

**Illinois Department of Public Health
Swimming Pool and Bathing Beach
DROWNING/INJURY/ILLNESS REPORT**

Section 820.315 of the Swimming Pool and Bathing Beach Code requires that all drownings, injuries or illnesses requiring hospitalization shall be reported to the Department within 24 hours. In addition, this form must be completed and returned to the office that serves your facility within seven days of the incident (see reverse side for correct office). A separate report shall be completed for each victim. In the event of a drowning, the Department's Springfield Office should be advised immediately at 217/782-5830. During non-working hours, contact the Illinois Emergency Management Agency at 1-800-782-7860. This form may also be used to advise the Department of illnesses, skin irritations or minor injuries associated with use of the facility.

FACILITY INFORMATION

The facility is licensed as	Type of Facility	
<input type="checkbox"/> Indoor Swimming Pool	<input type="checkbox"/> Educational	<input type="checkbox"/> Hotel/Motel
<input type="checkbox"/> Outdoor Swimming Pool	<input type="checkbox"/> Fitness/Health Club	<input type="checkbox"/> Municipal/County/Park District
<input type="checkbox"/> Bathing Beach	<input type="checkbox"/> Apartment/Condominium	<input type="checkbox"/> Country Club
	<input type="checkbox"/> State Owned Facility	<input type="checkbox"/> Other _____

Name of Facility _____

Street Address _____ City _____ County _____

DESCRIPTION OF INCIDENT

ILLNESS

INJURY

FATALITY

Name of Victim _____ Age _____ Male Female

Home Address _____ Telephone # _____

City _____ State _____ Zip Code _____

Description of incident, including date, time, circumstances (Attach additional sheets if necessary and any police reports if available.) _____

SUPERVISION AT TIME OF ACCIDENT

If lifeguards were provided, names of all guards on duty at time of incident and attach copy of their current certificates _____

If lifeguards not provided and victim was less than 16 years old, list name(s) of responsible supervisor(s) at time of incident _____

Was facility open for swimming at time of incident? _____

Name of medical facility that provided treatment or diagnosis
Name _____
Address _____ City _____

For additional information concerning this incident, the Department may contact
Name _____ Title _____ Telephone # _____

This report was completed and submitted by
Name _____ Title _____ Date _____

This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under Public Act 78-1149. Disclosure of this information is mandatory.