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 Dependants 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.

_____

_____

_____

_____

(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