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_____________________________________________________________
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)