NOTICE OF CLAIM FOR DAMAGES AGAINST THE COUNTY OF PASSAIC

For and to: PASSAIC COUNTY LEGAL DEPARTMENT
PASSAIC COUNTY ADMINISTRATION BUILDING
401 GRAND STREET
PATERSON, NEW JERSEY 07505

1. CLAIMANT:

Last Name First Middle

Date of Birth

Street Address

Mailing Address if other than street address

City State Zip Code

Social Security Number

If notices and correspondence in connection with this claim are to be sent to a person other than claimant, complete item #2.

2.

Name

Mailing Address

City State Zip Code

Relationship to Claimant: Attorney-at-Law) or

Explain Relationship

The occurrence or accident which gave rise to this claim:

3A.

Date

Time

b Describe the location or place of the accident or occurrence

Municipality

Exact location of the occurrence

c. Describe how the accident or occurrence happened: If a diagram will assist your explanation, please use the reverse side of this form.

d State the name and address of the County agency or agencies that you claim caused your damage.

State the names of County employees whom you claim were at fault, including any information that will assist in identifying and locating them.

e. State the negligence or wrongful acts of the County agency and County employees which caused your damages.

State the name and address of all witnesses to the accident or occurrence.

g State the names of all police officers and police departments who investigated the accident.

4a Claim for Damages (check appropriate block)

) Personal Injury

( ) Other - Explain in detail

b. If you claim personal injury,

(1 Describe your injuries resulting from this accident or occurrence:

(2) Do you claim permanent disability resulting from this injury?
( ) Yes ( ) No

If yes, describe the injuries believed to be permanent

(3) For each hospital, doctor, or other practitioner rendering treatment, examination, or diagnostic service, state:

Name of hospital, Doctor, or other Facility	Address	Dates of treatment or services	Amount of charges	Amount Paid by other sources

4 If you claim loss of wages or income as a result of the injury, state:

Name of Employer	Address of Employer
Your Occupation	Date you Became Employed
Rate of Pay	Dates Absent from Work
Total Lost Wages To Date	If Still Out of Work, Expected Date of Return

NOTE: If your claimed loss of income arises from self-employment or other than wages, attach a calculation showing the basis of your calculation of lost income.

5. Set forth any and all other losses or damages claimed by you

c If you claim property damage:

(1) Describe the property damaged.

(2) The present location and time when the property may be inspected.

(3) Date property acquired _____

(4) Cost of the property $_____

(5) Value of property at time of accident $_____

(6) Description of damage _____

(7) Has the damage been repaired? _____ If so, by whom, when and cost of repairs _____

(8) Attach each estimate of repair costs to this form.

(9) Set forth in detail the loss claimed by you for property damage

(d) Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

5 The amount of the claim. $ _____

6. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice? _____

If yes, set forth the names and addresses of all persons and insurance companies against whom you have made such claims.

7 Are any of the losses or expenses claimed herein covered by any policy of insurance? _____ For each such policy, state the name and address of the insurance company, policy number, and benefits paid or payable _____

8. Have you received or agreed to receive any money from anyone for the damages claimed herein? _____ if so, set forth the details of such agreement. _____

9 The following items must be submitted with this notice:

(1) Copies of itemized bills for each medical expense and other losses and expenses claimed.

(2) Full copies of all appraisals and estimates of property damage claimed by you.

(3) Copies of all written reports of all expert witnesses and treating physicians.

(4 A letter from your employer verifying your lost wages. If self-employed, a statement showing the calculation of your claimed lost income.

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statement made herein is willfully false, or fraudulent, that I am subject to punishment provided by law.

Dated: _____

_____
Claimant or Representative of Claimant

TO WHOM IT MAY CONCERN:

I hereby authorize any and all doctors, hospitals, or other medical service facilities to release to the State of New Jersey any and all records, reports, and other information concerning the treatment of the claimant named herein.

Dated:

_____

Signature

(This form may be signed by the Claimant or the Parents of Claimant if Claimant is a Minor.)