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.

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_____

(Rev. 10/15)