# Borough of Elmwood Park

Municipal Building
**182 Market Street**
**ELMWOOD PARK, NJ 07407**
TEL (201) 796-4085
FAX (201) 794-0976

## Notice of Claim

PURSUANT TO TITLE 59

**Forward to:**
Borough Clerk of Elmwood Park
182 Market Street
Elmwood Park, NJ 07407

**1. CLAIMANT:**

Last First Middle Area Code/Phone Number

Street Address Municipality /State/Zip Code

Additional Address Municipality /State/Zip Code

Date of Birth Soc. Security No. City State Zip

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please complete this section.

Name Street Address

Additional Address City State Zip

Area Code/Telephone No. Relationship to Claimant

**3. ACCIDENT:**

A. The occurrence or accident which gave rise to this claim:

Date Time

B. Describe the location or place of the accident or occurrence:

*Exact Location of the Occurrence*

C. Describe how the accident or occurrence happened. If a diagram will assist your explanation, please use the reverse side of this form.

D. State the name and address of the municipality(s) that you claim caused your damage.

E. State the names of municipal employees whom you claim were at fault, including any information that will assist in identifying them.

F. State in detail each and every negligent or wrongful act of the municipality and the municipality's employees which caused your damage.

G. State the name and address of all witnesses to the accident or occurrence.

H. If a vehicle accident, state the names, ages, addresses, phone numbers and relationship to you, of all passengers in your vehicle.

I. State the names of all police officers and police departments who investigated the accident.

**4. CLAIM FOR DAMAGES:**

A. Claim for damages (Check appropriate box)

_____Bodily Injury _____Property Damage _____Other

If other, explain:_____

_____

B.

1. If you claim bodily injury - describe your injuries resulting from this accident or occurrence.

_____

_____

_____

2. Do you claim permanent disability resulting from this injury?

_____

_____

_____

3. For each hospital, doctor or other practitioner rendering treatment, examination or diagnostic service, please list:

_____
Name of Hospital, Doctor, or other Facility

_____ _____
Address City State Zip

_____ _____
Date of Treatment Amount of Charges

_____ _____
Doctor or other Facility City/State/ Zip Code

_____
Amount Paid if Payable by other sources, i.e., insurance

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

| | |
|---|---|
| Name of Employer | Your Occupation |
| Address | City State Zip |
| Date Employed at this Job | Rate of Pay |
| Dates of Absences 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 wage, 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. If vehicle, include make, model, year, color, vehicle identification number, license plate number, state, and parts of vehicle damaged.

2. The recent location and time when the property can 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? ☐Yes ☐ No
If yes, by whom, 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 and the method by which you made the calculation.

_____

_____

_____

1. The amount of the claim_____

2. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice?

☐Yes ☐ No

If yes, set forth the names and address of all persons and the insurance companies against whom you have made such claims.

_____

_____

_____

3. Are any of the losses or expenses claimed herein covered by any policy of insurance?

☐Yes ☐ No

For each such policy, state the name and address of the insurance company, policy number, and benefits paid or payable.

_____

_____

_____

_____

4. Have you received or agreed to receive any money from anyone for damages claimed herein?

☐Yes ☐ No

If yes, set forth the details of such agreement.

_____

_____

_____

## 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 claim lost income.

I hereby certify that the foregoing statements made by me are true, that the attached statements, bill, 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, I am subject to punishment as provided by law.

_____ _____

Date Claimant or person filing on behalf of claimant.

_____

Print Name as Signed Above

# AUTHORIZATION FOR MEDICAL REPORTS AND RECORDS

**TO WHOM IT MAY CONCERN:**

I hereby authorize any and all doctors, hospitals or other medical service facilities to release to claims servicing organizations or its representatives any and all records, reports and other information concerning the treatment of the claimant named herein. Photostatic copies of the Authorization carry the same Authority as the original.

_____ _____

Date Signature

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

_____

Print Name as Signed Above

# AUTHORIZATION FOR INFORMATION ON EMPLOYMENT

**TO WHOM IT MAY CONCERN:**

I hereby authorize_____to release any and all information concerning my employment, past or present, including rate of pay, duties performed, dates of absences and reasons therefor. Photostatic copies of this Authorization carry the same Authority as the original.

_____ _____

Date Signature

_____

Print Name as Signed Above