

# INSTRUCTIONS TO THE ON~LINE INCIDENT REPORTING SYSTEM

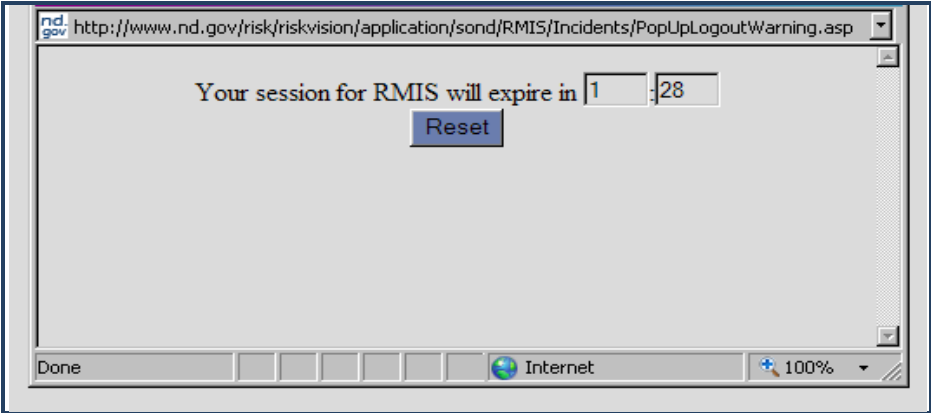
State of North Dakota  
Office of Management & Budget  
Risk Management Division  
September 2011

**Preparation:** To expedite the reporting process and avoid timing out of the System, make sure you have all of the necessary and required information ready before you start. **Note,** [sample forms](#) as they appear in the System, which identify required fields, are located at the end of these instructions.

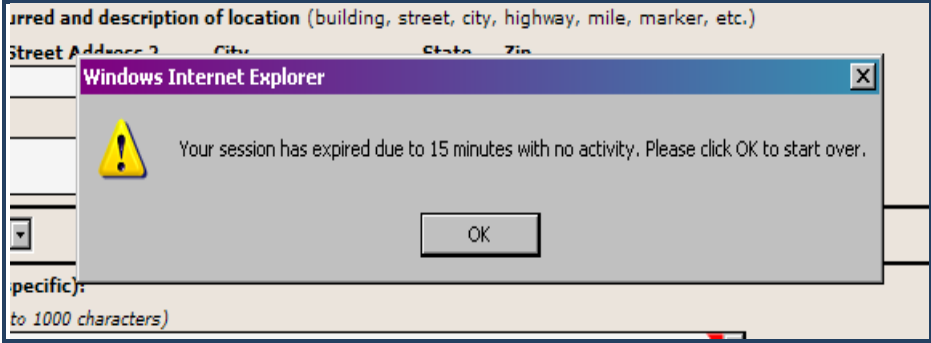
Because the On-Line Incident Reporting System is web-based, Microsoft limits the time a session can be open on the web server. Thus, the time an entry user has to report an incident through the System is also limited. That time is 15-20 minutes. You will be given notice with a **Countdown Timer and Reset** option when that time is about to expire, which will appear as follows:

**Countdown Timer & Reset**

- (1) If the reporting session is open for **15 minutes** without any activity, a message and timer will pop up on the screen, along with a sound chime, giving the user notification that the session will expire in **5 minutes**. This pop up message will give you the option to “**Reset**” the session within the 5 minute time frame. If “**Reset**” is selected, the pop up will close and the session will run for another 15 minutes. The user can continue resetting the session until the report is submitted.



- (2) If “**Reset**” is **NOT** selected, a message will pop up explaining that your session expired and you will need to start the reporting session from the beginning.



## How To Start

- Go to Risk Management's website home page at: [www.nd.gov/risk](http://www.nd.gov/risk)
- Click on the **Online Incident Reporting** link.

North Dakota nd.gov Official Portal for North Dakota State Government

**OMB**  
Risk Management Division

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Services

- Risk Management Fund
- Workers Compensation
- Contingency Planning
- Publications
- Training
- About Us

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866.534.2834 toll free  
[rminfo@nd.gov](mailto:rminfo@nd.gov)

### Risk Management Division

#### Welcome

The Risk Management Division was established in 1995 to implement a program to address the State's exposures to tort liability claims and lawsuits due to the loss of sovereign immunity.

Subsequently, in an effort to save premium dollars through a deductible program, and to establish a cross agency return-to-work program for the state of North Dakota, the 2001 Legislature directed the establishment of a single workers compensation state account. The administration of that program was assigned to the Risk Management Division of the Office of Management and Budget.

We hope you find our new site to be an easy-to-use resource. If you do not find what you are looking for, [please contact us](#) with any questions you may have about risk management issues.

#### Important Dates

Public Hearing **Accident Review Board Proposed Administrative Rules**-September 26th, 2011 at 10:00 am, Fort Totten Room, State Capitol Building. For more information [click here](#).

Find it Fast...

