

ILLINOIS FORM 45: Employer's First Report of Injury or Illness

Employer's FEIN: 366006035	Case or File #: TBD	Date of Report: / /	Is this a lost workday case? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Employer's Name: VILLAGE OF ORLAND PARK			
Street address: 14700 RAVINIA AVENUE		ORLAND PARK	IL 60462
Doing business as: VILLAGE OF ORLAND PARK	Nature of business: MUNICIPALITY	State: IL	ZIP Code: 60462
Name of workers' compensation carrier/admin.: CCMSI	Policy/Contract #: AGC-8756-IL	Self-insured? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Employees Full Name: Matthew R. Hanna	Social Security Number: 350-70-8199	Birth Date: 5/18/81	
Employee's Mailing Address: 1001 W. 172nd St. E. Hazel Crest, IL 60429		Home Phone Number: (708) 825-4922	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input checked="" type="checkbox"/> Single	# of Dependents: 0	Average Weekly Salary: \$ 1500
Job Title or Occupation: Maint. III	Date Hired: 3/20/2000	Full Wages Paid Date of Accident: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Time Employee Began Work: 12:00 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	Date of Accident: 1/5/2014	Last Day Employee Worked: / / OR <input checked="" type="checkbox"/> No lost work time	
Time of Accident: 9:30 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM			
If the employee died as a result of the accident, give the date of death: X/X/X	Did the accident occur on the employer's premises? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Location Name and Address of Accident: 9750 143rd St. Orland Park, IL 60462 (west parking lot)			
What was the employee doing when the accident occurred? Plowing			
How did the accident occur? Backed into light pole while plowing			
What was the injury or illness? List the part of body affected and explain how it was affected. No injury			
What object or substance, if any, directly harmed the employee? No injury			
Name and address of physician/health care professional: No doctor			
If treatment was given away from the worksite, list the name and address of the place it was given. No treatment			
Was the employee treated in an emergency room? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was the employee hospitalized overnight as an inpatient? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Report Prepared by: Title: Maint III	Signature: Matthew R. Hanna		Telephone: (708) 825-4922

**PLEASE RETURN THIS FORM TO HUMAN RESOURCES AS SOON AS POSSIBLE FOLLOWING INCIDENT.
14700 S. RAVINIA AVENUE, ORLAND PARK, IL 60462**

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.

Supervisor's Report of an Accident

Location: 9750 143rd St. Orland Park IL 60462

Name of Injured Employee: Matthew R Hanna Date: 1-5-11

*** No Injury ***

- | | | | | | |
|--|---|--|-------------------------------------|---------------------------------|------------------------------------|
| <input type="checkbox"/> head | <input type="checkbox"/> hands | <input type="checkbox"/> wounds | <input type="checkbox"/> amputation | <input type="checkbox"/> death | <input type="checkbox"/> lost time |
| <input type="checkbox"/> eyes | <input type="checkbox"/> legs | <input type="checkbox"/> strain & sprain | <input type="checkbox"/> burns | <input type="checkbox"/> hernia | |
| <input type="checkbox"/> medical aid only | <input type="checkbox"/> trunk | <input type="checkbox"/> feet | <input type="checkbox"/> arms | | |
| <input type="checkbox"/> foreign body | <input type="checkbox"/> internal | <input type="checkbox"/> fracture | | | |
| <input type="checkbox"/> skin (occupational) | <input type="checkbox"/> due to delayed medical treatment | | | | |

Remarks _____

Describe accident, include the machine, object or substance involved...all details...use reverse side if necessary.

Plowing parking lot in 2012 Ford F550 dump truck and backed into street light pole.

Cause:

Mark basic cause

Unsafe Acts

- ☐ Operating without authority
- ☐ Operating at unsafe speed
- ☐ Making safety devices inoperative
- ☐ Using unsafe equipment or equipment unsafely
- ☐ Unsafe loading, placing, mixing
- ☐ Taking unsafe position
- ☐ Working on moving or dangerous equipment
- ☐ Distraction, teasing, horse play
- ☐ Failure to use personal protective devices

Unsafe Conditions

- ☐ inadequately guarded
- ☐ unguarded
- ☐ defective tools, equipment or substance
- ☐ unsafe design or construction
- ☐ hazardous arrangement
- ☐ unsafe illumination
- ☐ unsafe ventilation
- ☐ unsafe clothing
- ☐ unsafe procedure

Why was the unsafe procedure followed? Lost visual location of obstruction while backing up

Why was the unsafe act committed? Unintentional

Why did the unsafe condition exist? Blowing drifting snow

Supervisor: _____

Guides to Corrective Action:

Based on the cause checked above, check below the corrective action you are taking:

UNSAFE ACT

- ☐ Stop the worker
- ☐ Study the job
- ☒ Instruct (Tell X show X try X check)
- ☐ Follow-up
- ☐ Enforce

UNSAFE PROCEDURE

- ☐ Institute new procedure
- ☐ Instructed other employees in new procedure

What are you actually doing to prevent similar injury? _____

What further recommendations? Double check surroundings

UNSAFE CONDITION

- ☐ Remove
- ☐ Guard
- ☐ Warn

If Supervisor can't handle then:

- ☐ Recommend to: (a) own supervisor, or (b) safety committee, or (c) maintenance committee, or _____
- ☐ Follow-up

Accident Statement Form

Name: Matthew R. Hanna Date: 1-5-14

Department: Building Maintenance

Check One: ☒ Involved in accident or injury

☐ Witness to accident or injury

Time of occurrence: 9:30 a.m./p.m.

Location of occurrence: 9760/43rd St. Orland Park, IL 60462

Names of other people present: None

General statement regarding occurrence: Backed into street light pole
while plowing parking lot. Pole damaged beyond repair and
truck spreader box dented on drivers side. Box is operational,
no major damage

Signature: Matthew R. Hanna

Date: 1-5-14

Supervisor's Signature: Dennis G. White

Date: 1-5-14