

(E)

ILLINOIS COUNTIES RISK MANAGEMENT TRUST

**INSTRUCTIONS FOR COMPLETION OF “EMPLOYERS FIRST
REPORT OF INJURY OR ILLNESS”
(ILLINOIS FORM 45)**

- A) Date report completed; our file number, if known.
- B) Company’s full name; check box yes if time loss, check no if loss has not resulted in more than 3 full working shifts of lost time (not including the date of accident).
- C) Company name for mailing purposes, city, state, and zip code.
- D) Mailing address, city, state, and zip code.
- E) Company address, if different from mailing address.
- F) Type of business or service; SIC code, leave blank; number of employees at location.
- G) Your policy number, if known; self-insured, check “yes” box; county where injury occurred.
- H) Employee’s full name (last, first, middle) and social security number. Also place employee’s home telephone number next to his name.
- I) Employee’s home address.
- J) Check appropriate box (male/female), birth date and number of dependent children under 18, if known.
- K) Date, time of injury, employee’s average weekly wage (can be estimated), last date employee worked. If employee did not lose time from work, enter NLT (No Lost Time).
- L) List employee’s job title or occupation and the department he/she works in.
- M) Address where incident occurred (if same as listed above, write “same as above”).
- N) Check yes box if death of employee occurred, date of death, if applicable.
- O) Check appropriate box in response to questions.
- P) List type of injury (i.e., sprain, fracture, laceration).

(E) - continued

- Q) Part of body injured (specify right or left side, if appropriate).
- R) What task was employee performing when the incident occurred?
- S) What caused the injury? (machine, wet floor, etc.)
- T) How did the accident occur? (slipped, tripped, fell, unsafe act, etc.)
- U) Any contributing factors?
- V) Any unsafe act? If so, describe.
- W) Any medical services rendered.
- X) List full name of physician with completed address.
- Y) If a hospital, give complete name and address.
- Z) Print name of person completing the report, signature, title and phone number.

**THIS IS NOT TO BE SIGNED OR COMPLETED BY THE
INJURED EMPLOYEE**