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 __________________

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 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

(Rev. 1/10)