



State of Oklahoma
Office of Management and Enterprise Services
Division of Capital Assets Management
Risk Management Department

Employment Incidents
Standard Liability Incident Report

DCAM-RISK MGMT P.O. BOX 53364

OKLAHOMA CITY, OKLAHOMA 73152

TEL: 405/521-4999 (24h), FAX: 405/522-4442

Claim Number _____

Incident Date: _____ Time: _____ Date of agency notification: _____

Claim Form Requested? Yes No

Location:

_____ Address/Highway _____ City _____ State _____ County _____

Claimant's Information

Claimant's Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Was Claimant Injured? Yes No

Describe: _____

Name of Doctor or Hospital: _____

Agency Information

Agency Name: _____ Agency #: _____ Phone: _____

Div or Dept: _____ Address: _____ Phone: _____

Type of Issue

Termination Sexual Harassment Constitutional Rights Civil Rights Failure to Promote

Discrimination of _____ Misrepresentation Other _____

Describe Incident, include any co-workers involved:

Witnesses:

Name _____ Address _____ Phone _____

Attach supporting documentation: *PMPs, Progressive Discipline, EEOC, court documents, emails etc.*

_____ Risk Coordinator Signature _____ Risk Coordinator Printed Name _____ Date _____

_____ Email _____ Phone Number _____