



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

**Vehicle and Other Property
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 _____

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: _____

Was Claimant or Passenger Injured? Yes No

Describe _____

Name of Doctor or Hospital: _____

Claimant' Vehicle: _____
Year Make Model License Tag #

Where Damaged: _____

Agency Information

Agency Name _____ Agency # _____ Phone _____

Type of Employment: Full Time Temporary Volunteer Contract

Driver or Employee: _____ Job Title: _____

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

Owned By: State _____ Other _____ Make _____ Year _____

Model: _____ Vehicle Tag #: _____ Vehicle #: _____

Where Damaged: _____

Witnesses/Passenger

Name Address Phone