- [Online Incident Reporting](#)
- [Certificate of Financial Responsibility](#)
- [Risk Management Seminar](#)
- [Coming Soon](#)
- [Risk Quick Tips Newsletter](#)
- [Online Training Management System](#)

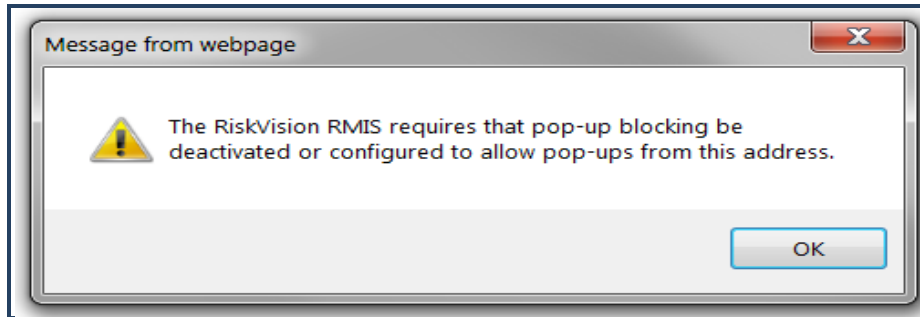
- Then go to **Click Here to Report An Incident**.

STATE OF NORTH DAKOTA  
risk management information system

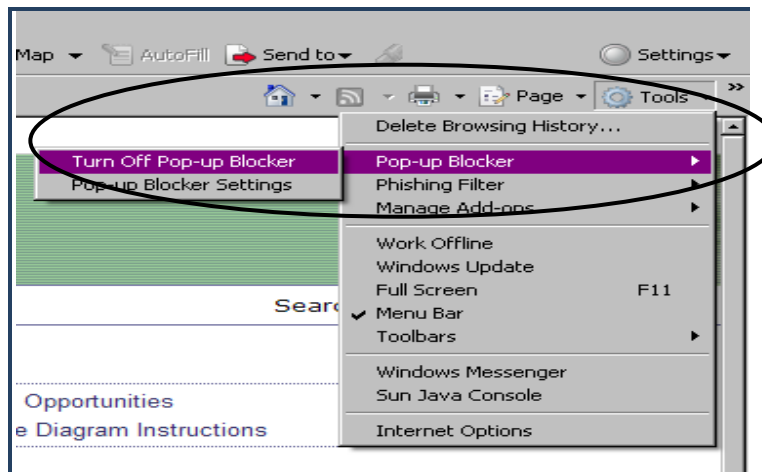
[Click Here to Report an Incident](#)

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- You will get a message about the Pop-up Blocker as follows:



- The Pop-up Blocker on your computer **MUST BE** deactivated: Go to (1) Tools, (2) Pop-up Blocker, and (3) Turn Off Pop-up Blocker.



- You will get a list and the descriptions of the three different incident reports – click on the report you need to complete based upon the descriptions.



### Incident Reports Online

State of North Dakota Risk Management Information Reporting System

**Please review the description and select a form from the list below. Only one form per incident is necessary.**

**All incidents may be an EXEMPT RECORD (Contact the Risk Management Division)**

**DETAILED INSTRUCTIONS ARE AVAILABLE [HERE](#).**

**INTERNET EXPLORER BROWSER MUST BE USED OR YOU COULD ENCOUNTER PROBLEMS.**

**SFN 50508 – Incident Report**  
This form is used to report incidents involving alleged injuries (to non-employees and employees) OR property damage of any type which occurred at any location/building/property owned or managed by the State or that involved actions by State employee(s) that caused the alleged injury or property damage.  
Use this form to make the first report of an employee's injuries to Risk Management Workers Compensation.

**SFN 51301 – Motor Vehicle Report**  
This form is used to report incidents involving any type of vehicle owned or driven by the State or State employees (including permitted drivers) and it may also include causing injuries to individuals or damage to property that is not owned/managed or leased by the State when a State owned vehicle is involved.

**SFN 53601 – Medical Services Incident Report**  
This form is NOT for reporting vehicle accidents or employee injuries (workers compensation). This form is used to report incidents involving any medical treatment or services provided by State employees or any injury to a third party at a State owned or managed medical facility (i.e. Human Service Centers, State Hospital, Developmental Center, Veteran's Home, or clinics).

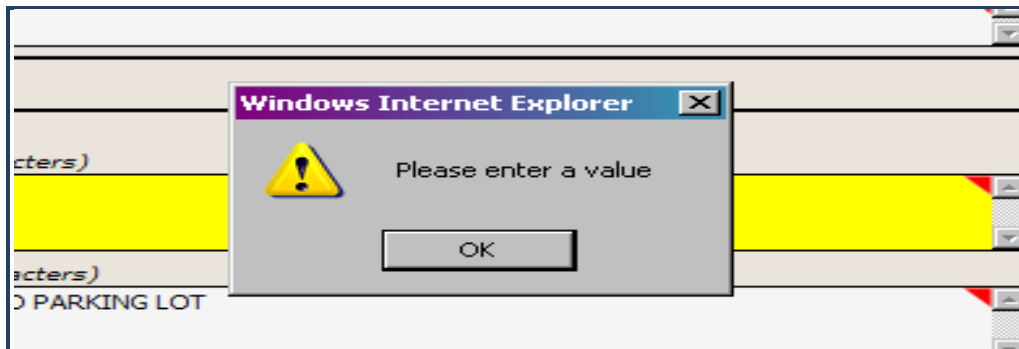
[LOG OUT](#)





- Type in the information about the person submitting the report – **ALL** fields on this screen are required (identified with a **red triangle**).



