UNIVERSITY OF ILLINOIS
PUBLIC INJURY REPORT – UIUC / UIS

PLEASE TYPE, OR PRINT CLEARLY USING INK – ALL FIELDS MUST BE COMPLETED TO INITIATE INVESTIGATION PROCESS

DATE OF INCIDENT ________________________________

TIME ____________________________ A.M. □ P.M. □

TYPE OF INJURY ________________________________________________________________

WHERE DID THIS HAPPEN?

PROPERTY OWNER ________________________________________________________________

ADDRESS

CITY________________________ STATE________ ZIP________

INJURED PARTY IS A STUDENT ☐ VISITOR ☐

IMPORTANT: Senate Bill 2499 requires you indicate if you are MEDICARE ELIGIBLE or CURRENTLY A MEDICARE BENEFICIARY Check for YES ☐

HICN________________________ SSN/UIN________________________

NAME________________________ PHONE (____)________

ADDRESS

CITY________________________ STATE________ ZIP________

DATE OF BIRTH (required)_____________JOB TITLE_________________________DEPT________

WHAT EXACTLY HAPPENED?

DESCRIPTION OF ACCIDENT

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

WHO WITNESSED THIS INCIDENT? (USE REVERSE IF MORE THAN ONE WITNESS)

NAME________________________ PHONE (____)________

ADDRESS

CITY________________________ STATE________ ZIP________

WERE POLICE NOTIFIED? YES ☐ NO ☐ ATTACH COPY - REPORT #________

DEPARTMENT CONTACTED __________________________ DATE REPORTED ________________

PHONE NUMBER/DEPARTMENT LOCATION (IF KNOWN) __________________________________

This form should be completed by the injured party but may be completed by the facility representative that wishes to report an incident.

Please indicate if you (the injured party) would like to be contacted by a representative from The Office Claims Management. Yes ☐ NO ☐
RESOURCE INFORMATION
The University of Illinois General Liability Policy may be found at:
https://www.treasury.uillinois.edu/risk_management/general_liability/
Please visit the website for additional information and other helpful links.

ADDITIONAL WITNESS INFORMATION:
NAME __________________________________________ PHONE (___) ______
ADDRESS ________________________________
CITY________________________ STATE________________________ ZIP __________

SEND ORIGINAL TO: Office of Worker’s Compensation and Claims MGMT
449 Henry Administration Bldg. 506 S. Wright St. MC-300, Urbana IL 61801
(217) 333-1080 • Fax (217) 244-5152 • workcomp@uillinois.edu
RETAIN A COPY FOR YOUR DEPARTMENTAL OR PERSONAL RECORDS

Additional Information you would like to provide in consideration of your claim:

NAME OF INDIVIDUAL COMPLETING THIS REPORT
JOB TITLE __________________ DEPT ____________ OFFICE PHONE ____________
(IF APPLICABLE) (IF APPLICABLE) (IF APPLICABLE)

SIGNATURE______________________________________________________DATE____________________