When Injured:

Employer's Usual Full-Time Schedule For This Type of Work At Time of Employee's Injury:

Part-Time Employment Information: Are there other part-time workers doing the same work with the same schedule? Yes ☐ No ☐ If yes, how many?

Number of **full-time** employees doing the same type of work:

INJURY INFORMATION

Injury Date Mo Day Yr | Time of Injury _____ AM _____ PM | Last Day Worked Mo Day Yr | Date Employer Notified Mo Day Yr | Date Returned to Work Mo Day Yr | Estimated Date of Return

Did injury cause death? ☐ Date of Death Mo Day Yr

Was this a lost time or other compensable injury? Yes ☐ No ☐

Did injury occur because of: ☐ Substance Abuse ☐ Failure to Use Safety Devices ☐ Failure to Obey Rules

Was employee treated in an emergency room? Yes ☐ No ☐ Was employee hospitalized overnight as an in-patient? Yes ☐ No ☐

Name and Address of Treating Practitioner and Hospital:

Case Number from the OSHA Log:

Injury Description - Describe activities of employee when injury or illness occurred and what tools, machinery, objects, chemicals, etc. were involved.

What happened to cause this injury or illness? (Describe how the injury occurred)

What was the injury or illness? (State the part of body affected and how it was affected)

Report Prepared By | Work Phone Number ( ) | Position | Date Signed

WKC-12 (R. 10/2001)

SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT