COUNTY OF MORRIS
DEPARTMENT OF EMPLOYEE RESOURCES
OFFICE OF RISK MANAGEMENT

P.O. Box 900
Morristown, New Jersey 07963-0900

(973) 285-6353
FAX (973) 285-6360

NOTICE OF CLAIM

NOTICE: This form has been adopted by the County of Morris pursuant to N.J.S.A. 59:8-6. It is not a supplemental form. It is in lieu of the statutory Notice prescribed by N.J.S.A. 59:8-4 and is the only form of Notice accepted by the County of Morris.

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25 — **Resolution #**

December 28, 2005 — **Dated**

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CLAIMANT INFORMATION

Name _____ **Telephone** _____

Address _____ **Date of Birth** _____

_____

ATTORNEY INFORMATION

Name _____ **Telephone** _____

Address _____ **Telefax** _____

_____ **File No.** _____

GENERAL INSTRUCTIONS: **Pursuant to the provisions of the New Jersey Tort Claims Act, this Notice of Tort Claim form is the form for filing of claims in accordance with N.J.S.A. 59:8.1 et seq. The questions are to be answered to the extent of all information available to the claimant or to his/her attorneys, agents, servants, and employees. The fully completed claim form and the documents requested shall be returned within ninety (90) days of the date of accrual to the:**

COUNTY OF MORRIS, DIVISION OF RISK MANAGEMENT
P.O. BOX 900, MORRISTOWN, NJ 07963-0900

This form is designed as a general form for use with respect to all claims. Some of the questions may not be applicable to your particular claim. In that event, please indicate "Not Applicable". N.J.S.A. 59:9-2 provides that if there are policies of insurance which would cover all or part of your loss, you can only claim that damage which is not covered by insurance. Describe in full and complete detail the factual basis for your cause of action.

1. CLAIMANT INFORMATION (cont'd)

a) Any other name by which the claimant has been known:

b) Marital Status (at the time of incident and current).

c) Identify each person residing with the claimant and the relation, if any, of the person to the claimant.

d) Occupation.

e) Provide all addresses of the claimant for the past 10 years, the dates of residence, the persons residing at the addresses at the same time as the claimant resided at the address and the relation, if any, of the person to the claimant.

2. THE OCCURRENCE WHICH GAVE RISE TO THIS CLAIM

a) Date _____ Time _____ Day of Week _____

b) Describe the location or place of the occurrence.

[Municipality/Exact location] Street Address and Municipality of the occurrence

c) State the name and address of the Morris County Departments or Agencies that you claim caused your damages.

d) Describe how the accident or occurrence happened. If a diagram will assist, please use the one on page 6.

e) State the names of Morris County employees whom you claim were responsible for you injuries/damages, including any information that will assist in identifying and locating them.

f) State the negligence or wrongful acts of the Morris County Department and/or employees which allegedly caused your damages.

_____

_____

_____

g) State the name, [and] address and phone numbers of all witnesses to the accident or occurrence.

_____

_____

_____

h) State the names of all police officers and police departments who investigated the accident and provide a copy of the Police Report.

_____

_____

_____

i) If you or any other party or witness consumed any alcoholic beverages, drugs or medications within twelve (12) hours before the incident forming the basis of the claim, identify the person consuming the same and for each person (a) what was consumed, (b) the quantity thereof, (c) where consumed, and (d) the names and addresses of all persons present.

_____

_____

_____

_____

CLAIM FOR DAMAGES (CHECK APPROPRIATE BLOCK)

( ) Personal Injury ( ) Property Damage

( ) Other – Explain in detail _____

3. IF YOU CLAIM PROPERTY DAMAGE:

a) State the amount of your claim: _____

b) Describe the property damaged.

_____

_____

c) The present location and time when the property may be inspected.

_____

d) Date property acquired. _____

e) Value of property when acquired._____

f) Value of property at time of accident. _____

g) Description of damage._____

_____

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

_____

i) Attach each estimate of repair costs to this form. (Two estimates are required if damage exceeds $1,000.)

j) Set forth in detail the loss claimed for property damage.

