



RISK MANAGEMENT FUND
INCIDENT REPORT
 STATE OF NORTH DAKOTA
 SFN 50508 (07-2013)

May be EXEMPT RECORD
 (Contact Risk Management Division)

Department Location Code

Incident				
Claim Form Requested				
Destruction Hold Notice				

(Attach additional sheets if necessary)

1. Date of Incident		2. Day of Week		3. Time of Incident	
4. Address where incident occurred and description of location (building, street, city, highway, mile marker, etc.)					
5. Weather Conditions <input type="checkbox"/> Clear <input type="checkbox"/> Raining <input type="checkbox"/> Snowing <input type="checkbox"/> Sleetng <input type="checkbox"/> Other _____					
6. Description of Incident (Be Specific) a. What happened? b. How did it happen?					
7. Result - who or what was injured or damaged? (Check applicable box and complete)					
Bodily Injury <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Injured		Age or Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Visitor <input type="checkbox"/> Client <input type="checkbox"/> Employee <input type="checkbox"/> Volunteer <input type="checkbox"/> Student		Was a Worker's Compensation Claim Filed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Address		City	State	Zip Code	Telephone Number
Describe Injury (List body parts, if applicable)				Request for Ergonomic Evaluation <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Injured		Age or Date of Birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Visitor <input type="checkbox"/> Client <input type="checkbox"/> Employee <input type="checkbox"/> Volunteer <input type="checkbox"/> Student		Was a Worker's Compensation Claim Filed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Address		City	State	Zip Code	Telephone Number
Describe Injury					
<input type="checkbox"/> Property Damage		What was damaged?			
Who is the owner?		Owner's Address		Owner's Telephone Number	
Where can damaged property be seen?				Was any State property damaged? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Were there any witnesses? <input type="checkbox"/> No <input type="checkbox"/> Yes - provide the following information					
Witness Name		Address		Telephone Number	

Submit online at: www.nd.gov/risk. If you have any question please call 701-328-7584.

9. Describe policies and procedures in effect that relate to this incident.
 Were policies and procedures followed? Yes No - Explain

10. List all causes or incident (equipment, procedure, environment, behavior)

11. Action Taken

a. Has corrective action been initiated? Yes No
 If yes, what corrective action is being taken?
 If no, when will corrective action be taken?

b. Work Order Submitted Yes No

c. What safety equipment/training could have prevented this injury?

12. Comments and/or Diagram

Report Prepared By (Name of State Employee)	Title	
12. Signature	Telephone Number	Date
13. Signature of Agency Risk Management Contact	Telephone Number	Date

Date Submitted to Risk Management	Date Submitted to Loss Control	Date Reviewed by Loss Control
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