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 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)
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REPORTED BY _________________________________
DEPARTMENT CONTACTED __________________________ DATE REPORTED __________________________
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