

**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 _____