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________________________
NAME______________________________ SSN/UIN
STREET________________________________ PHONE (___)________
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.

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**ADDITIONAL WITNESS INFORMATION:**

<table>
<thead>
<tr>
<th>NAME</th>
<th>PHONE (___) ______</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td></td>
</tr>
<tr>
<td>CITY</td>
<td>STATE</td>
</tr>
</tbody>
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SEND ORIGINAL TO: Office of Worker’s Compensation and Claims Management  
100 Trade Centre, Suite 103, MC-686, Champaign, IL 61820  
(217) 333-1080 • Fax (217) 244-5152 • workcomp@uillinois.edu  
RETAIN A COPY FOR YOUR DEPARTMENTAL OR PERSONAL RECORDS

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

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NAME OF INDIVIDUAL COMPLETING THIS REPORT  
JOB TITLE ___________________ DEPT ___________________ OFFICE PHONE ___________________  
(If applicable) (If applicable) (If applicable)

SIGNATURE ___________________________________________ DATE ___________________  

(Rev. 10/15)