- Click **Continue** when all fields are completed.
- Fill out the necessary information on the first screen. Any field that has a **red triangle** is a required field. If the **Time of Incident** is unknown or cannot be determined type in "??" and then choose either AM or PM.
- The **Department/Agency Where Incident Occurred** may differ from the Department identified in the box above; i.e. a Dept. of Human Services employee witnesses an incident that occurred at the Capitol, therefore the 'Agency Where Incident Occurred' is OMB Facility Management.
- Select **Claim Form Requested** if the other party indicates that he/she will be looking for compensation/reimbursement for the incident, then select Yes.

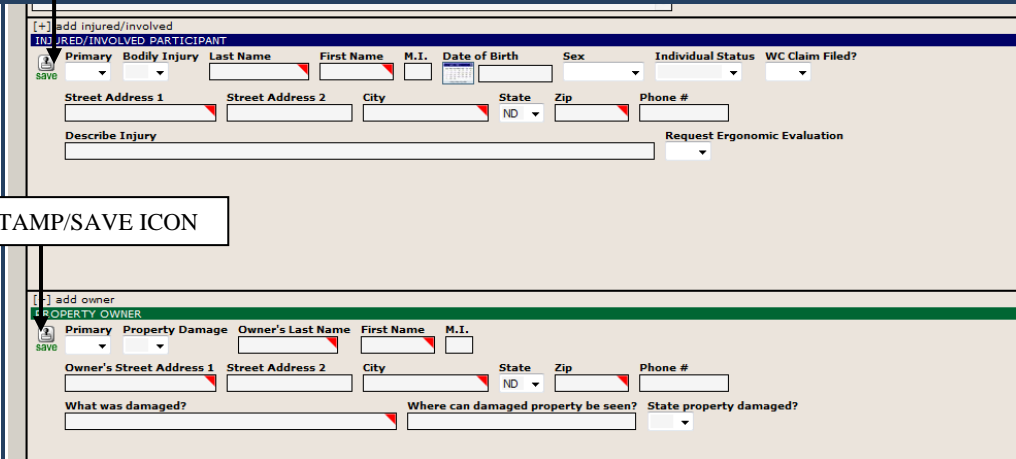
- Click **Continue** after filling in **ALL** the required fields.

- You will get the following message to "Please enter a value" if any of the required fields were missed and are not completed. The particular field will be highlighted in yellow and must be filled in before you can continue to the next screen.



- Fill out the necessary information on the second screen. Remember, any field that has a **red triangle** is a required field. The information that you typed in the first screen will carry over into the second screen.
- When finished entering information about the (a) **Injured/Involved Participant (blue section)**, (b) **Property Owner (green section)** and/or (c) **Witness (red section)**, you **MUST** click on the **stamp/save icon** on the left side to save each section.  **SAVE**
- Either the **Injured/Involved Participant (blue)** and/or **Property Owner (green)** must be filled out or the form will not submit. However, both sections do not need to be completed to submit.
- If you need to add more than one individual into these sections, click on the (a)  **add injured/involved**, (b)  **add owner**, or (c)  **add witness**. This option eliminates re-entry of the same incident if multiple parties are involved. It is located at the top of each the **blue**, **green**, and **red** section.
- Note that any phone numbers entered must be in the following format:  
000-000-0000

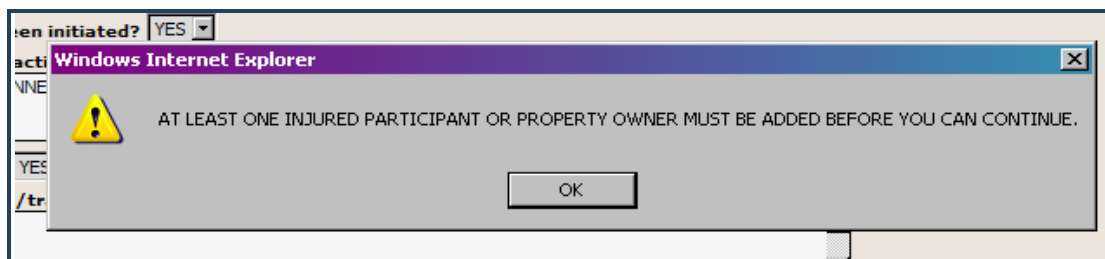
EXAMPLE showing stamp/save icon  and add icon .







ADD INJURED/  
INVOLVED

STAMP/SAVE ICON

- You will get the following message if **(a)** you do not enter an injured/involved participant or property owner and/or **(b)** you do not select the stamp/save icon, even if information has been entered.




- If you get the message above and you do not correct the error, the report will **not** submit properly and you will need to re-enter the incident.
- If you need to make any changes after saving the information, you can either click on the **pencil icon**  to edit data or the **eraser icon**  to delete data.

EXAMPLE showing pencil  and eraser icon  which show up after the data is saved with the stamp/save icon.

