UNIVERSITY OF ILLINOIS
PUBLIC INJURY/PROPERTY DAMAGE REPORT

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

WHY ARE YOU MAKING THIS REPORT?  PROPERTY DAMAGE ☐  BODILY INJURY ☐

WHEN DID THIS HAPPEN?  DATE OF INCIDENT ________________________________________________
TIME __________________ A.M. ☐ P.M. ☐

WHERE DID THIS HAPPEN?
WHERE EXACTLY DID THIS OCCUR? ______________________________________________________________________
__________________________________________________________________________________________
________________________________________________________________________________________________

PROPERTY OWNER _________________________________________________________________________________
ADDRESS _____________________________________________ _____________________________________________
CITY___________________________________________ STATE ___________________________ ZIP _______________

WHO ARE YOU?  GENERAL PUBLIC ☐  STUDENT ☐  VISITOR ☐  EMPLOYEE ☐ (Complete Workers’ Compensation form)

IMPORTANT: Senate Bill 2499 requires you answer affirmatively if you are MEDICARE ELIGIBLE or CURRENTLY A MEDICARE BENEFICIARY ☐

NAME________________________________________________________  SSN/UIN ____________________________
STREET ___________________________ PHONE (_____)_______________________
CITY ____________________________________________ STATE_______________________ ZIP __________________

DATE OF BIRTH (required)_________________ JOB TITLE ________________________________DEPT ____________

WHAT EXACTLY HAPPENED?
DESCRIPTION OF ACCIDENT/DAMAGE/INJURY ___________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

WHO WITNESSED THIS INCIDENT?  (USE REVERSE IF MORE THAN ONE WITNESS)
NAME __________________________________________ PHONE (_____)
ADDRESS ___________________________________________________________________________________
CITY___________________________________________ STATE ___________________________ ZIP _______________

WERE POLICE NOTIFIED?  YES ☐  NO ☐  REPORTED BY _______________________________
DEPARTMENT CONTACTED ____________________________________ DATE REPORTED __________________
PHONE NUMBER/DEPARTMENT LOCATION (IF KNOWN) ________________________________

NAME OF INDIVIDUAL COMPLETING THIS REPORT _____________________________________________
JOB TITLE ______________________________ DEPT ________________ OFFICE PHONE ______________________

SEND ORIGINAL TO: Office of Claims Management,
301 HRB, 715 S. Wood, M/C 939, Chicago, IL  60612
(312) 996-6516
RETAIN A COPY FOR YOUR DEPARTMENTAL OR PERSONAL RECORDS

(Rev. 1/10)