



DCAM-RISK MGMT P.O. BOX 53364

OKLAHOMA CITY, OKLAHOMA 73152

TEL: 405-521-4999 FAX: 405-522-4442

Incident date \_\_\_\_\_ Time \_\_\_\_\_ Claim No. (CAM use only): \_\_\_\_\_

Employee name \_\_\_\_\_ Job title: \_\_\_\_\_

State agency name \_\_\_\_\_ Agency number \_\_\_\_\_

Division or dept. \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Type of employment:  Full Time  Temporary  Volunteer  Contract

Who authorized this specific duty? \_\_\_\_\_

Was employee aware of incident?  Yes  No

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

\_\_\_\_\_  
Employee signature

\_\_\_\_\_  
Supervisor signature

\_\_\_\_\_  
Employee name printed

\_\_\_\_\_  
Supervisor name printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date