ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

Please type or print.

Employer's FEIN	Date of report	Case or File# **(HR to Complete)**	Is this a lost workday case?
37-0889813			Yes / No

Employer's name	Doing business as
Danville Area Community College	**Education - Community College**

Employer's mailing address
2000 E. Main St. Danville IL 61832

Nature of business or service	SIC code
Education-Community College	**8222**

Name of workers' compensation carrier/admin.	Policy/Contract#	Self-insured?
Indiana Insurance	**8245125N**	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
AM **PM**		

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?	Was the employee hospitalized overnight as an inpatient?
Yes / No	Yes / No

Report prepared by	Signature	Title and telephone #

PLEASE RETURN THIS FORM TO HUMAN RESOURCES