First Report of Injury

1. Whenever an injury/accident occurs to an employee on district property, it is imperative that a first report of injury report (attached) be completed by that employee's SUPERVISOR.

2. All spots indicated with highlighter are to be filled in.

3. Should there be any witnesses to the injury/accident, please have those individuals write down a quick summary of what they witnessed.

4. Once the report is completed, forward to the Unit Office to Nichole Mathews.

Note: *Supervisors are responsible for completing this form.*

Forms completed by employee will be returned to the Supervisor for completion.

ILLINOIS FORM 45: EMPLOYER's FIRST REPORT OF INJURY *Please TYPE or PRINT.*

Employer's FEIN: **36-6004763**	Date of report:	Case or File No.:	Is this a lost work day case? YES / NO
Employer's name: **Herscher Community Unit School Dist #2**		Doing business as: **Same**	
Employer's mailing address: **501 North Main Street, PO Box 504, Herscher Illinois 60941**			
Nature of business or service: **Education**		SIC Code:	
Name of workers' compensation carrier/admin.: **Illinois Public Risk Fund**	Policy/Contract No.: **AGC-2Q36-IL**	Self Insured? YES / **NO**	
Employee's full name:	Social Security No.:	Date of Birth:	
Employee's mailing address:		Employee's email address:	
MALE / FEMALE	MARRIED / SINGLE	Number of dependants:	Employee's average weekly wage:
Job title or occupation:			Hire date:
Time employee began work day: _____ AM _____ PM	Date and time of accident: _____ AM _____ PM	Last day employee worked:	
If employee died as a result of accident/injury, 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 the body affected and explain how.			
What object or substance, if any, directly harmed the employee?			
Name and address of physician/health care provider:			
If treatment was given away from the worksite, list the name and address of the place it was given:			
Was the employee treated in the emergency room? YES / NO		Was the employee hospitalized overnight as a patient? YES / NO	
Were there any witnesses? If so, please list name and title YES / NO		Was there video footage of the incident? YES / NO	
Report prepared by: (PRINT)	Signature:	Title and telephone no.	

Illinois Workers' Compensation Commission: 701 S Second St., Springfield IL 62704 IC45 12/04

Filing this form does not affect liability under the Workers' Compensation Act and is not incriminatory in any sense. This information is confidential.