**NOTICE OF CLAIM FOR DAMAGES**
**AGAINST THE CITY OF CAMDEN**

**1. Claimant:**

Last Name First Middle

Date of Birth

Street Address

Medicare/Medicaid Recipient: ( )Yes ( )No
If yes, provide Medicare Health Ins. Claim # (HICN):
#

City State Zip

Social Security Number

Mailing address (if different from street address)

Marital Status

Home Telephone Business Telephone

Number of Dependents

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

Attorney at Law ( ) or Other:
Relationship to Claimant

City State Zip

The occurrence or accident which gave rise to this claim:

**3.** a.
Date

Time A.M./P.M.

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 attach.

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

_____

_____

State any 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.

_____

_____

_____

_____

_____

f. 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.

_____

_____

_____

**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 services, state:

| Name of Hospital, Doctor, or other Facility | Address | Dates of treatment or services | Amount of charges to date | Amount paid of other sources such as insurance |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

(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 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 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 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 for such agreement.

_____

_____

_____

**9.** The following items must be submitted with this notice:

a. Copies of itemized bills for each medical expense and other losses _____ _____and expense claimed.

b. Full copies of all appraisals and estimates of property damage claimed by you.

c. Copies of all written reports of all expert witnesses and treating physicians.

d. 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 will fully false or fraudulent, that I am subject to punishment provided by law.

Dated: _____ _____

Claimant or person filing claim on behalf of Claimant

TO WHOM IT MAY CONCERN:

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

Dated: _____ *_____

(Signature)

(***This must be signed by the claimant or the parents of claimants who are minors.**)

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 MONTHS FROM THE DATE OF THE RECEIPT OF A COMPLETED CLAIM FORM TO REVIEW AND SETTTLE MERITORIOUS CLAIMS. FAILURE TO PROVIDE COMPLETE ANSWERS TO ALL QUESTIONS AND/OR THE WITHHOLDING OF INFORMATION MAY RESULT IN FORFEITURE OF THE CLAIMANT'S RIGHTS. (N.J.S. 59:8-1, ET SEQ.)

THIS FORM HAS BEEN ADOPTED BY THE CITY COUNCIL FOR THE CITY OF CAMDEN AS THEIR ACCEPTED FORM PER THE AUTHORIZATION OF N.J.S. 59:8-6 AND MUST BE COMPLETED IN ORDER TO PROCESS A CLAIM.

**FORWARD TO:**
City of Camden, Office of City Attorney
City Hall, 4th Floor- Suite 419
P.O. Box 95120
Camden, NJ 08101-95120

*Revised 01/27/2023*