

Directions for reporting a claim to the Office of Risk Management:

**** Please note the Employee Accident Report is the ONLY form required by ORM. If any additional forms are needed, the Claim Examiner will contact you at a later date.**

For users with Full Adobe Acrobat:

1. All fields are writeable. Type directly into the form.
2. Print a copy for your records
3. Click on the email form button on your toolbar. Your default email program will open a new outgoing message, with the loss notice attached as a PDF file.
4. Request a delivery receipt for your email message (under the Options menu of your toolbar).
5. Send the email
6. If the form continues to display on your browser, click on Clear Form at the bottom of the page before closing your browser window.

For users with free Adobe Reader:

1. You will be unable to save this form or submit it electronically over the web.
2. You may type in the fields, however you will have to print it in order to send it by fax .. OR .. print the blank form and fill it out.
3. Once the form is completed and printed, fax to ORM at 614-466-0427.
4. Click the Clear Form button at the bottom of the page before closing your browser window.

Completed Loss Reports can be submitted to ORM by:

Email: risk.management@das.state.oh.us

Fax: 614-466-0427



STATE OF OHIO

EMPLOYEE LOSS NOTIFICATION

AUTOMOBILE ACCIDENT OR INCIDENT

DEPARTMENT OF ADMINISTRATIVE SERVICES
 OFFICE OF RISK MANAGEMENT
 4200 SURFACE ROAD
 COLUMBUS, OHIO 43228-1395
 PHONE: (614) 466-6761
 FAX: (614) 466-0427

AGENCY / DEPARTMENT NAME:									
SUPERVISOR:						PHONE NUMBER: ()			
ADDRESS:						CITY:			
TIME & PLACE	DATE OF ACCIDENT:			TIME:			COUNTY:		
	LOCATION (BE SPECIFIC):						INVESTIGATING AGENCY:		
	REORT NO.			WHO WAS CITED:			CITATION ISSUED:		
STATE VEHICLE INFORMATION: (UNIT 1)									
OPERATOR:						WORK PHONE: ()			
ADDRESS:				CITY:		STATE: OHIO		ZIP:	
SOCIAL SECURITY NUMBER:		OPERATOR'S LICENSE NUMBER:				STATE PLATE NUMBER:			
VEHICLE YEAR:		MAKE:		MODEL:		VIN NUMBER:			
DAMAGE:	NONE <input type="radio"/>		DRIVEABLE <input type="radio"/>		NOT DRIVEABLE <input type="radio"/>				
PART OF CAR DAMAGED?									
FRONT []	REAR []	RT. FRONT []	LT. FRONT []	RT. SIDE []	LT. SIDE []	RT. REAR []	LT. REAR []	WINDSHIELD []	UNDER CARRIAGE []
WHAT SPECIFIC JOB ASSIGNMENT WERE YOU PERFORMING AT THE TIME OF THE ACCIDENT?:									
OTHER VEHICLE (UNIT 2) OR PROPERTY DAMAGE TO OTHERS:									
DRIVER / PEDESTRIAN NAME:									
ADDRESS:				CITY / STATE / ZIP:		HOME PHONE: ()		WORK PHONE: ()	
OWNER OF VEHICLE:						INSURANCE COMPANY:			
ADDRESS:				CITY / STATE / ZIP:		HOME PHONE: ()		WORK PHONE: ()	
VEHICLE YEAR:	MAKE:	MODEL:		BODY STYLE:	COLOR:		VEHICLE PLATE NUMBER:		
DAMAGE:	NONE <input type="radio"/>		DRIVEABLE <input type="radio"/>		NOT DRIVEABLE <input type="radio"/>				
PART OF CAR DAMAGED?									
FRONT []	REAR []	RT. FRONT []	LT. FRONT []	RT. SIDE []	LT. SIDE []	RT. REAR []	LT. REAR []	WINDSHIELD []	UNDER CARRIAGE []
DESCRIBE PROPERTY DAMAGE TO OTHERS (i.e.: MAILBOX, TREE, BUILDING, FENCE):									
GIVE NAMES OF ALL PERSONS INJURED:									
NAME								AGE:	
ADDRESS:				CITY / STATE / ZIP:		HOME PHONE: ()		WORK PHONE: ()	
NAME								AGE:	
ADDRESS:				CITY / STATE / ZIP:		HOME PHONE: ()		WORK PHONE: ()	

