



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

Scope of Employment

DCAM-RISK MGMT P.O. BOX 53364

OKLAHOMA CITY, OKLAHOMA 73152

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

Incident Date _____ Time _____ Claim No (DCAM 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