

MISSISSIPPI DEPARTMENT OF REVENUE OFFICE OF ALCOHOLIC BEVERAGE CONTROL

DRY CONCEALED DAMAGE CLAIM - FORM 100

NAME OF BUSINESS _____ **PERMIT NUMBER** _____ **DATE** _____

ITEM NO.	ITEM NAME	ITEM SIZE	QUANTITY	SUPPLIER REPRESENTATIVE		PRINT NAME	REASON
			# OF BOTTLES	NUMBER	SIGNATURE		
TOTALS							

Send completed and signed form to:

Alcoholic Beverage Control

Attention: Processing

P.O. Box 540

Madison, MS 39130 - 0540

Approved at ABC by: _____

Date: _____

Processed by: _____

Date _____