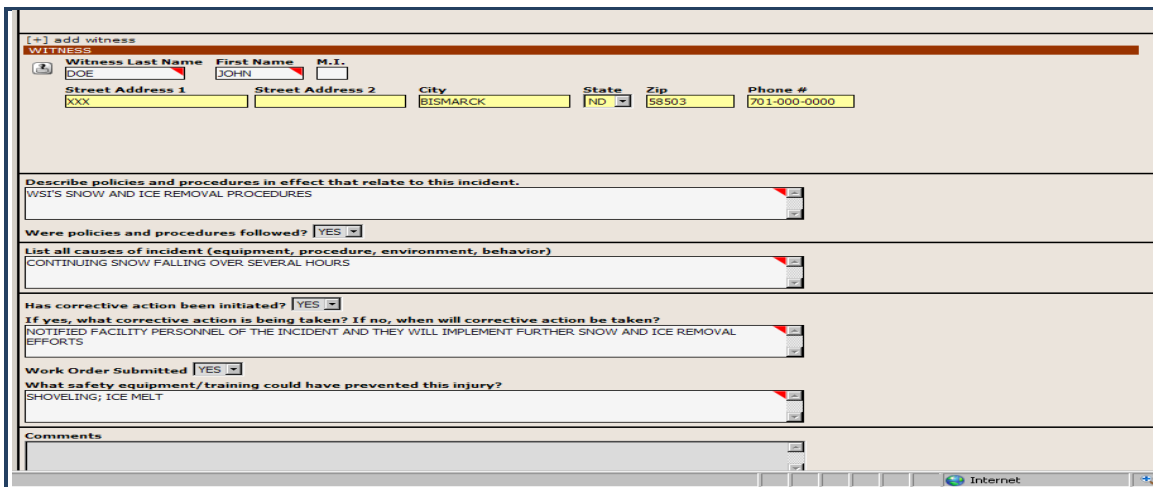
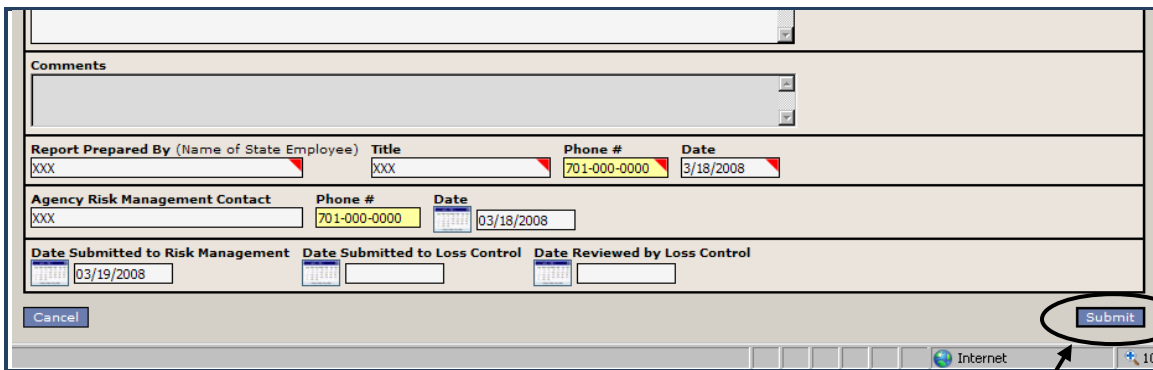
- Note that the fields appear different after the stamp/save icon saves the information.

PENCIL ICON

ERASER ICON

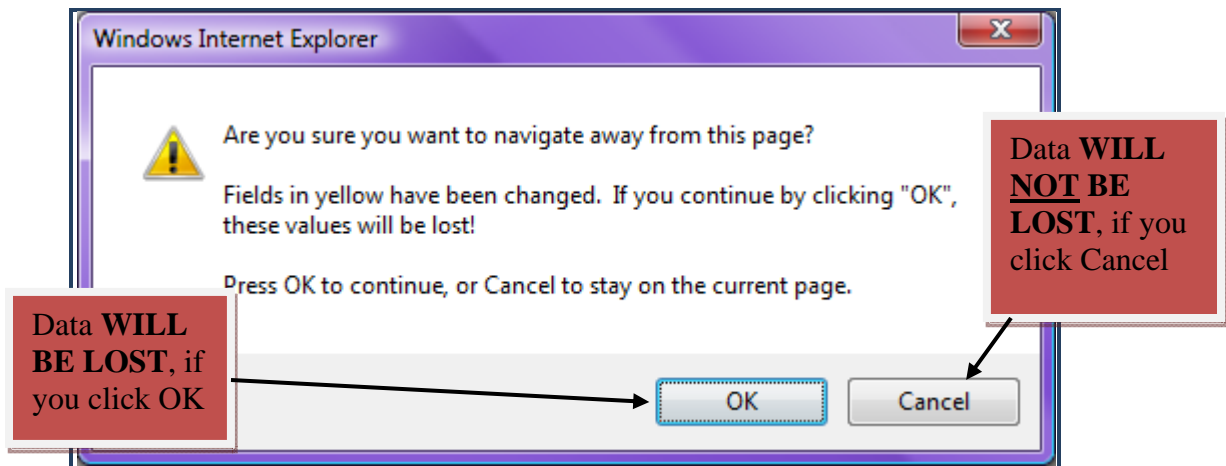


EXAMPLES of the following screens:

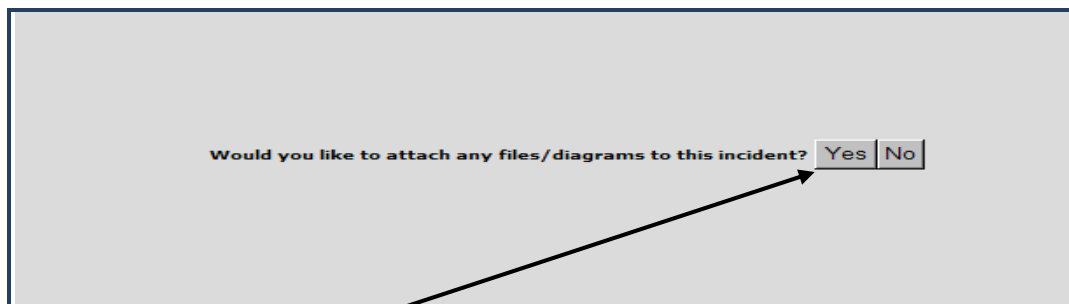



- When you are finished entering in the information, click **SUBMIT**. If any of the required fields are missing, they will be highlighted in yellow and must be filled in before you will be able to submit the incident report.

