



Employment Incidents Standard Liability Incident Report

DCAM-RISK MGMT P.O. BOX 53364 OKLAHOMA CITY, OK 73152 TEL: 405/521-4999 (24h), FAX: 405/522-4442 EMAIL: fdip@omes.ok.gov

Claim Number _____

Incident Date: _____ Time: _____ Date of Fire Dept 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: _____

Fire Department Information

Fire Dept Name: _____ Fire Dept #: _____ 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.

_____ Fire Chief Signature	_____ Fire Chief Printed Name	_____ Date
_____ Email	_____ Phone Number	