Fire Department Insurance Program

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