ILLINOIS FORM 45: EN	IPLOYER'S FIRST	KEPO	<u>/K I _ (</u>	OF INJURY	Please type or p	orint.	
Employer's FEIN	Date of report	Ca	ase or I	File #	Is this a lost workday case?		
					Yes	No	
Employer's name			Doing business as				
Employer's mailing address					Employer's email	address	
Employer's maining address					Employer 3 cmail	addi C33	
No. 10 Charles and 10 Charles					CIO I		
Nature of business or service					SIC code		
Name of workers' compensation carrier/admin.			olicy/C	ontract #	Self-insured?		
					Yes	No	
Employee's full name					Birthdate	-	
Employee's mailing address					Employee's e-ma	il address	
Employee 3 maining address					Linployee 3 e-ina	iii addi e33	
	Г	1					
Gender	Marital status	#	Depen	dents	Employee's avera	age weekly wage	
Male Female	Married Single						
Job title or occupation					Date hired	Date hired	
Time employee began work				Last day employ	Last day employee worked		
If the employee died as a result of the	e accident give the date of o		Did t	he accident occur o	 on the employer's pre	mises?	
in the employee died as a result of the	ie accident, give the date of t	Jeatii.	Dia ti	ne accident occur o	in the employer 3 pro	:::::::::::::::::::::::::::::::::::::::	
				Yes N	0		
Address of accident							
What was the employee doing when	the accident occurred?						
How did the accident occur?							
What was the injury or illness? List t	he part of body affected and	explain h	now it v	was affected.			
What abject or substance if any di	enably barroad the arrangey of						
What object or substance, if any, dir	ectly narmed the employee?						
Name and address of physician/heal	th care professional						
If treatment was given away from th	e worksite, list the name and	address	of the	place it was given.			
Was the employee treated in an emergency room?			Was the employee hospitalized overnight as an inpatient?				
Yes No Report prepared by	Signature	Title and	Yes d telen	No hone #	Email address		
	S.g.iacai S	cic ail	- colop				

Please send this form to: ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE RD SPRINGFIELD, IL 62703
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 way. This information is confidential. IC45 8/12