



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

Personal/Bodily Injury
Standard Liability Incident Report
(Non-Vehicle Injury)

DCAM-RISK MGMT P.O. BOX 53364

OKLAHOMA CITY, OKLAHOMA 73152

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

Claim Form Requested? Yes No

Claim Number _____

Incident Date: _____ Time: _____

Date of Agency Notification: _____

Location: _____

Address/Highway _____ City _____ State _____ County _____

Describe Incident:

Photos of accident scene and location need to be taken.

Was Employee Aware of Incident? Yes No

Claimant's Information:

Claimant's Name: _____ Phone: _____

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

Email Address: _____

Was the Claimant Injured? Yes No

Describe: _____

Name of Doctor or Hospital: _____

Agency Information

Agency Name: _____ Agency # _____ Phone: _____

Type of Employment: Full Time Temporary Volunteer Contract

Employee Name: _____ Job Title: _____

Div. or Dept. _____ Address: _____ Phone: _____

Witnesses:

Name	Address	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Slip and Fall

Was the person distracted? Yes No If so, by what? _____
How did the person fall? Forward Backward Other _____
What part(s) of the body was injured? _____
Was the person talking to someone? Yes No Were there children present? Yes No
Was the person a client of the place where the incident occurred? Yes No
Was the surface wet, oily, dirty, slippery, etc.? Wet Oily Slippery Dirty Other _____
Were danger or caution signs posted? Yes No If so, what? _____
Was there a transition in walkway surfaces, or any tripping hazards? If so, explain _____
Was weather (rain/snow) a factor in the incident? If so, describe _____
Was site cleanup needed? (spill, dirt, etc.)? Yes No Describe _____
How long after first notice was incident cleaned up? _____
Type of footwear worn? athletic shoes sandals high heels flats other _____
Type of material of shoe heel? rubber leather synthetic other _____
Did footwear contribute to the fall? Yes No Explain _____

Machinery Incidents

Was injury due to machinery? Yes No If so, who was operating? _____
What type of machinery was involved in the incident? _____
Policy/procedure regarding operation of machinery? Yes No Operator trained? Yes No
Machinery last service date? _____ Machinery last safety inspection? _____
Were safety features in place? (guards, chains etc?) Yes No Explain _____

General Questions

Type of terrain? (i.e. flat, hilly, grassy gravel?) _____
Area inspected/cleared of debris and safety hazards? _____
Did you speak to a witness? Yes No If so, what was said? _____
Was assistance provided? Yes No If so, what? by whom? _____
Was any non-medical personnel called to accident site? If so, who? _____
Was the incident reported to local authority? Yes No If so, provide police report.

Attach additional sheet, if needed

By signing this form you are attesting the information contained is accurate.

Employee Signature Date Risk Coordinator Signature Date

Employee Name Printed Coordinator Name Printed