# NOTICE OF TORT CLAIM AGAINST
# GLOUCESTER COUNTY, NEW JERSEY
# AND/OR ITS ENTITIES

1. Identification of Claimant:

_____
Last Name First Middle

_____
Street Address City State Zip Code

_____ _____
Date of Birth Phone No.

Marital Status:

_____ _____
At time of incident Currently

Name of each person living with Claimant and relationship to Claimant:

_____

_____

_____

_____

2. Post Office address where person presenting the claim desires notices to be sent:

_____
Street Address City State Zip Code

Relationship to Claimant: Attorney ☐ or _____
Relationship

3. Circumstances of the occurrence giving rise to the claim:

A. Date: _____ Time: _____

B. Give the exact location of occurrence (Indicate exact street address, if applicable):

C. Describe in detail how the incident occurred.

D. Provide the names and addresses of all eyewitnesses to the occurrence.

E. Provide the names and addresses of all persons who have knowledge of the occurrence.

F. Identify each and every Department, Division, Agency or Authority you claim is liable to you for any injury or property damages resulting from the occurrence.

G. Identify each and every County employee you claim is liable to you for any injury or property damages resulting from the occurrence.

H. Describe in detail the negligence or wrongful acts of the entities and/or employees that you claim caused your damages.

I. Identify each and every other person or entity you claim is liable to you for any injury, damage or loss resulting from the occurrence.

J. If you allege a dangerous condition of public property, describe such condition in detail, state the basis on which you claim the public entity was responsible for such condition, and give the date(s) on which you claim the public entity received notice of such condition.

K. State the names of each and every Police Officer, Police Department, law enforcement agency or joint agency that investigated the occurrence. Attach a copy of all written reports.

L. State the name and address of each expert witness retained by you and the subject matter each expert will address. Attach a copy of each expert report obtained by you.

4. Injury, damage or loss (check appropriate box)

☐ Personal Injury ☐ Property Damage ☐ Other – explain

_____

_____

A. If you claim personal injury, describe in detail all injuries resulting from the occurrence.

B. Describe in detail all injuries you claim to be permanent.

C. If observed, tested, treated and/or confined to any hospitals as a result of the occurrence, state (a) the name and address of each hospital; (b) the dates of admission to and discharge from each hospital; (c) the nature of the testing and/or treatment of each hospital. Attach a copy of all hospital reports.

D. If diagnostic tests were taken, state (a) the name and address of each place where such test was taken; (b) the dates of each test; (c) the result or diagnosis of each test. Attach a copy of all test reports.

E. If treated by doctors, including psychiatrists or psychologists, state (a) the name and address of each doctor; (b) the dates of all treatments; (c) the nature of each treatment; (d) the last date of each treatment, or state if any treatment is continuing. Attach a copy of all medical reports.

F. If you have any physical impairment affecting your ordinary movements or senses that you allege resulted from the injury forming the basis of your claim, state in detail the nature of the impairment and what corrective device, support or appliance you use to alleviate the impairment.

G. If you claim that a previous injury has been aggravated or exacerbated, describe in detail such injury and provide the name and address of each and every doctor who treated you for such injury, the cause of the previous injury and the period during which you received such treatment.

H. If any treatment or surgery in the future has been recommended for the injury forming the basis of your claim, state the name and address of the doctor who has recommended such treatment or surgery, and the nature and extent of the treatment or surgery. Attach a statement of anticipated expenses for each treatment.

I. Describe in detail the nature and extent of all injuries you claim to be permanent. Attach a copy of all supporting medical reports.

J. Itemize any and all expenses incurred for hospitals, doctors and other medical personnel, diagnostic tests, care and appliances and indicate which expenses were paid by insurance coverage.

K. If employed at the time of the occurrence, state:

(1.) name and address of your employer

(2.) position held and the nature of your job duties

(3.) your average weekly wages for the year prior to the occurrence, attaching a copy of payroll stubs or other complete payroll record

asfasf

(4.) period of time lost from employment, giving dates

asfdasd

(5.) total amount of lost wages to date, if any

sdasd

(6.) if still out of work, expected date of return

(7.) List each and every source of income replacement, including but not limited to income continuation benefits, worker's compensation, social security, or public or private disability benefits.

L. If other loss of income, profit or earnings is claimed, (a) describe the nature of the loss; (b) give a detailed computation of the loss, including dates and total amount.

M. If you claim property damage:

(1.) describe the property that was damaged

(2.) give the present location and time when the property may be inspected

(3.) give the date the property was acquired

(4.) state the value of the property on the date of the occurrence

(5.) give a description of the damage

(6.) state the amount of loss being claimed

(7.) if the property was repaired, state by whom, the amount of the repair, attaching a copy of each repair estimate.

N. If any other losses are being claimed as a result of the occurrence, state the nature and dates of each item of loss, and give a complete itemized computation of each item of loss.

O. State whether you have agreed to receive any money from any person or entity for the damages claimed herein. If so, identify each such person or entity and set forth the details of each such agreement, and attach a copy of any written agreements.

P. Are any of the damages or losses for personal injury, property damage, wage loss or other loss covered by any policy of insurance? If so, specify each item loss covered, and state the name and address of the insurance company and policy number covering each item of loss.

