



**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