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 __________________
(IF APPLICABLE) (IF APPLICABLE) (IF APPLICABLE)

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

(Rev. 1/10)
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 ______
DATE OF BIRTH (required)______________ JOB TITLE ________________________________ DEPT ___________________
(IF APPLICABLE) (IF APPLICABLE)

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 ______________________
(IF APPLICABLE) (IF APPLICABLE) (IF APPLICABLE)

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)