BOROUGH OF FREEHOLD
MUNICIPAL BUILDING
30 MECHANIC STREET
FREEHOLD, NJ 07728
PHONE: 732-462-1259

NOTICE OF TORT CLAIM

General Instructions: Pursuant to the provisions of the New Jersey Tort Claims Act, this Notice of Tort Claim form has been adopted as the official form for the filing of claims against the Borough of Freehold.

The questions are to be answered to the extent of all information available to the Claimant or to his or her attorney, agents, servants and employees, under oath. The fully completed claim form and the documents requested shall be returned to the:

BOROUGH CLERK
BOROUGH OF FREEHOLD
30 MECHANIC STREET
FREEHOLD, NJ 07728

NOTE CAREFULLY: Your claim will not be considered filed as required by the New Jersey Tort Claims Act until this completed form has been filed with the Borough of Freehold. Failure to provide the information requested, including such responses as "To Be Provided" or "Under Investigation" will result in the claim being treated as not being properly filed.

Timely notices of claim must be filed within 90 days after the incident giving rise to the claim.

The 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. For example, if your claim does not arise out of an automobile accident, questions regarding road conditions might not be applicable. In that event, please indicate "Not Applicable".

If you are unable to answer any question because of a lack of information available to you, specify the reason the information is not available to you. If a questions asks that you identify a document, it will be sufficient to furnish true and legible copies. Where a question asks that you "identify all persons" provide the name, address and telephone number of the person.

If you need more space to provide a full answer, attach supplementary pages identifying the continuation of the answer with the number of the page and question.

CLAIM FOR DAMAGES AGAINST THE BOROUGH OF FREEHOLD

THIS CLAIM FORM MUST BE FILED WITHIN NINETY (90) DAYS OF ACCIDENT/OCCURENCE OR YOU MAY FORFEIT YOUR RIGHTS PURSUANT TO N.J.S.A. 59:1 ET SEQ.

1) CLAIMANT INFORMATION

_____ $_____
DATE OF ACCIDENT AMOUNT OF CLAIM

_____ _____
LAST NAME, FIRST, MIDDLE DATE OF BIRTH

_____ _____
STREET ADDRESS MAILING ADDRESS

_____ _____
CITY, STATE, ZIP CODE SOCIAL SECURITY NUMBER

_____ _____
MARITAL STATUS NUMBER OF DEPENDENTS

_____ _____
HOME/CELL PHONE E-MAIL

2) If notice and correspondence in connection with this claim are to be sent to a person other than the claimant, complete item number 2.

_____ _____
NAME MAILING ADDRESS

_____ _____
PHONE NUMBER CITY, STATE, ZIP CODE

_____
E-MAIL

RELATIONSHIP TO CLAIMANT: ATTORNEY AT LAW ( ) OR_____
RELATIONSHIP

3) The occurrence or accident which gave rise to this claim:

a._____ _____

DATE TIME

b. Describe the location of the occurrence:

_____

MUNICIPALITY EXACT LOCATION

c. Describe how the accident or occurrence happened. If a diagram will assist your explanation, please attach hereto:

_____

_____

_____

d. State the names of public employees and or public agencies whom you claim were at fault, including any information that will assist identifying and locating them:

_____

_____

_____

e. State the negligence or wrongful acts of the public agency or its employees which allegedly 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:

_____

_____

_____

h. Did loss or injury occur during the course of your employment?

_____

_____

_____

4) Claim for Damages (check appropriate block)

( ) Property Damages
( ) Personal Injury
( ) Other – Explain in detail _____

If you claim personal injury:

a. Describe your injuries resulting from this accident or occurrence:

_____

_____

_____

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

( ) Yes ( ) No

If yes, describe the injuries believed to be permanent.

_____

_____

_____

c. For each hospital, doctor or other practitioner rendering treatment, examination or diagnostic service, state the name and address of hospital, doctor or other facility, dates of treatment or service and amount of charges to date:

_____

d. Are you covered by any health insurance policy? If so, please advise name and address of carrier, named insured and policy number:

e. List bills submitted to carrier:

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

Name and Address of Employer:

Date of Hire and Occupation:

Rate of Pay and Total Lost Wages to Date:

Dates of Absence from work and expected date to return:

If injury is associated with an auto accident, please provide name of auto insurance carrier and policy number:

NOTE: If you claimed loss of income arises from self-employment or other than wages, attach a calculation showing the basis of your calculation of lost income.

6) Set forth any and all losses or damages claimed by you:

_____

_____

_____

7) If you claim property damage:

a. Describe the property damaged:

_____

_____

_____

b. Present location and time when property may be inspected:

_____

_____

c. Date property acquired: _____

d. Cost of property: _____

e. Value of property at time of accident: _____

f. Has the damage been repaired? _____
If so, by whom, when and cost of repairs? (Attach each estimate of repair costs)

_____

_____

g. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation:

_____

_____

_____

8) State the total amount of damages (personal, property and other) you are claiming:

9) 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, addresses of all persons and insurance companies against whom you have made such claims:

10) 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:

11) Have you received or agreed to receive any money from anyone for the damages claimed herein? If so, set forth in details of such agreement:

12) The following items must be submitted with this notice if available:

a. Copy of police or accident report related to this claim.

b. Photographs of the property or vehicle damage.

c. Copy of all estimates and appraisals of property or vehicle damage claimed by you.

d. Copies of all written reports of all expert witnesses and treating physicians and itemized bills for each medical expense or other losses and expenses claimed by you.

e. A letter from your employer verifying 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 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.

_____ _____

Claimant or person filing on behalf of claimant Date

MEDICAL/EMPLOYMENT INFORMATION RELEASE AUTHORIZATION

TO WHOM IT MAY CONCERN:

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

I also hereby authorize my employer to release all wages, salary and related compensation information.

_____ _____

Signature Date

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