UNIVERSITY OF ILLINOIS
PUBLIC INJURY/PROPERTY DAMAGE REPORT

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

<table>
<thead>
<tr>
<th>WHY ARE YOU MAKING THIS REPORT?</th>
<th>PROPERTY DAMAGE ☐</th>
<th>BODILY INJURY ☐</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>WHEN DID THIS HAPPEN?</th>
<th>DATE OF INCIDENT</th>
<th>TIME</th>
<th>A.M. ☐</th>
<th>P.M. ☐</th>
</tr>
</thead>
</table>

<table>
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<tr>
<th>WHERE DID THIS HAPPEN?</th>
<th>WHERE EXACTLY DID THIS OCCUR?</th>
</tr>
</thead>
<tbody>
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PROPERTY OWNER
ADDRESS
CITY
STATE
ZIP

<table>
<thead>
<tr>
<th>WHO ARE YOU?</th>
<th>GENERAL PUBLIC ☐</th>
<th>STUDENT ☐</th>
<th>VISITOR ☐</th>
<th>EMPLOYEE ☐ (Complete Workers’ Compensation form)</th>
</tr>
</thead>
</table>

**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

<table>
<thead>
<tr>
<th>WHAT EXACTLY HAPPENED?</th>
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<tbody>
<tr>
<td>DESCRIPTION OF ACCIDENT/DAMAGE/INJURY</td>
</tr>
<tr>
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<tr>
<th>WHO WITNESSED THIS INCIDENT? (USE REVERSE IF MORE THAN ONE WITNESS)</th>
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<tbody>
<tr>
<td>NAME</td>
<td>PHONE (____)</td>
</tr>
<tr>
<td>ADDRESS</td>
<td></td>
</tr>
<tr>
<td>CITY</td>
<td>STATE</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>NAME OF INDIVIDUAL COMPLETING THIS REPORT</th>
<th>JOB TITLE</th>
<th>DEPT</th>
<th>OFFICE PHONE</th>
</tr>
</thead>
</table>

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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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)

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NAME ____________________________________________
SSN/UIN ____________________________
STREET ____________________________ PHONE (____)_______________________
CITY ____________________________ STATE ____________________________ ZIP __________________
DATE OF BIRTH (required)______________________ JOB TITLE ____________________________ DEPT __________________

WHAT EXACTLY HAPPENED?
DESCRIPTION OF ACCIDENT/DAMAGE/INJURY ____________________________________________
__________________________________________________________________________________
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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 __________________________________
PHONE NUMBER/DEPARTMENT LOCATION (IF KNOWN) __________________________________

NAME OF INDIVIDUAL COMPLETING THIS REPORT ____________________________
JOB TITLE ____________________________ DEPT ____________________________ OFFICE PHONE ____________________________
(IF APPLICABLE)  (IF APPLICABLE)  (IF APPLICABLE)

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