

IN CASE OF AN ACCIDENT...

STEP #1

Aid the injured

Do not move injured individuals unless absolutely necessary.

STEP #2

DON'T COMMENT!!!

Do not make any statements concerning the assumption of liability. Only give information required by authorities. Do not sign any statement except from an authorized representative of the Risk Management Division or your agency's authorized legal counsel.

STEP #3

Call the police

Give exact location and advise if medical help is needed. Write down the name(s) and badge number(s) of police officer(s) who assist you.

Name _____

Badge # _____

Traffic violation issued to:

State Vehicle Other Vehicle

STEP #4

Facts about your vehicle

Agency _____ Department _____

Driver's Name _____

Department Phone # _____

Make / Year _____ Tag No. _____

Location of Damage _____ Amount _____

STEP #5

Obtain facts about other vehicles

Name _____ Phone No. _____

Address _____

Make / Year _____ Tag No. _____

Drivers License No. _____ Insurance Co. _____

Location of Damage _____ Amount _____

STEP #6

Obtain facts about injured person(s)

Name _____ Age _____

Address _____

Injured Party:

In State Vehicle Pedestrian

In other Vehicle

STEP #7

Record facts about other property damage (Non-Vehicular)

Owner's Name _____ Phone No. _____

Address _____

Property Damaged _____

Nature of Damage (be brief) _____

STEP #8

GET WITNESSES

AND SEND TO YOUR AGENCY RISK MANAGEMENT COORDINATOR IMMEDIATELY.

Name _____ Phone No. _____

Address _____

STATE OF OKLAHOMA

RISK MANAGEMENT DIVISION
P.O. BOX 53364
OKLAHOMA CITY, OKLAHOMA 73152
405-521-4999

ACCIDENT INFORMATION FORM



STEP #9

Call Risk Management

OKC Area 521-4999
Statewide Toll Free 1-888-521-RISK

Date of Incident: _____

Time: _____

Address: _____

Claim Form Requested? Yes No

GET THE FACTS!!!!



STATE OF OKLAHOMA

Department of Central Services

RISK MANAGEMENT DIVISION

THIS FORM IS TO BE KEPT IN THE GLOVE COMPARTMENT OF ALL STATE AND PERSONAL VEHICLES BEING USED BY STATE EMPLOYEES WHILE ACTING WITHIN THE SCOPE OF THEIR EMPLOYMENT. THE FACTS REQUIRED IN THIS FORM MUST BE COMPLETED TO THE EXTENT THAT INFORMATION IS AVAILABLE AT THE TIME OF THE ACCIDENT.

THIS FORM IS NOT TO BE GIVEN TO CLAIMANTS

SIGNATURE OF DRIVER _____ DATE _____

CONTACT YOUR SUPERVISOR IMMEDIATELY. COMPLETE A STANDARD LIABILITY INCIDENT REPORT FORM, SCOPE OF EMPLOYMENT FORM

STATE WIDE TOLL FREE
(For Agency Use Only)

1-888-521-RISK (7475)