

**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 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](mailto:workcomp@uillinois.edu)**

**RETAIN A COPY FOR YOUR DEPARTMENTAL OR PERSONAL RECORDS**

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