FORM 45: **Employers First Report of Injury or Illness** PLEASE TYPE OR PRNT

Filing of this report does not affect your liability under the Workers' Compensation Act and is not incriminatory in any sense

A	***45** ILLINOIS UNEMPLOYMENT COMPENSATION NUMBER		DATE OF REPORT	MONTH DAY YEAR	CASE OR FILE NUMBER		
B	EMPLOYER'S NAME VALLEY VIEW SCHOOL DISTRICT 365U				Is this a lost Workday case? YES / NO		
C	DOING BUSINESS UNDER THE NAME OF			CITY, STATE	ZIP CODE		
D	MAIL ADDRESS 755 LUTHER DRIVE 60446			CITY, STATE ROMEOVILLE IL	ZIP CODE		
E	EMPLOYER LOCATION IF DIFFERENT FROM MAIL ADDRESS -						
F	NATURE OF BUSINESS OR SERVICE		SIC CODE		TOTAL NUMBER OF EMPLOYEES AT THE LOCATION WHERE ILLNESS OR INJURY OCCURED		
G	NAME OF WORKERS' COMP. INSURANCE CARRIER National Safety Casualty Corp		POLICY NUMBER		SELF INSURED? YES / NO	COUNTY WHERE INJURY OCCURED	
H	EMPLOYEE'S NAME (LAST, FIRST, MIDDLE)				SOCIAL SECURITY NUMBER		
I	HOME ADDRESS CITY, STATE			ZIP CODE			
J	MALE OR FEMALE ?	MARRIED SINGLE WIDOWER DIVORCED BIRTH DATE		MONTH DAY YEAR	NUMBER OF DEPENDENT CHILDREN UNDER 18 AT TIME OF INJURY OR ILLNESS		
K	DATE AND TIME OF THE INJURY OR EXPOSURE	MONTH DAY YEAR	EMPLOYEE'S AVERAGE WEEKLY EARNINGS	$	LAST DAY EMPLOYEE WORKED	MONTH DAY YEAR	
L	JOB TITLE OR OCCUPATION			DEPARTMENT NORMALLY ASSIGNED			
M	ADDRESS OF LOCATION WHERE INJURY OR EXPOSURE OCCURRED CITY, STATE			ZIP CODE			
N	DID EMPLOYEE DIE AS A RESULT OF THE INJURY OR ILLNESS?	IF EMPLOYEE DIED AS A RESULT OF THE INJURY OR ILLNESS, GIVE DATE OF DEATH		MONTH DAY YEAR			
0	WAS THE INJURY OR EXPOSURE ON THE EMPLOYER'S PREMISES?	DID THIS INCIDENT RESULT IN: OCCUPATIONAL INJURY OCCUPATIONAL DISEASE		Was Employee given Industrial Commission Handbook?			
P	NATURE OF THE INJURY						
Q	PART OF THE BODY AFFECTED (BE SPECIFIC)						
R	WHAT TASK WAS EMPLOYEE PERFORMING WHEN ILLNESS OR INJURY OCCURRED						
S	OBJECT OR SUBSTANCE RESPONSIBLE FOR INJURY OR ILLNESS (SOURCE)						
T	HOW DID ACCIDENT OR ILLNESS OCCUR (TYPE)?						
U	WHAT HAZARDOUS CONDITIONS, METHODS OR LACK OF PROTECTIVE DEVICES CONTRIBUTED?						
V	WHAT UNSAFE ACT BY A PERSON CAUSED OR CONTRIBUTED TO THE INJURY OR ILLNESS?						
W	HAVE MEDICAL SERVICES BEEN RENDERED TO THE EMPLOYEE?		IS OR HAS THE EMPLOYEE BEEN HOSPITALIZED?				
X	NAME AND ADDRESS OF PHYSICIAN CITY, STATE			ZIP CODE			
Y	NAME AND ADDRESS OF HOSPITAL CITY, STATE			ZIP CODE			
Z	REPORT PREPARED BY: (NAME-PRINT OR TYPE)		SIGNATURE		TITLE AND TELEPHONE NUMBER		

NOTE: DISCLOSURE OF THIS INFORMATION TO THE INDUSTRIAL COMMISSION IS MANDATORY UNDER IL. REV. STAT. CH. 48,s 138.6. FAILURE TO PROVIDE ANY INFORMATION COULD RESULT IN PROSECUTION. APPROVED BY FORMS MANAGEMENT.