_____

_____

SET FORTH IN DETAIL ALL OTHER ITEMS OF LOSS OR DAMAGE CLAIMED BY YOU AND THE METHOD BY WHICH YOU MADE THE CALCULATION.

_____

_____

k) If any photographs were taken of the scene or property damage, attach copies

4. IF YOU CLAIM PERSONAL INJURY:

a) State the amount of your claim: _____

b) Describe all injuries resulting from the accident/ occurrence.

_____

_____

c) Do you claim permanent disability resulting from this injury?

( ) YES ( ) NO

If yes, describe the injuries believed to be permanent.

_____

_____

d) Was any complaint made to the public entity or to any official or employee of the public entity? State the time and place of the complaint and the person or persons to whom the complaint was made.

_____

_____

_____

e) 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 service	Amount of charges to date	Amount paid or payable by other sources

Attach copies of all reports from hospitals and/or doctors.

****You must sign the attached HIPAA Authorization form for each doctor or medical provider listed above. (Make copies of the Authorization form where necessary.)**

f) **If you claim loss of wages or income as a result of injury, state:**

Name of Employer	Address of Employer
Rate of Pay	Date of Employment
Total Lost Wages To Date	Dates of Absence from Work
If still out, expected return to work date	

Note: If your claimed loss of income arises from self-employment or other income, attach a statement showing the basis of your calculation of lost income.

g) **Set forth any and all other losses or damages claimed by you.**

h) **If you claim that a previous injury has been aggravated or exacerbated, describe the injury and give the name and present address of each doctor who treated you for the condition, the period during which treatment was received and the cause of the previous injury. Specifically list any impairment, including use of eyeglasses, hearing aid or similar device, which existed at the time of the injury forming the basis of the claim.**

5. **HAVE YOU MADE A CLAIM AGAINST ANYONE ELSE FOR ANY OF THE LOSSES OR EXPENSES CLAIMED IN THIS NOTICE?_____**
If yes, set forth the name (s) and address (es) of all persons and insurance companies against whom you have made such claims.

6. **ARE ANY OF THE LOSSES, EXPENSES, OR INJURIES CLAIMED HEREIN COVERED BY ANY POLICY OF INSURANCE (HEALTH, AUTO, HOMEOWNER'S)?**

For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable.
<u>You must attach a copy of your policies.</u>

7. **HAVE YOU RECEIVED OR AGREED TO RECEIVE ANY MONEY FROM ANYONE FOR THE DAMAGES CLAIMED HEREIN? _____**
If so, set forth the details of such agreement.

8. THE FOLLOWING ITEMS MUST BE SUBMITTED WITH THIS NOTICE:

   a. Copies of itemized bills for each medical expense and other losses and expenses 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 claim for lost income.

   e. Copies of declaration pages of all insurance policies [i.e., automobile, homeowners, etc.] which would apply to this occurrence.

   f. Copies of police reports.

   g. Diagram of incident.

   h. Photographs of damage claimed.

   i. Provide copies of all documents, memoranda, correspondence, reports (including police reports), etc. which mention or pertain to the subject matter of this claim.

   j. Signed copies of HIPAA authorization for release of Medical and Hospital Records form and authorization for release of Employment Records form.

9. PLEASE ILLUSTRATE ON THE DIAGRAM HOW ACCIDENT OCCURRED. WRITE IN STREET NAMES, AND IF POSSIBLE, THE POINTS OF THE COMPASS. MARK "X" AT THE EXACT LOCATION AND STATE DISTANCE IN FEET FROM NEAREST INTERSECTING STREETS IF LOCATION IS NOT OTHERWISE IDENTIFIABLE. INDICATE ANY PUBLIC PROPERTY.

