County of Passaic
Administration Building
401 Grand Street • Paterson, New Jersey 07505-2023

COUNTY LEGAL DEPARTMENT
Room 214
TEL: (973) 881-4466
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tortclaims@passaiccountynj.org

NOTICE OF CLAIM FOR DAMAGES AGAINST THE COUNTY OF PASSAIC

CLAIMANT:

Last | **MI** | **First** | **Date of Birth**

Street Address | **Mailing address if other than street address**

City | **State** | **Zip Code** | **Social Security Number**

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

1. RELATIONSHIP TO CLAIMANT:

Last | **MI** | **First** | **Relationship to Claimant: Attorney/Explain Relationship**

Street Address | **City** | **State** | **Zip Code**

2. PROVIDE ACCIDENT/INCIDENT CLAIM INFORMATION :

a. **Date** | **Time**

b. Describe the location/place of the accident/incident.

Municipality | **Exact location of accident/incident**

c. Describe how the accident/incident happened: If a diagram will assist your explanation, please attached to this form.

Attach additional information to this form

d. State the name(s) and address(s) of the County agency/agencies you claim caused your damage.

Agency Name	Agency Address

State the name(s) of the County employee(s) whom you claim were at fault, including any information that will assist in identifying and locating the individual(s).

e. State the negligence or wrongful acts of the County Agency/County Employee(s) which caused your damages.

f. State the name(s) and address(s) of all witness(s) to the accident/incident.

Witness Name	Address	Telephone Number

g. State the name(s) of the police officer(s) or police department(s) who investigated the accident.

Police Officer Name	Police Department Address	Precinct Telephone Number

3. Claim for Damages (check appropriate box)

a. Person Injury Other (explain in detail) _____

b. If you claim personal injury,

1. Describe your injury(s) resulting from the accident/incident:

Attach additional information to this form

2. Do you claim permanent disability resulting from injury(s)?: YES NO

If yes, describe the injuries believed to be permanent:

3. **Attach additional information to this form**

4. Provide names of each hospital/doctor/practitioner rendering treatment/examination/diagnostic service(s)

Name of Hospital, Doctor, or other Facility	Address	Treatment/Service Date	Amount Charged	Amount Paid

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

_____ _____

Name of Employer **Address of Employer**

_____ _____

Occupation **Date of Hire**

_____ _____

Rate of Pay **First Day of Absent**

_____ _____

Total Loss Wages to Date **Retuned Date/Expected Date 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.

4. Provide any/all other losses/damages claimed:_____

_____

_____

Attach additional information to this form

1. If you claim property damage:
   a. Describe the property damage: _____

   b. The present location and time when the property may be inspected: _____

   c. Date property acquired:_____

   d. Cost of the property: _____

   e. Value of the property at the time of the accident: _____

   f. Description of damage(s): _____

   g. Was the damage(s) repaired: . YES . NO If so, by whom, when and cost of repair(s):

   _____

   _____

   Attach each estimate of repair to this form.

   h. Provide all details of the loss claimed by your property damage: _____

   _____

   _____

   i. Provide all details of all other items loss/damage(s) claimed:_____

   _____

2. Total amount of the claim: _____

5. Have you made a claim against anyone else for any of the losses/expenses claimed in this notice: YES . NO

   If yes, provide the names and addresses of the person(s) and insurance company(s) whom you have filed a claim against.

Name	Insurance Company	Telephone Number

6. Are any of the loss(s)/expense(s) claimed herein covered by insurance? Provide the following information:

Insurance Company	Address of Insurance Company	Policy Number	Amount Paid	Unpaid Amount

7. Have you received/agreed to receive any money from anyone for the damages claimed? YES NO

If so, provide the detail of agreement. _____

_____

_____

Attach additional information to this form

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.
   3. Copies of all written reports of all expert witness(s) or treating physician(s).
   4. A letter from your employer verifying your lost wages. If self-employed, a statement showing the calculations 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 know to me to be in existence at this time. I am aware that any statement provided herein is willfully false, or fraudulent, that I am subjected to punishment provided by law.

_____ _____

Date **Claimant/Representative of Claimant Signature**

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 name herein.

_____ _____

Date **Signature**

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