- If you receive the following message all the data you have entered *could possibly be lost*. If you press "**OK**" all the data you have entered **WILL** be lost. If you press "**Cancel**" it will take you back to the current page.

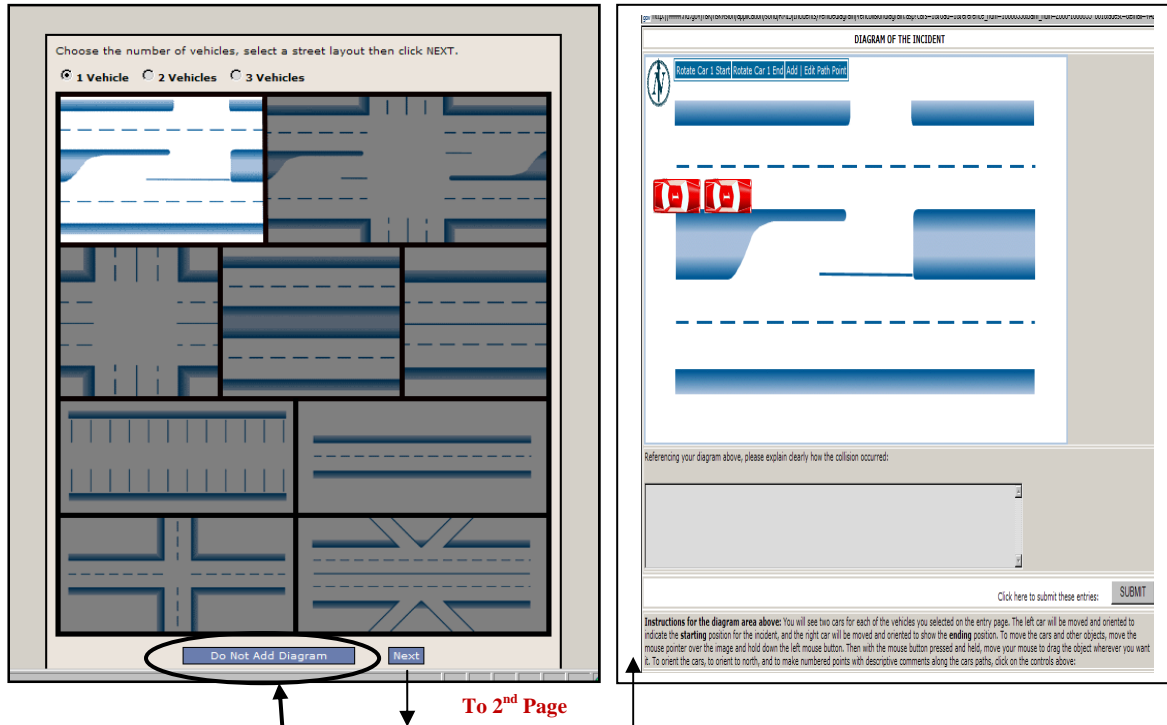


- The next screen allows you to attach documents/pictures and submit them with the incident report.

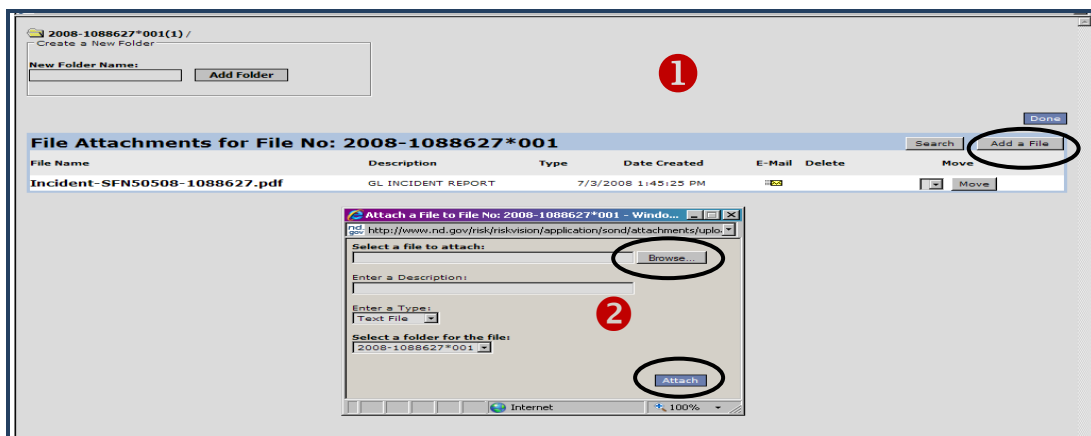


- To attach documents, emails, diagrams, pictures, etc. you will need to select **Yes**.
- The first option available is to prepare a **Vehicle Diagram**. If that applies to your incident/accident, then complete the diagram. Separate instructions for the vehicle diagram feature are at [Vehicle Diagram Instructions](#).