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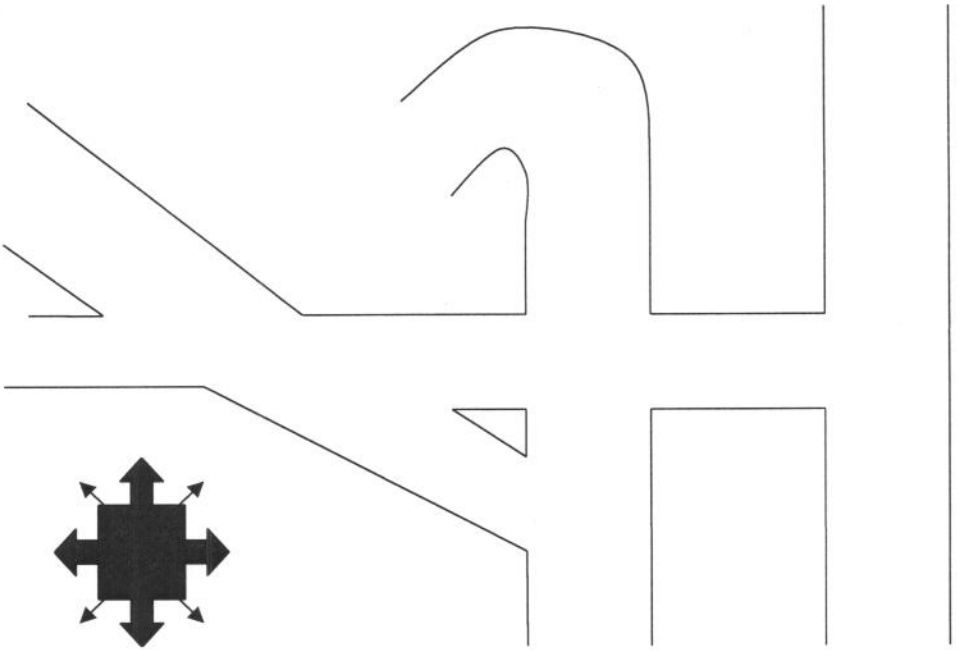
Motor Vehicle or County Roads



*Use compass for direction

For Occurrences Other Than Roads

10. **PRIOR CLAIMS:**

Have you ever made a claim before against The County of Morris or anyone else?
( ) Yes ( ) No

If so, list the date of accident, location, parties involved, insurance carrier and claim number. _____

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 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 the law.

Date: _____ _____
Claimant or person filing claim on behalf of claimant

(Claimant or the parents of claimants who are minors must sign this)
*****If there is a claim for lost wages, you must sign the following:**

Name and Address of Employer: _____

You are hereby authorized and requested to release to the County of Morris employment records of the claimant named hereunder. This authorization shall remain in effect until my claim against The County of Morris has been resolved.

Date: _____ _____

(Signature)

AUTHORIZATION
Release of Medical Information
Pursuant to the Health Care Insurance Portability and Accountability Act of 1996 (HIPAA)

PATIENT'S NAME: _____

ADDRESS: _____

_____

DATE OF BIRTH: _____

I authorize _____
to use and/or disclose a copy of the above named individual's health information as described below.

Information to be provided/released to: The County of Morris or the Attorney General's Office of New Jersey.

Information to be released: Entire medical file and related information to include, but not limited to all notes, reports, diagnostic test results, X-ray films, CT Scan films, MRI films, etc. 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 behavior or mental health services, and treatment for alcohol and drug abuse.

Purpose: This information for which I am authorizing release and disclosure will be used for a personal injury claim or litigation against The County of Morris or a County of Morris employee.

Revocation: I understand that I may revoke this authorization in writing to the medical provider listed above, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire at the end of three (3) years, or at the close of my claim or litigation against The County of Morris or a County of Morris employee.

Disclosure is voluntary: I understand authorizing the use or disclosure of this information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I also understand that once the above information is disclosed, it may be re-disclosed by the recipient during the defense of the pending claim or litigation, and the information may not be protected by the Federal privacy laws or regulations.

_____ _____
Signature of patient, or legal representative Date:

_____ _____
If signed by Legal Representative, relationship to patient Date:

_____ _____
Signature of witness Date:

USE THIS PAGE FOR ADDITIONAL ANSWERS/ STATEMENTS (INCLUDE THE QUESTION NUMBER)