BRADLEY University

ILLINOIS FORM 45: EMPLOYEE'S FIRST REPORT OF INJURY

Please type or print

Date of Report	Date of Injury	Case or File #	Is this a lost workday case? Yes / No
Employer's name **Bradley University**		Doing business as **Bradley University**	
Employer's mailing address **1501 W. Bradley Avenue, Peoria, IL 61625**			
Name of Witness to Accident		Witness Phone Number	
Name of worker's compensation carrier/admin. **Travelers Insurance**		Policy/Contract # **000029433**	Self-insured? **Yes** / No
Employee's full name		Social Security # **XXX - XX** -	Birth date - -
Employee's mailing address		Employee's email address	
Male / Female	Married / Single	# of Dependents	Employee's average weekly wage
Job title or occupation			Date hired
Time employee began work AM PM	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 in 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 #