Reporting Procedure for 3rd Party Incident/Accident

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The following procedures are the DIRECT RESPONSIBILITY of the Agency Risk Coordinator.

Anytime there is contact with the public concerning an accident or incident:

1. Immediately report the incident to your supervisor;
2. Fill out a **STANDARD LIABILITY INCIDENT REPORT**;
3. Fill out a **SCOPE OF EMPLOYMENT** form and
4. Send completed copies to the Fiscal Services Risk Management Division

Do not wait for notification of a claim from this office before sending the incident and scope of employment.

When you send in a "Standard Liability Incident Report", regardless of the type of incident, the form must be filled out by your employees, **(NOT THE CLAIMANT)**, with the following questions answered:

WHO

Claimant's name, address, phone number

Who at your agency was involved: agency name, employee name, position, phone number, etc?

If a State employee is directly involved in an incident or accident, then we need the enclosed "Scope of Employment" Form filled out and signed by the employee's supervisor. In case of a vehicle accident call the police regardless of who's at fault and try to obtain a police report.

WHAT happened to the claimant?

Personal Injury

For slip and fall's find out how the claimant was dressed, type of shoes, approximate weight, etc. What were they carrying and how much (arms full, couldn't see where stepping). Total over-all appearance.

Where the claimant was injured (i.e. left leg, right knee, neck, lower back, etc.)

Vehicle Damage

Describe area of damage (i.e. left front fender, passenger side tail light, right door etc.

Describe condition of the vehicle, not any possible pre-existing damage.

Get pictures if possible.

Personal Property Damage

Get a description of the property; note the prior condition of the property if possible.

WHEN

Date and time of incident

WHERE

Exact location of the incident. Pictures of the site are very beneficial, especially for slip and fall incidents.

State of Oklahoma
Department of Central Services
Risk Management Division

Scope of Employment

DCS-RISK MGMT P.O. BOX 53364 **OKLAHOMA CITY, OKLAHOMA 73152** **TEL: 405/521-4999, FAX: 405/522-4442**

Incident Date: ______________ Time: ____________ Claim No (DCS use only): ____________________

Employee Name: ________________________________ Job Title: ________________________

State Agency Name ____ Code ______________

Division or Dept: ____ Phone ______________

Address: ______________________________ City: ______________ State: ________ Zip: ________

Type of Employment: ☐ Full Time ☐ Temporary ☐ Volunteer ☐ Contract

Who Authorized This Specific Duty: ____

Please describe in detail what specific duty was being performed at the time of the incident.

________________________________ Employee Signature

________________________________ Supervisor Signature

________________________________ Please Type or Print Name (Supervisor)

________________________________ Date

________________________________ Date

State of Oklahoma
Department of Central Services
Risk Management Division

Standard Liability Incident Report

DCS-RISK MGMT P.O. BOX 53364 OKLAHOMA CITY, OKLAHOMA 73152 TEL: 405/521-4999 (24h), FAX: 405/522-4442

Claim No: ___________________

Agency Information:

Agency Name ____________________ Agency # __________ Phone __________________

Type of Employment: ☐ Full Time ☐ Temporary ☐ Volunteer ☐ Contract

Driver or Employee: ____________________ Job Title: ____________________

Div. or Dept: ____________________ Address: ____________________ Phone: ____________________

Specific Duty Being Performed:

Vehicle Information:

Owned By: State ____________ Other ____________ Make ____________ Year ____________

Body Type: ____________ Vehicle Tag #: ____________ Vehicle #: ____________

Amount Damage: ____________ Where Damaged: ____________________

Claimant's Name: ____________________ Phone: ____________

Address: ____________________ City: ____________ State: ________ Zip: ________

Was Claimant or Passenger Injured? ☐ Yes ☐ No

Describe ____

Name of Doctor or Hospital: ____

Claimant Vehicle: ____________ ____________ ____________ ____________

Make Yr Body Type Damage Amt.

Where Damaged: ____

Claim Form Requested? ☐ Yes ☐ No

Incident Date: ____________ Time: ____________

Location:

____________ ____________ ____________ ____________

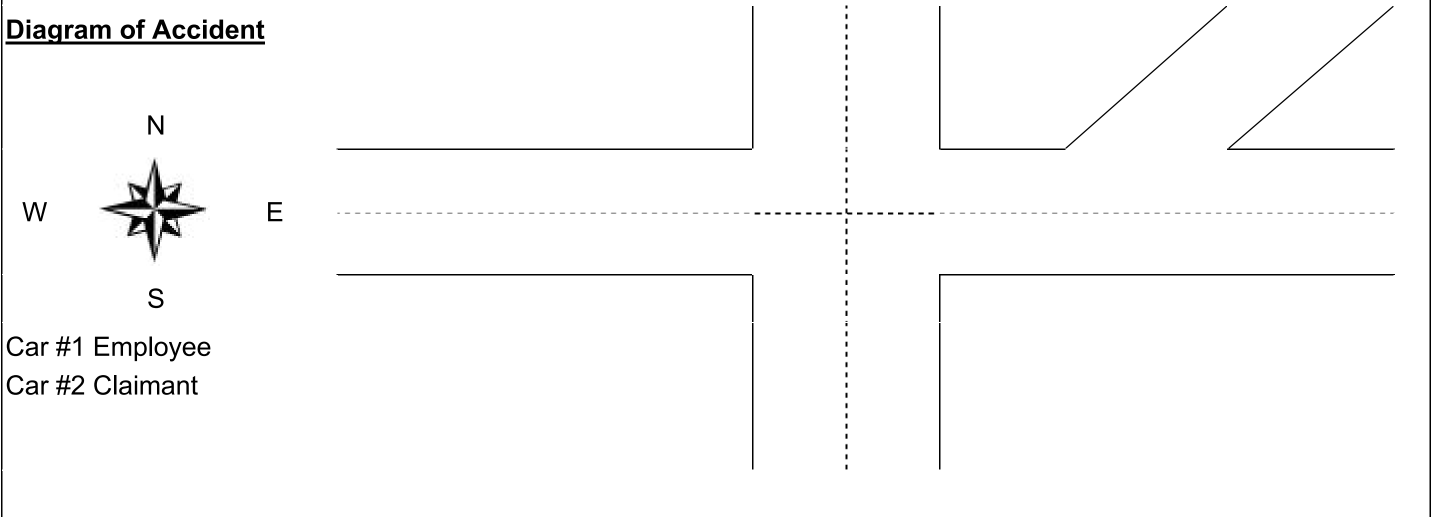
City Street Highway County

Describe Incident:

Was Employee Aware Of Incident? ☐ Yes ☐ No

Remarks:

Diagram of Accident



Car #1 Employee
Car #2 Claimant

Witnesses

Name	Address	Phone

Incident Citations

Authorities reported to: ______________________ Name: ______________

Were there any citations: ☐ Yes ☐ No

Who: ______________ What: ______________

Reported by: ______________ Date: ________ Phone: ________

Driver's signature: ______________ Driver's license #: ______________