Reporting Procedure for 3rd Party Incident/Accident

The following procedures are the DIRECT RESPONSIBILITY of the Agency Risk Coordinator.

Anytime there is contact with the public concerning an accident or incident:
   1. Immediately report the incident to your supervisor;
   2. Fill out a STANDARD LIABILITY INCIDENT REPORT;
   3. Fill out a SCOPE OF EMPLOYMENT form and
   4. Send completed copies to the Fiscal Services Risk Management Division

Do not wait for notification of a claim from this office before sending the incident and scope of employment.

When you send in a “Standard Liability Incident Report”, regardless of the type of incident, the form must be filled out by your employees, (NOT THE CLAIMANT), with the following questions answered:

WHO

   Claimant’s name, address, phone number
   Who at your agency was involved: agency name, employee name, position, phone number, etc?

If a State employee is directly involved in an incident or accident, then we need the enclosed “Scope of Employment” Form filled out and signed by the employee’s supervisor. In case of a vehicle accident call the police regardless of who’s at fault and try to obtain a police report.
**WHAT** happened to the claimant?

**Personal Injury**

For slip and fall’s find out how the claimant was dressed, type of shoes, approximate weight, etc. What were they carrying and how much (arms full, couldn’t see where stepping). Total over-all appearance.

Where the claimant was injured (i.e. left leg, right knee, neck, lower back, etc.)

**Vehicle Damage**

Describe area of damage (i.e. left front fender, passenger side tail light, right door etc.

Describe condition of the vehicle, not any possible pre-existing damage.

Get pictures if possible.

**Personal Property Damage**

Get a description of the property; note the prior condition of the property if possible.

**WHEN**

Date and time of incident

**WHERE**

Exact location of the incident. Pictures of the site are very beneficial, especially for slip and fall incidents.
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
Claim No: ______________

Agency Information:
Agency Name ___________________________ Agency # ______ Phone ________
Type of Employment: ☐ Full Time ☐ Temporary ☐ Volunteer ☐ Contract
Driver or Employee: ______________________ Job Title: ______________________
Div. or Dept: ___________________________ Address: ______________________ Phone: ______________________
Specific Duty Being Performed:

Vehicle Information:
Owned By: State __________ Other __________ Make ________ Year ________
Body Type: _______________ Vehicle Tag #: __________ Vehicle #: __________
Amount Damage: _______________ Where Damaged: _______________

Claimant's Name: ___________________________ Phone: ______________________
Address: ___________________________ City: __________ State: ________ Zip: ________
Was Claimant or Passenger Injured? ☐ Yes ☐ No
Describe _________________________________________________________________
Name of Doctor or Hospital: ___________________________
Claimant Vehicle: __________________________________________
Make __________ Yr __________ Body Type __________ Damage Amt. __________
Where Damaged: __________________________________________
Claim Form Requested? ☐ Yes ☐ No
Incident Date: __________ Time: __________

Location:
City __________ Street __________ Highway __________ County __________
Describe Incident:

Was Employee Aware Of Incident? ☐ Yes ☐ No
Remarks:

Diagram of Accident

N
W
E
S

Car #1 Employee
Car #2 Claimant

Witnesses
Name | Address | Phone
--- | --- | ---
| | | 
| | | 
| | | 

Incident Citations
Authorities reported to: ___________________________ Name: ___________________
Were there any citations: ☐ Yes ☐ No
Who: ___________________________ What: ___________________________
Reported by: ___________________________ Date: ___________ Phone: ___________

Driver’s signature: ___________________________ Driver’s license #: ___________________________