**DOTD REPORT OF INCIDENT**

|  |  |  |
| --- | --- | --- |
| **DATE OF REPORT** | **TIME OF REPORT** | **DOTD DISTRICT NUMBER** |
|  |  |  |
| **CONTRACTOR (IF APPLIES)** | **S.P.N. (IF APPLIES)** | **DISTRICT LOCATION** |
|  |  |  |

**NAME, JOB TITLE, AND TELEPHONE NUMBER OF DOTD EMPLOYEE COMPLETING REPORT*:***

|  |  |
| --- | --- |
| **Name** |  |
| **Title** |  |
| **Telephone #** |  |

1. **INCIDENT DETAILS:**

|  |  |
| --- | --- |
| **Date & Time** |  |
| **Location** |  |
| **Description** |  |

1. **NAME AND ADDRESS OF PERSON REPORTING INCIDENT:**

|  |  |
| --- | --- |
| **Name** |  |
| **Address** |  |
| **Telephone #** |  |

**Send original report to: Sedgwick Email:** [Sedgwick](mailto:ORMRH@sedgwickcms.com?subject=DOTDclaim)

Maintain a copy in the district

Email to [ORMRH@sedgwickcms.com](mailto:%20ORMRH@sedgwickcms.com) using above link or fax to 225-368-3440