**TAKE NOTICE** that, pursuant to N.J.S.A, 59:8-6, The County of Gloucester or its designee may require you to submit to a physical or mental examination by a physician of our choice,.

**TAKE FURTHER NOTICE** that you may also be required to permit The County of Gloucester to inspect all appropriate records relating to your claim for liability and damages via written authorizations. Accordingly, please execute and return the attached authorizations for release of medical records and for release of employment/wage records.

I CERTIFY that all of the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false I am subject to punishment.

_____

CLAIMANT

**<u>NOTE</u>: AUTHORIZATIONS FOLLOW ON THE NEXT FEW PAGES!**

Authorization for Release of Medical Records

HIPAA Compliant / Pursuant to 45 CFR 164.508

**THIS AUTHORIZATION MUST BE FULLY COMPLETED, SIGNED AND DATED**

TO: _____ RE: _____
Name of Health Care Provider/Physician/Facility Patient Name

_____ _____

_____ _____

_____ _____
Date of Birth Social Security Number

I authorize the disclosure of all protected health information and I expressly request that the designed records custodian of all covered entities under HIPAA identified above disclose full and complete protected health information, including the following:

☐ Complete patient chart/file including but not limited to office notes, treatment notes, radiographic/ diagnostic testing results, etc.

☐ Complete patient chart/file including but not limited to office notes, treatment notes, radiographic/ diagnostic testing results, etc. from date of accident ___/___/___ thru present. [provide description of information to be used or disclosed that identifies the information in a specific and meaningful fashion.]

NOTE: Release of "psychotherapy notes" as defined in 45 CFR 164.501 requires completion of separate authorization form. Information about diagnosis or treatment for alcohol/substance abuse and HIV/AIDS may be disclosed as follows: (check all that apply)

☐ Yes, disclose HIV/AIDS information OR ☐ No, do NOT Disclose HIV/AIDS information

☐ Yes, disclose alcohol/drug abuse information OR ☐ No, do NOT disclose alcohol/drug abuse information

This protected health information is disclosed for the following purposes:

☐ This disclosure is made at my request in compliance with 45 CFR 164.508(c)(1)(iv).

Description of legal proceeding Tort claim against Gloucester County or its entities

_____

☐ Other (describe)

_____

You are authorized to release the foregoing records to the following representatives of Gloucester County and its entities in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

Inservco Insurance Services, Inc.
*Name of Representative*

Third Party Claims Administrator (duly appointed via GCIC resolution)
*Representative Capacity (e.g., Attorney, Records Requestor, Agent, etc.)*

3150 Brunswick Pike
*Street Address*

Lawrenceville, NJ 08648
*City, State and Zip Code*

This authorization does not apply to psychotherapy notes.

I acknowledge that I have the right to revoke this authorization, in writing, by sending written notification to you at the above-referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer to be protected under HIPAA privacy rules.

I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization, unless a condition set forth at 45 CFR 164.508(b)(4) applies.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

This authorization shall be in force and effect until:

☐ Date: _____

☐ Event (describe): dismissal or settlement of claim_____

_____

_____ Dated: _____

**Signature of Patient or Personal Representative**

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority to Sign for Patient (attach documents that show authority)

_____ Dated: _____

**Witness Signature**

**Authorization and Request for Employment Records**
**(Accident/Loss of Income)**

**TO:** _____ **RE:** _____
Name of employee

_____ _____
Address

_____ _____

**SSN:** _____

You are hereby requested and authorized to furnish to the following representatives of Gloucester County and its entities whose name and address is:

**Inservco Ins. Services, Inc.**
**3150 Brunswick Pike**
**Lawrenceville, NJ 08648**

The information requested below, concerning my loss of wages or earnings as a result of an accident which occurred on:

Dated: _____ _____
Employee

1. Occupation and kind of work

2. How long employed by you prior to date of accident

3. Average number of hours per day

4. Average number of days per week

5. Date stopped work

6. Date returned to work

7. Wages or earnings before date of accident: Hourly rate $

   Average regular weekly pay $ ; Average weekly overtime pay $

8. Wages or earnings after date of accident: Hourly rate $

   Average regular weekly pay $ ; Average weekly overtime pay $

9. If any wages or earnings were paid to employee for period during which he/she was out:

   a. How much was paid (total) $
   b. for what period
   c. nature of payment

ADDITIONAL REMARKS:

Dated: _____ By: _____
Title:

**Authorization and Request for Employment Records**
**(History Status)**

**TO:** _____

_____

_____

**RE:** _____
Name of employee

_____
Address

_____

**SSN:** _____

You are hereby requested and authorized to furnish to the following representatives of Gloucester County and its entities whose name and address is:

**Inservco Ins. Services, Inc.**
**3150 Brunswick Pike**
**Lawrenceville, NJ 08648**

any and all records, reports, notes, charts or other information you may have regarding my past or present employment. Please provide copies of the foregoing along with any other requested information. I would appreciate your full cooperation.

Dated: _____ _____
, Employee

ADDITIONAL REMARKS: _____

_____

_____

_____

Dated: _____ By: _____
Title: