State of Illinois
Department of Human Services

Report of Personal Injury

1. CASE NAME: _____
Last First Middle Initial

2. CASE ADDRESS: _____
Street or Post Office Box City

_____
County State Zip Code

3. CASE NUMBER: _____

4. PERSON INJURED: _____

5. DATE INJURED: _____

6. STATUS OF CASE AT TIME OF INJURY: _____

7. RELATIONSHIP OF INJURED PERSON TO GRANTEE: _____

8. IDENTIFY WHERE (LOCATION) THE ACCIDENT TOOK PLACE.

9. DESCRIBE HOW THE ACCIDENT OCCURRED

10. IDENTIFY THE CLINIC, HOSPITAL OR PHYSICIAN WHO TREATED THE INJURY.

11. DOCUMENTATION OR EXPLANATION REQUIRED
A. Attach a copy of any Policy reports filled.
B. Attach a copy of any Tax and Title Searches conducted.
C. Give details of any lawsuits or claims in items 17 & 20.
D. Give details of the injured person's work history in items 18 & 21.

ENTER THE COMPLETE NAME AND ADDRESS WITH ZIP CODES, PHONE NUMBERS AND POLICY OR CLAIM NUMBERS FOR THE PARTIES IDENTIFIED BELOW.

12. PERSON RESOPNSIBLE FOR THE INJURY

13. RESPONSIBLE PERSON'S ATTORNEY

14. RESPONSIBLE PERSON'S INSURANCE COMPANY OR AGENT

Phone Number: Policy or Claim Number:

15. INJURED RECIPIENT'S ATTORNEY

Phone Number: _____

16. INJURED RECIPIENT'S INSURANCE COMPANY OR AGENT

Phone Number: _____ Policy or Claim: _____

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17. BASIS OR SUIT/CLAIM, IF KNOWN (CHECK ONE)

- A. ☐ Common Law
- B. ☐ Worker's Compensation
- C. ☐ Workers' Occupational Disease Act
- D. ☐ Wrongful Death Act
- E. ☐ Crime Victim's Compensation Act
- F. ☐ Medical or Legal Malpractice

18. INJURED PERSON'S WORK STATUS (CHECK ONE)

- A. ☐ Employed at time of injury.
- B. ☐ Employable but not employed.
- C. ☐ Working when injured.
- D. ☐ Unemployable.

19. IS THIS INJURY WORK-RELATED?

A. ☐ Yes ☐ No If yes complete 21

20. PROVIDE DETAILS OF ANY LAWSUITS OR CLAIMS RESULTING FROM THIS INJURY.

A. Court or county where filed:

B. Docket or Claim Number:

C. Date filed:

21. IF INJURY IS WORK-RELATED:

A. Indicate name, address, and telephone number of employer:

B. Was this injury reported to employer? ☐ Yes ☐ No

If no, please advise the client to do so immediately.

C. Are **Workers'** Compensation medical or disability benefits being received? ☐ Yes ☐ No

If no, please inform the client to file for these benefits immediately.

22. DESCRIBE THE INJURY RECEIVED.

23. ADDITIONAL INFORMATION:

24. NAME, TITLE AND PHONE NUMBER OF THE WORKER COMPLETING THIS FORM.

25. DATE FORM COMPLETED

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