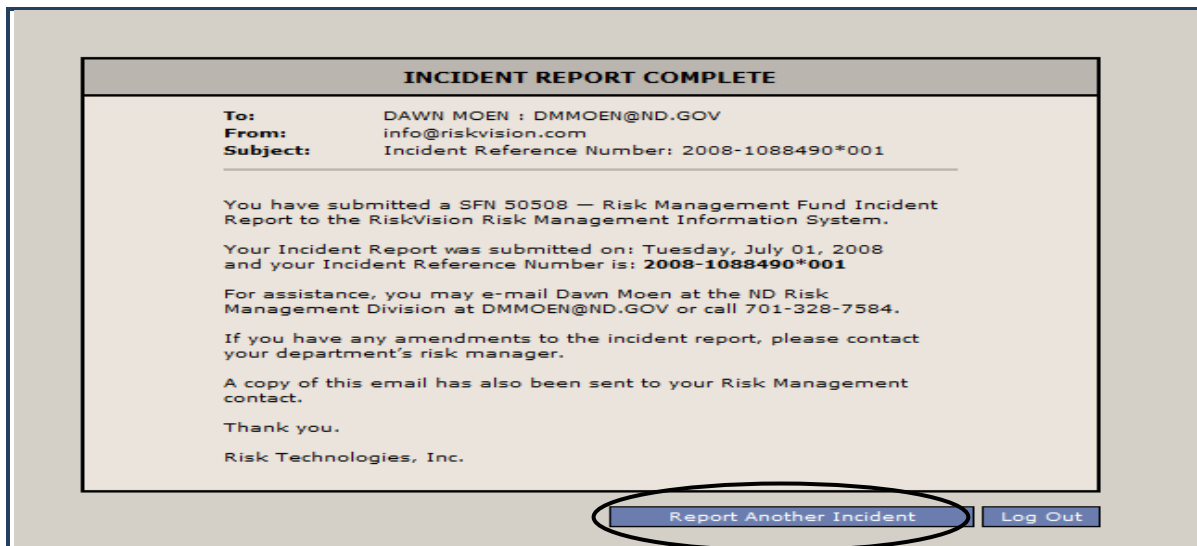
EXAMPLE of Vehicle Diagram pages.



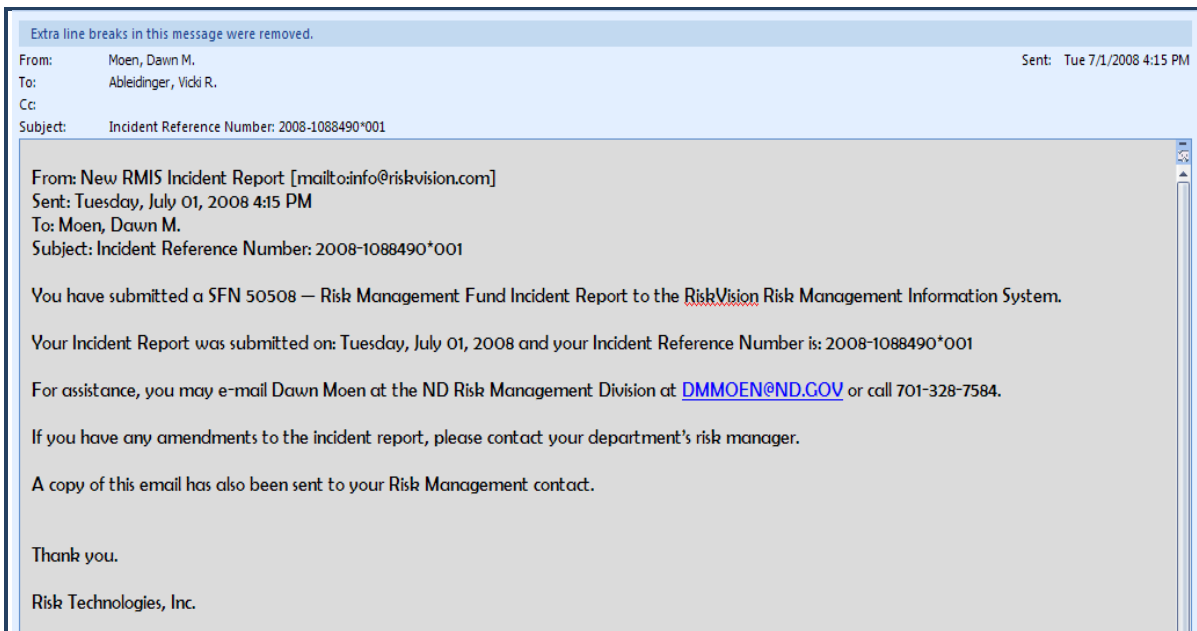
- If the Vehicle Diagram option does not apply to your incident/accident, select **“Do Not Add Diagram”**.
- The next screens are identified by ❶ and ❷, which will take you through the steps to **“Add a File”**, locate it (**“Browse”**), and **“Attach”** it.



- After attaching files or choosing not to, the next screen will confirm that the report was submitted successfully. You also have the option to submit another report without entering the user's contact information again.

