University of Illinois College of Medicine
Student Clinical Experience Incident Report Form
Chicago

Student Information

Name: _____ **UIN:** _____

Email: _____ **Cell Phone:** _____

Incident and Reporting Information

Clinical Rotation: _____

Location (Site and Department): _____

Date/Time: _____

Reported to (MUST list both individuals)**:**

Clinical Site: _____ **Date:** _____

School Official: _____ **Date:** _____

Description of Incident:

Follow-up Information

Contacted Campus Care or Insurance Provider for primary coverage within 24 hours of incident:

Yes ☐ No ☐

If no, please explain:

Follow-up with University Health Service (312 996 7420): Scheduled ☐ **Completed** ☐

Signature of Injured Party: _____ Date: _____

Signature of Clinical Supervisor: _____ Date: _____

Please return form to: Assistant Dean for Student Affairs