



STATE OF MISSISSIPPI
Agency Incident Reporting Form

Agency: _____ **Department/District:** _____
Address: _____ **City/State/Zip:** _____
Person to Contact: _____ **Telephone Number:** _____

1. If accident, other than automobile, please complete this section:

Name: _____ Social Security No.: _____
Home Address: _____ City/State/Zip: _____
Home Telephone Number: _____ Work Telephone Number: _____
Date of Loss: _____ Time of Loss: _____ Location of Accident: _____
Description of Accident: _____

2. If automobile accident, please complete the following: (State Employee and State Vehicle):

Name of State Driver: _____ Social Security No.: _____
Home Address: _____ City/State/Zip: _____
Home Telephone Number: _____ Work Telephone Number: _____
Date of Loss: _____ Time of Loss: _____ Description of State Vehicle Involved: _____
Tag No.: _____
Description of Accident: _____

3. If property, other than State owned, was damaged, please complete the following:

Describe Property: _____ Describe Damage: _____
Owner's Name: _____ Telephone Number: _____
Home Address: _____ City/State/Zip: _____
Where can property be seen? _____

4. If injuries involved, please complete the following: (Other than State Employee)

**All injured State employees should be reported to Workers' Compensation.

Injured Party's Name: _____
Home Address: _____ City/State/Zip: _____
Home Telephone Number: _____ Work Telephone Number: _____
Describe Injury: _____
Was injured person taken to doctor/hospital? _____
If yes, where was the injured person taken? _____

5. If more than one person injured, please list names and addresses of all other injured parties: (Other than State Employee)

A. Injured Party's Name: _____
Home Address: _____ City/State/Zip: _____
Home Telephone Number: _____ Work Telephone Number: _____
Injured Party's Name: _____
Home Address: _____ City/State/Zip: _____
Home Telephone Number: _____ Work Telephone Number: _____

6. Witnesses/Passengers:

Witness's Name: _____
Home Address: _____ City/State/Zip: _____
Home Telephone Number: _____ Work Telephone Number: _____

7. Person completing this form: _____ **Date Form Completed:** _____