Employer's name Doing business as Employer's mailing address Nature of business or service SIC code Name of workers' compensation carrier/admin. Argent / Fax: 888-926-929/ Policy/Contract # Self-insured? Self-insured? Self-insured? Employee's full name Social Security # Self-insured? Employee's e-mail address Employee's e-mail address Employee's e-mail address Date infred Jate hired Jate hired Time employee began work If the employee died as a result of the accident, give the date of death. Did the accident occur on the employer's premises? Address of accident What was the employee doing when the accident occurred? What was the employee doing when the accident occurred? 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?	ILLINOIS FORM 45					Please type or print.			
Employer's mailing address Nature of business or service Name of workers' compensation carrier/admin. Argent Fax: 88-926-939 / email: Argent Fax: 88-926-939 / email: Argent MCC Scan Ctr@wbml.com Employee's full name Social Security # Single/Married? Social Security # Employee's e-mail address Employee's mailing address Employee's mailing address Employee's average weekly wage Job title or occupation Date hired Time employee began work Date and time of accident If the employee died as a result of the accident, give the date of death. Did the accident occur on the employer's premises? 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?	Employer's FEIN		Date of repo	ort	Case or File #	#		Is this	s a lost workday case?
Employer's mailing address Nature of business or service Nature of business or service Argent / Fax: s88-926-9299 / Service / Social Security # Self-insured? Argent / Fax: s88-926-9299 / Semail: Argent WCC Scan Ctr@wbmi.com Employee's full name Social Security # Birthdate Employee's mailing address Employee's e-mail address Employee's e-mail address Male/Female? Single/Married? # Dependents Employee's average weekly wage Job title or occupation Date hired Time employee degan 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? 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?									
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Argent Fax: 88-926-9299 / memal: Argent WCC_Scan_Ctr@wbmi.com Employee's full name Social Security # Sirthdate Employee's mailing address Employee's e-mail address Male/Female? Single/Married? # Dependents Employee's average weekly wage Job title or occupation Date hired Job title or occupation If the employee began work Date and time of accident If the employee died as a result of the accident, give the date of death. Did the accident occur on the employer's premises? 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?	Nature of business or service					s	IC code		
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Report prepared by Signature Title and telephone #	Was the employee treated in	an emergency	room?	Was the employ	vee hospitalize	d overnigh	t as an inpatien	nt?	
	Report prepared by		Signature			Title	and telephone #	#	

Please send this form to:

ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE ROAD SPRINGFIELD, IL 62703-5118 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. IC45 6/09