

THIS CLAIM MUST BE FILED WITHIN 90 DAYS OF THE ALLEGED INCIDENT

NOTICE OF CLAIM FOR DAMAGES AGAINST THE CITY OF BAYONNE

Date of Claim_____

1. CLAIMANT:

_____	_____	_____	_____
Last Name	First	Middle	Date of Birth
_____			_____
Street Address			Mailing Address if other than Street address.
_____	_____	_____	_____
City	State	Zip Code	City State Zip Code
_____			_____
Social Security Number			Marital Status
_____	_____	_____	
Number of Dependents	Home Phone No.	Work Phone No.	
_____	_____		
Cellular Phone No.	Email Address		

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

2. _____

_____	_____	
Name	Street Address	

_____	_____	_____
City	State	Zip Code

Relationship to claimant: Attorney at-Law () or _____

Explain Relationship

3. The occurrence or accident which gave rise to this claim:

a. _____

_____	_____	_____
Date	Time	A.M. / P.M.

Describe the location or place of the accident or occurrence. (Indicate exact location of the occurrence)

Municipality

Exact Location

City

State

Zip Code

b. Describe how the accident or occurrence happened:

c. Draw a diagram (in the space provided at the right) showing the street plan at the location of the accident. Label all intersecting streets, indicate "North" by an arrow and show the direction of each vehicle before and after contact.

Indicate house numbers where applicable. Mark "X" exactly the spot of the occurrence and state the distance in feet from nearest intersecting streets. If spot is not otherwise identifiable, indicate public property.

Please "X" if attaching a picture or photograph.



d. If you allege that a dangerous condition contributed to your injury or damages, indicate the exact location of said condition with reference to fixed object on the above diagram. Indicate said condition by "circling" it on the above diagram. **Please "circle" if attaching a picture or photograph.**

e. State the name address of the City agency or agencies that you claim caused your damage/injury.

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

g. State the negligence or wrongful acts of the City agency and City employees which caused your damages.

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

i. State the names of all police officers and police departments who investigated the accident or occurrence.

j. Submit a copy of Police Report or Central Complaint number.

4. a. Claim for damages (check appropriate block)

Personal Injury Property Damage

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 to date.	Amount paid or payable by other sources such as insurance.
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(4) If you claim loss of wages or income, as result of injury, state

Name of Employer

Address of Employer

Your Occupation

Date You Became Employed at this Job

Rate of Pay

Dates of Absence from Work

Total Lost Wages to Date

If still out of Work, Expected Date of Return.

Note: If you 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 property \$ _____

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

(6) Description of damage _____

(7) Has the damage been repaired? () Yes () No

If so by whom, when and costs 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. If you claim vehicle damage:

Description of your vehicle involved in accident.

Year_____ Make_____ Model_____ License
Plate No._____

Driver's Name_____ Lic. No._____

Address_____

State_____ Zip Code_____

Owner's Name and Address_____

Insurance Co. _____ Policy No._____

Insurance Co. Address _____

Damages to Vehicle_____

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

f. The amount of the claim_____

5. Have you made a claim against anyone (including insurance companies) 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.

6. Are any of the losses or expenses claimed herein covered by any policy of insurance?

() Yes () No

If so, for each such policy, state the name and address of the insurance company, policy number, and benefits paid or payable:

7. Have you received or agreed to receive any money from anyone for the damages claimed herein?

() Yes () No

If so, set forth the details of such agreement:

8. 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 damaged claimed by you.
- (3) Copies of all written reports of all expert witnesses and treating physicians.
- (4) A letter from your employer verifying your 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 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 as provided by law.

Dated: _____

Claimant or person filing claim on behalf of claimant.

ALL INFORMATION REQUESTED IN THIS FORM MUST BE PROVIDED SO THAT FAIR AND FULL DISCLOSURE OF INFORMATION NECESSARY TO THE ORDERLY AND EXPEDIENT ADMINISTRATIVE DISPOSITION OF THE CLAIM MAY BE HAD UNDER THE SCHEME OF THE NEW JERSEY TORT CLAIMS ACT, A GOVERNMENTAL ENTITY IS AFFORDED AT LEAST SIX (6) MONTHS FROM THE DATE OF THE RECEIPT OF A COMPLETED CLAIM FORM TO REVIEW AND SETTLE MERITORIOUS CLAIMS. FAILURE TO PROVIDE COMPLETE ANSWER TO ALL QUESTIONS, OR TO RETURN THIS FORM IN A TIMELY MANNER, MAY ADVERSELY AFFECT THE CLAIMANT'S RIGHTS, PURSUANT TO N.J.S.A. 59:87-1, et seq.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Health Record Number _____

Date of Birth: _____ S.S. # _____

Address: _____

1. I authorize the use or disclosure of the above individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure.

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

problem list

medication list

list of allergies

immunization records

most recent history and physical

most recent discharge summary

laboratory results from (date) _____ to (date) _____

x-ray and imaging reports from (date) _____ to (date) _____

consultation reports from (doctors' names) _____

____ entire record

____ other _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual organization:

City of Bayonne and/or its attorneys

for the purpose of LITIGATION.

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provided my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient or Legal Representative

Date

If Signed by Legal Representative, Relationship to Patient

Date