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?
36-6644390			Yes / No

Employer's name	Doing business as
Little Rock-Fox Fire Protection District	**same**

Employer's mailing address
PO Box 154, Plano IL 60545

Nature of business or service	SIC code
Volunteer Fire District	

Name of workers' compensation carrier/admin.	Policy/Contract #	Self-insured?
Illinois Public Risk Fund		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
Volunteer Firefighter	

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 send this form to the ILLINOIS WORKERS' COMPENSATION COMMISSION 701 S. SECOND STREET SPRINGFIELD, IL 62704. IC45 12/04

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.

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?
#1	#2	#3	#4 Yes / No

Employer's name	Doing business as
#5	#6

Employer's mailing address
#7

Nature of business or service	SIC code
#8	#9

Name of workers' compensation carrier/admin.	Policy/Contract #	Self-insured?
#10 Illinois Public Risk Fund	#11 AGC4042962	#12 Yes / (No)

Employee's full name	Social Security #	Birthdate
#13	#14	#15

Employee's mailing address	Employee's e-mail address
#16	#17

		# Dependents	Employee's average weekly wage
#18 Male / Female	#19 Married / Single	#20	#21

Job title or occupation	Date hired
#22	#23

Time employee began work	Date and time of accident	Last day employee worked
#24 _____AM _____PM	#25	#26

If the employee died as a result of the accident, give the date of death.	Did the accident occur on the employer's premises?
#27	#28 Yes / No

Address of accident
#29

What was the employee doing when the accident occurred?
#30

How did the accident occur?
#31

What was the injury or illness? List the part of body affected and explain how it was affected.
#32

What object or substance, if any, directly harmed the employee?
#33

Name and address of physician/health care professional
#34

If treatment was given away from the worksite, list the name and address of the place it was given.
#35

Was the employee treated in an emergency room?	Was the employee hospitalized overnight as an inpatient?
#36 Yes / No	#37 Yes / No

Report prepared by	Signature	Title and telephone #
#38	#39	#40

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Worker's Compensation Form 45
First Report of Injury
Completion Instructions

1. Enter member's Federal Tax I.D. Number.
2. List the date this report is being completed.
3. Leave blank—used internally.
4. If the employee has or will lose 4 or more scheduled working days, please check "Yes." If the employee has lost or will lose 3 scheduled working days or less, check "No."
5. List the IPRF member's name.
6. If the member is doing business under any other name other than listed on #5, please indicate this name.
7. List the mailing address including city, state and zip code of the member.
8. Indicate the type of business in which the member is involved.
9. Leave blank—used internally.
10. Prefilled-out
11. Prefilled-out
12. Prefilled-out
13. List the injured employee's full name (last name, then first name and middle name or initial).
14. List the injured employee's nine-digit social security number.
15. Indicate the date of birth of the injured employee.
16. List the injured employee's home street address including city, state and zip code. List the phone number, if known.
17. List e-mail address, if available.
18. Indicate the sex of the injured employee.
19. Indicate the marital status of the injured employee.
20. List the number of dependent children under the age of 18 for which the injured employee is legally responsible.
21. Indicate the average amount of gross wages the injured employee receives on a weekly basis **(excluding overtime)**.
22. List the title of the position for the injured employee at the time of the accident.
23. List date the employee was hired.
24. List time employee started work.
25. List the exact date and time of the accident.
26. List the last full or partial day the injured employee worked.

Worker's Compensation Form 45
First Report of Injury
Completion Instructions

27. If the employee's injuries resulted in his/her death, indicate the day the employee died and call Kim DiPiro, Claim Manager, immediately at 630.649.6071.
28. Indicate whether or not the accident occurred on the member's premises.
29. List the street address of the location where the accident occurred, including city, state and zip code.
30. Specifically describe what the employee was doing when he/she was injured, i.e. lifting boxes, sorting packages, unloading inventory, etc.
31. Describe how the accident happened, i.e. employee was lifting boxes and felt pain in lower back, employee was moving cartons when one fell striking his left foot, employee was cleaning paint brushes when chemicals splashed in her right eye.
32. Specifically describe the employee's injury, i.e. strain, sprain, laceration, etc. Specifically indicate the part of the employee's body that was injured, i.e. left forearm, right shoulder, left great toe, etc.
33. What unsafe circumstances led to this accident, i.e. employee was not wearing safety glasses, employee did not use a forklift for lifting, chemical containers were left open.
34. List the name, address (and phone number, if available) of the physician.
35. If the injured was treated at the hospital, list the name, address (and phone number, if available) of that hospital.
36. Indicate whether or not the injured employee required treatment in an emergency room.
37. Indicate whether or not the injured employee was hospitalized.
38. Print the name of the person preparing this report.
39. The person preparing the report should sign here.
40. Indicate the title of the person preparing this report, **along with his/her phone number.**

Illinois Public Risk Fund
3333 Warrenville Road
Suite 550
Lisle, IL 60532-4552

Toll-Free Telephone: 888-532-6981
Toll-Free Fax: 888-223-1638

Little Rock-Fox Fire Protection District

5 East North Street • Plano, Illinois 60545
630-552-3311 www.LRFFPD.com

ACCIDENT INVESTIGATION REPORT

1. City:	**2. Department:**
3. Exact Location:	**4. Date of Occurrence:**
5. Time of Occurrence:	**6. Date Reported:**
INJURY OR ILLNESS	**PROPERTY DAMAGE**
7. Injured's Name:	**13. Property Damaged:**
8. Occupation:	**14. Estimated Costs:**
9. Part of Body Affected:	**15. Actual Costs:**
10. Nature of Injury/Illness:	**16. Nature of Damage:**
11. Object/Equipment/Substance/Inflicting:	**17. Object/Equipment/Substance/Inflicting:**
12. Person with Most Control of Item # 11:	**18. Person with Most Control of Item # 17:**

DESCRIPTION
19. Describe clearly how the incident occurred:

ANALYSIS
20. What acts, failures to act and/or conditions contributed most directly to THIS ACCIDENT?
21. What are the basic or fundamental reasons for the existence of these acts and/or conditions?

PREVENTION
22. What action has or will be taken to prevent recurrence? (Number all items in sequence)
1.
2.

23. Investigated by: **Date:**	**24. Reviewed by:** **Date:**