Abingdon-Avon CUSD #276
Injury/Accident Report Form
Information for ALL Injuries

Today's Date:_____

Employee:_____ Student:_____ Visitor:_____ Vendor:_____

Injured Party Name:_____

Injured Party's Address:_____

Date of Injury:_____ Time of Injury:_____ AM PM

Location of the Incident:_____
(If injured is an employee, a Form 45 must also be completed.)

Cause of Injury

Bodily Reaction_____ Lifting_____
Caught In_____ Overexertion_____
Chemical Contact_____ Rep Motion_____
Exposure_____ Fall (Elevation)_____
Struck by_____ Slip/Trip/Fall_____
Struck on_____ Heat Contact_____
Other_____

Type of Injury

Bee Sting_____ Fracture_____
Bite_____ Hernia_____
Burn (Chem.)_____ Laceration_____
Burn (Heat)_____ Multiple_____
Chemical_____ Occ. Illness_____
Contusion_____ Puncture_____
Crush_____ Rash_____
Trauma_____ Sprain (Ligament)_____
Death_____ Strain (Muscle)_____
Foreign Objects_____ Stress_____
Other:_____

Description of Injury:

_____
_____
_____
_____

What was the Injured Party Doing?

_____
_____
_____

List any unsafe acts or conditions:

_____
_____
_____

Part of Body

Arm_____ Back_____ Eye_____ Foot_____ Ankle_____ Mental_____ Torso_____
Groin_____ Head/Face_____ Internal_____ Knee_____ Leg_____ Respiratory_____ Wrist/Hand_____

Immediate Action Taken

First-aid treatment given_____ By (Name):_____
Sent to Occupation Health or Hospital ER _____ By (Name):_____

Witnesses

1. Name_____ Address:_____
2. Name_____ Address:_____

What suggestions do you have for preventing other accidents of this type?

_____

_____

_____

_____

Any additional comments related to this injury?

_____

_____

_____

_____

Manager's Signature:_____ **Date:**_____

Manager's Name Printed:_____

Employee's Signature:_____ **Date:**_____

***Report should be completed immediately following an injury and given to the Superintendent's office.**

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? Yes No
Employer's name		Doing business as	
Employer's mailing address			Employer's email address
Nature of business or service			SIC code
Name of workers' compensation carrier/admin.		Policy/Contract #	Self-insured? Yes No
Employee's full name			Birthdate
Employee's mailing address			Employee's e-mail address
Gender Male Female	Marital status 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
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? Yes No		Was the employee hospitalized overnight as an inpatient? Yes No	
Report prepared by	Signature	Title and telephone #	Email address

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