

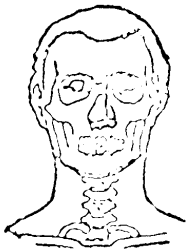
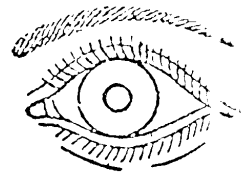
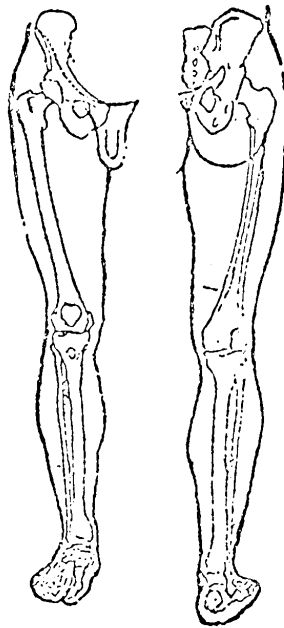
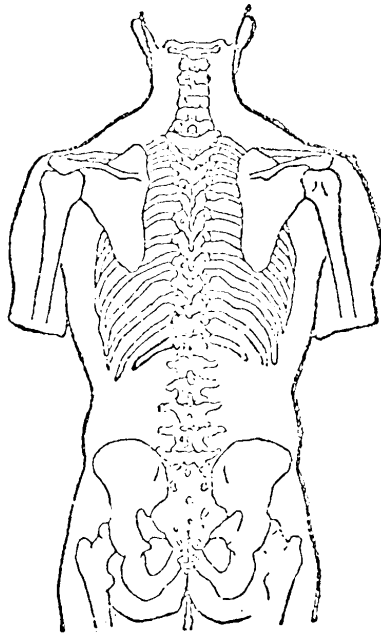
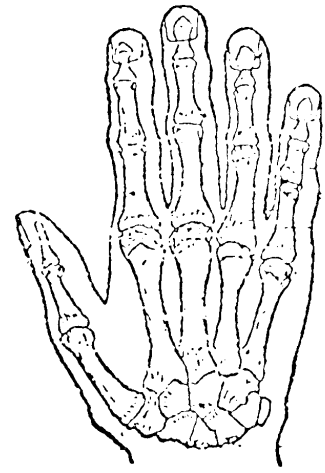
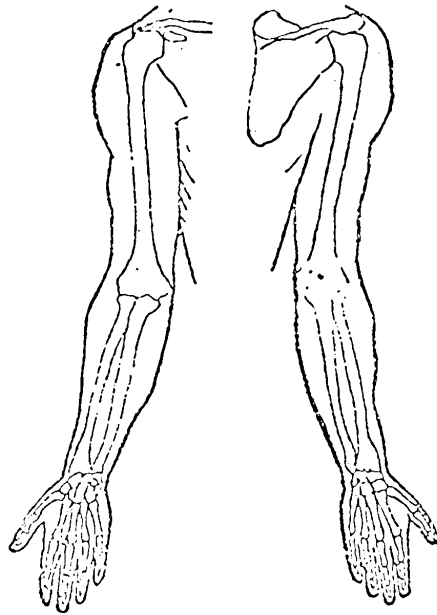
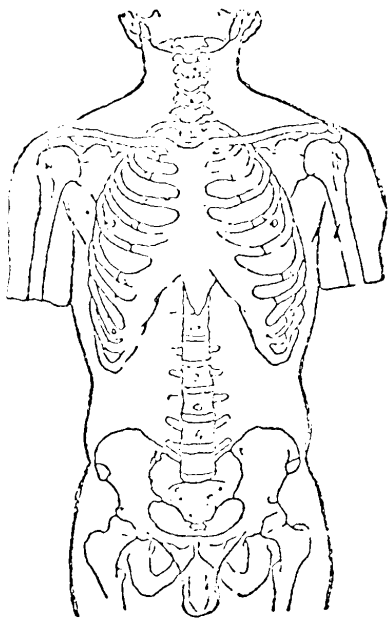
# Personal Injury/Accident Investigation Report

Case # \_\_\_\_\_

Name of Injured Person										
Home Address			Street				City		State	Zip
Home Phone		Work Phone			Birthdate	Month	Day	Year	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Category of Injured		Faculty <input type="checkbox"/>		Civil Service <input type="checkbox"/>		Student <input type="checkbox"/>		Grad. Asst. <input type="checkbox"/>		Visitor <input type="checkbox"/>
Date of Injury		Month	Day	Year	Time of Injury		_____ A.M.	_____ P.M.	Day of Week	
Location of Accident (Be specific)										
Was Injured Person Transported?			Yes <input type="checkbox"/> No <input type="checkbox"/>		If Yes, Check Method of Transportation Below					
UIS Police Car <input type="checkbox"/>		Ambulance <input type="checkbox"/>			Private Vehicle <input type="checkbox"/>			Other <input type="checkbox"/>		
Did the Injured Person Go to Health Services?				Yes <input type="checkbox"/> No <input type="checkbox"/>		If Treated at Another Location Indicate Below				
St. John's Hospital <input type="checkbox"/>		Memorial Medical Center <input type="checkbox"/>			Other <input type="checkbox"/>					
If Other, Indicate Who or Where										
Did the Injured Person Miss Time from Work?				Yes <input type="checkbox"/> No <input type="checkbox"/>		If Yes, Give Last Date Worked				
Was There Any Property Damage?			Yes <input type="checkbox"/> No <input type="checkbox"/>		What Was Damaged?					
What Was the Injured Person Doing When the Accident Occurred?										
Non-injury / Pre-existing medical condition:										
What Part of the Body was Injured?										
What Kind of Injury? (Cut, Burn, Sprain, etc.)										
What Treatment was Rendered?										
Name, Address, and Phone Number of Persons Witnessing Accident										
Have there been any previous accidents of a similar nature?				If yes, give specifics						
How Could the Accident Have Been Prevented?										
Did the Action or Attitude of the Injured Person Contribute to this Accident?							Yes <input type="checkbox"/>		No <input type="checkbox"/>	
If Yes, State How										
Date of Report		Month	Day	Year	Signature of Injured					
Signature and Title of Person Completing Report										

**PLEASE DO NOT WRITE BELOW THIS LINE**

Death <input type="checkbox"/>	Perm. Total <input type="checkbox"/>		Perm. Partial <input type="checkbox"/>		Temp. Total <input type="checkbox"/>		Days Lost		
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PERSONAL INJURY/ACCIDENT INVESTIGATION REPORT  
UNIVERSITY OF ILLINOIS AT SPRINGFIELD

WHERE CHART SHOWS ONE SIDE ONLY  
INDICATE RIGHT OR LEFT

**NARRATIVE REQUIRED**

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