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

f. State the names of City employees whom 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.

4a. Claim for damages (Check appropriate box)

Personal Injury Property Damage Other

If other, explain in detail. _____

b. If you claim personal injury,

(1) Describe in detail your injury 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	Date of treatment or services	Amount of charges to date	Amount paid or payable by other sources such as insur- ance

- (4) If future treatment is necessary, state anticipated expenses for each treatment.

- (5) If you claim loss of wages or income as a result of the injury, state:

Name of Employer

Address of Employer

Your Occupation

Date 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

Please provide income tax returns of claimant for last five (5) years.

- (6) 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) Condition when acquired: _____

- (5) Cost of the property \$ _____

- (6) Description of damage

- (7) Value of property at time of damage \$ _____

(8) Has the damage been repaired? _____ If so, by whom, when and the cost of repairs.

(9) Attach each estimate of repair costs to this form.

(10) 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 and 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 yes, set forth the details of such agreement.

9. 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 damage claimed by you.
- (3) Copies of all written reports of all expert witnesses and treating physicians.
- (4) 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 willfully false or fraudulent, that I am subject to punishment provided by law.

DATED: _____

SIGNED: _____

[] Claimant or [] person
filing claim on behalf
of claimant

FORM1.DLC

**AUTHORIZATION TO DISCLOSE INDIVIDUALLY
IDENTIFIABLE HEALTH INFORMATION**
[This form complies with the HIPAA Privacy Rule.]

TO:

I, _____ (DOB: _____) hereby authorize you to release the documents
Patient's Name

described below to:

City of Vineland
640 E. Wood Street
PO Box 1508
Vineland, NJ 08362-1508

- () Hospital records (photostatic or otherwise), including admission records, medical history, consultation notes, nurses/doctors notes, test/lab results, operative reports, prescriptions, x-ray reports, bills, discharge summaries, etc., inclusive of any and all records concerning psychiatric, drug, alcohol and/or HIV treatment.
- () Physician's office records, office notes, progress notes, etc., from the date of initial treatment and/or examination up to and including the present, inclusive of any and all records concerning psychiatric, drug, alcohol and/or HIV treatment.

I understand that the terms of this Authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA"). I understand that I have the right to revoke this Authorization, at any time prior to your compliance with the request set forth herein, provided that the revocation is in writing. I understand that any revocation must include my name, address, telephone number, date of this authorization and my signature and that I should send it to you.

I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the Recipient and, in that case, will no longer be protected by HIPAA.

This Authorization expires upon your release of the information described above or thirty days after the Date of Authorization, as set forth below, whichever comes first.

Patient's Name

Date of Authorization