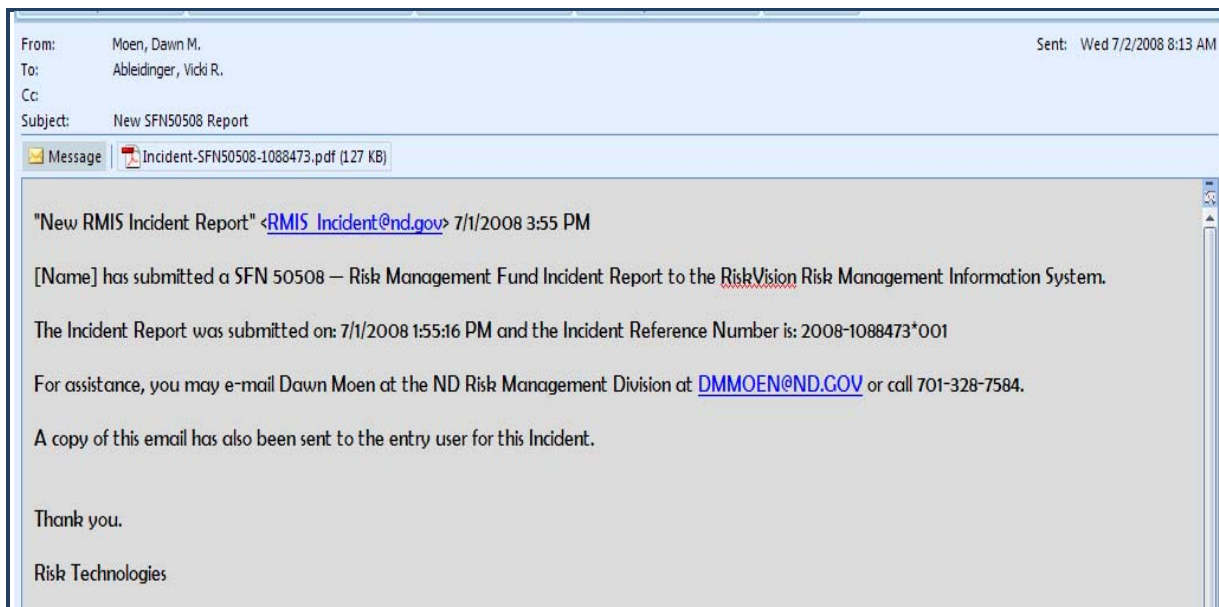


- The entry user will get an email confirming that he/she has submitted the incident report.



- After Risk Management has reviewed the incident report, the entity's Risk Management or Workers Compensation contact will also receive an email with a PDF attachment.
- If the incident is a Motor Vehicle Accident Report (SFN 51301) the shop foreman or DOT contact at the Vehicle Dispatch Office or DOT Repair Location that was selected will receive a copy of the accident report.

- The incident report can be reviewed and copied by opening the attached PDF file from the email. However, the copy should be shredded once it appears on the entity's loss run report.



The sample forms on the following pages are composite screen shots showing all of the sections of the fields requesting information in the System. These on-line forms will appear different than the paper forms you are familiar with (SFN 50508). However, when you have successfully completed this process, the System will automatically process the information entered into the fields and generate the report form exactly like the paper form, which will be sent by email to the Risk Management or Workers Compensation Contact.

SFN 50508 — Risk Management Fund Incident Report

Department/Agency Where Incident Occurred 10010-STATE BOARD OF MEDICAL EXAMINERS		Claim Form Requested NO	Destruction Hold Notice	Incident Type GENERAL
Date of Incident 9/13/2011	Day of Week TUESDAY	Time of Incident 7:00 AM		
Address where incident occurred and description of location (building, street, city, highway, mile, marker, etc.)				
Street Address 1 DEMO	Street Address 2	City DEMO	State ND	Zip 00000
Location Description DEMO				
Weather Conditions OTHER DEMO				
Description of incident (be specific):				
a. What happened? (limited to 1000 characters) DEMO				
b. How did it happen? (limited to 200 characters) DEMO				
[+] add injured/involved				
<b>INJURED/INVOLVED PARTICIPANT</b>				
Primary	Bodily Injury	Last Name	First Name	M.I.
Date of Birth	Age	Sex	Individual Status	WC Claim Filed?
Phone #				
Street Address 1	Street Address 2	City	State	Zip
			ND	
Province	Country	Postal Code		
	UNITED STATES			
Describe Injury				Request Ergonomic Evaluation
[+] add owner				
<b>PROPERTY OWNER</b>				
Primary	Property Damage	Owner's Last Name	First Name	M.I.
Phone #				
Owner's Street Address 1	Street Address 2	City	State	Zip
			ND	
Province	Country	Postal Code		
	UNITED STATES			
What was damaged?	Where can damaged property be seen?	State property damaged?		
[+] add witness				
<b>WITNESS</b>				
Witness Last Name	First Name	M.I.		
Street Address 1	Street Address 2	City	State	Zip
			ND	
Phone #				
Describe policies and procedures in effect that relate to this incident.				
Were policies and procedures followed?				
List all causes of incident (equipment, procedure, environment, behavior)				
Has corrective action been initiated?				
If yes, what corrective action is being taken? If no, when will corrective action be taken?				
Work Order Submitted				
What safety equipment/training could have prevented this injury?				
Comments				
Report Prepared By (Name of State Employee)	Title	Phone #	Date	
			9/13/2011	
Agency Risk Management Contact	Phone #	Date		
Date Submitted to Risk Management	Date Submitted to Loss Control	Date Reviewed by Loss Control		

