STD-430 REV. 08-2017

DATE PREPARED

REPORT OF INCIDENT/ACCIDENT

See Management Directive 630.2
Send completed report immediately

If additional space is needed, please attach an 8 ½ x 11 sheet referring to item number.

STD-430 (INCIDENT/ACCIDENT REPORT) BEING SENT TO BUREAU OF RISK & INSURANCE MANAGEMENT (BRIM) VIA:

☐ E-MAIL ☐ FAX ☐ MAIL

*** PLEASE DO NOT SEND MULTIPLE COPIES OF AN STD-430 INCIDENT/ACCIDENT REPORT TO BRIM UNLESS YOU FIRST VERIFY THAT THE ORIGINAL REPORT WAS NOT RECEIVED.**

THIS REPORT IS THE:

☐ ORIGINAL - 1ST NOTICE OF LOSS

☐ DUPLICATE COPY OF PREVIOUSLY SUBMITTED INCIDENT/ACCIDENT REPORT

1. TIME AND LOCATION

INCIDENT/ACCIDENT DATE	TIME:	LOCATION (STREET & NUMBER, BUILDING/INSTITUTION, CITY, COUNTY, STATE)
	☐ AM ☐ PM	

2. PERSONS INJURED

	NAME	ADDRESS & TELEPHONE NUMBER	AGE	EXTENT OF INJURIES
1	**Name:** **E-Mail:**			
2	**Name:** **E-Mail:**			
3	**Name:** **E-Mail:**			

3. PROPERTY DAMAGE

OWNER	OWNER'S SOCIAL SECURITY	ADDRESS & TELEPHONE NUMBER	ESTIMATED DAMAGE
Name: **E-Mail:**	- -		

PROPERTY DESCRIPTION	DESCRIPTION OF DAMAGE

4. DESCRIPTION OF INCIDENT/ ACCIDENT

5. DEPARTMENT STATEMENT

6. WITNESSES (Name, address and telephone number)

1	
2	
3	

7. CLAIM INFORMATION

NAME OF EMPLOYEE INVOLVED	WORKING TITLE	ADDRESS & TELEPHONE NUMBER
AGENCY	**IMMEDIATE SUPERVISOR**	**SUPERVISOR'S BUSINESS ADDRESS & TELEPHONE NUMBER**

8. NOTIFICATION OF POSSIBLE CLAIM

HOW NOTIFIED?	IS CLAIM BEING MADE?
☐ LETTER ☐ PHONE ☐ IN-PERSON	☐ YES ☐ NO ☐ UNCERTAIN

9. REPORTED BY

AGENCY	BUREAU/INSTITUTION/FIELD OFFICE

	NAME	WORKING TITLE	BUSINESS TELEPHONE NUMBER
INDIVIDUAL PREPARING REPORT			

FOR COMMONWEALTH USE ONLY