Cancel

Submit

SFN 51301 — Risk Management Fund Motor Vehicle Report

Department/Agency Where Incident Occurred 10010-STATE BOARD OF MEDICAL EXAMINERS		Claim Form Requested NO	Destruction Hold Notice
AGENCY	Agency Name 10010-STATE BOARD OF MEDICAL EXAMINER		District/Division
	Street Address 1 Street Address 2		City State Zip
TIME	Date of Accident 10/11/2011	Day of Week SATURDAY	Hour 00:00 AM
LOCATION	Location Description (i.e. Highway Number, Posted Speed Limit, Location from Nearest City, City, Street, and Intersection With) (limited to 1000 characters) DEMO		
TYPE	Accident Type		
STATE VEHICLE	Year Make Model Unit Number Citation Issued Est. Speed Direction Traveling Odometer Reading		
	Driver Last Name First Name M.I. License Number Work Phone # Home Phone # Street Address 1 Street Address 2 City State Zip Driver Injured Describe Injury Workers' Comp Claim Filed? Damage (List Parts) Estimate		
[+ ] add passenger (please click on the Stamp button AFTER participant information is completed)			
ADD STATE VEHICLE PASSENGER			
Passenger Last Name First Name M.I. Work Phone # Phone # Injured Killed Street Address 1 Street Address 2 City State Zip			
[+ ] add vehicle (please click on the Stamp button AFTER participant information is completed)			
OTHER VEHICLE & DRIVER			
Primary Year Make Model License Plate State Citation Issued Direction Traveling Driver Last Name First Name M.I. License Number Work Phone # Home Phone # Street Address 1 Street Address 2 City State Zip Province Country UNITED STATES Postal Code Driver Injured Describe Injury Damage (List Parts) Estimate Owner's Insurance Company Policy Number Phone # Street Address 1 Street Address 2 City State Zip Driver's Insurance Company Policy Number Phone # Street Address 1 Street Address 2 City State Zip			
[+ ] add witness (please click on the Stamp button AFTER participant information is completed)			
WITNESS			
Witness Last Name First Name M.I. Street Address 1 Street Address 2 City State Zip Phone #			
[+ ] add owner (please click on the Stamp button AFTER participant information is completed)			
PROPERTY OWNER			
Primary Owner's Last Name First Name M.I. Work Phone # Phone # Owner's Street Address 1 Street Address 2 City State Zip Province Country UNITED STATES Postal Code What Estimate			
[+ ] add injured (please click on the Stamp button AFTER participant information is completed)			
INJURED PARTICIPANT			
Primary Injured Last Name First Name M.I. Work Phone # Phone # Street Address 1 Street Address 2 City State Zip Province Country UNITED STATES Postal Code Nature and Extent of Injury			
REPORT CONDITIONS			
Weather Roadway Did Vehicle Have Any Defects? Were Seat Belts in Use? Were Lights On?			
Accident Reported To Law Enforcement? Vehicle Dispatch Office or DOT Repair Location			
Explain How Accident Occurred And Purpose of Trip (limited to 1000 characters) DEMO			
State Employee Department Phone # State Employee Completing Report Phone # Date Date Submitted to Risk Management demo 817-477-2197 10/3/2011			

Cancel

Submit

SFN 53601 – Medical Services Incident Report

Department/Agency Where Incident Occurred 10010-STATE BOARD OF MEDICAL EXAMINERS		Claim Form Requested NO	Near Miss NO
Date of Incident 9/13/2011	Day of Week TUESDAY	Time of Incident 7:00 AM	
Last Name	First Name	M.I.	Sex
Date of Birth	ID Number	Status	
Street Address 1	Street Address 2	City	State
Zip	Phone #		
Service Area	Ward	Physician Notified?	Family Notified?
Workers' Comp Claim Filed?			
[+] add witness			
<b>WITNESS</b>			
Witness Last Name	First Name	M.I.	
Street Address 1	Street Address 2	City	State
Zip	Phone #		
Date Reviewed by Loss Control	Property DMG	What:	
Occurrence Category (select one main category and one sub category)			
Main Category:	Sub Category:		
Part of Body Injured	Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Lower <input type="checkbox"/> Middle <input type="checkbox"/> Right <input type="checkbox"/> Unknown <input type="checkbox"/> Upper <input type="checkbox"/>		
Bodily Injury	Selected Bodily Injury		
ABRASION/SCRAPES AMPUTATION ANOREXIA/RESP DISTRESS BITE INTACT SKIN BITE BROKEN SKIN BLISTER BURN FIRST DEGREE BURN SECOND DEGREE	<input type="button" value="&gt;"/> <input type="button" value="&lt;"/>		
Process	Selected Process		
BATHROOM BEHAVIOR DAY PROGRAM EXAM HOME VISIT HOUSEHOLD DUTIES HYGIENE/GROOMING INTERPERSONAL ALTERCATION	<input type="button" value="&gt;"/> <input type="button" value="&lt;"/>		
Area of Occurrence			
Description of Incident (limited to 1000 characters)	DEMO		
Describe policies and procedures in effect that relate to this incident.			
Were policies and procedures followed? <input type="checkbox"/>			
List all causes of incident (equipment, procedure, environment, behavior)			
Has corrective action been initiated? <input type="checkbox"/>			
If yes, what corrective action is being taken? If no, when will corrective action be taken?			
Work Order Submitted <input type="checkbox"/>			
What safety equipment/training could have prevented this injury?			
Comments			
Individual Preparing Report	Title	Date	
Dept. Head/Supervisor	Title	Date	
Additional Sign-Off	Title	Date	
Risk Management Review	Title	Date	Date Submitted to Risk Management

Cancel

Submit