Mercer County Improvement Authority
Notice of Tort Claim
Pursuant to N.J.S.A. 59:8-6

To: Executive Director, With Copy to Clerk to the Board
Mercer County Improvement Authority
80 Hamilton Avenue, 2nd Floor
Trenton, NJ 08611

1. Claimant Name: _____

   Address: _____
   _____
   _____

   Date of Birth: _____

   Mailing Address if other than street address above:
   _____
   _____

   Social Security Number: _____

If Notice and correspondence in connection with this claim are to be sent to a person of firm other than claimant, please complete item #2.

2. Name: _____

   Mailing Address: _____
   _____
   _____

   Relationship to Claimant: _____

3. The Occurrence or Accident which gave rise to this claim:

   a. Date: _____

   b. Describe the location or the place of the accident or occurrence:
   _____
   _____
   _____

   Exact location of occurrence or accident: _____
   _____
   _____

c. Describe how the accident or occurrence happened: (If diagram will assist with explanation, please use the reverse side of this form.)

_____
_____
_____
_____

d. State the name and address of the agency or agencies that you claim cause your damages:

_____
_____
_____

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

_____
_____
_____

f. State the negligence or wrongful acts of the agency and employees which caused your damage.

_____
_____
_____

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

_____
_____
_____

h. State the names of all Police officers and Polic departments who investigated the accident.

_____
_____
_____
_____

i. Claim for damages:

_____
_____
_____

4. If you claim person injury:

    1. Describe your injuries resulting from this accident or occurrence.

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

       If yes, describe the injuries believed to be permanent:

    3. For each hospital, doctor or the other practitioner rendering treatment, examination or diagnostic services, state:

       Name of Hospital, Doctor, or other facility:

       Dates of treatment or service:

       Amount of charges to date:

       Amount paid or payable by other sources such as insurance, and the names, addresses, policy numbers and claim numbers of all insurance carriers.

5. If you claim a loss of wages or earnings, state:

    a. Name and address of employer

    b. Dates out of work.

    c. Weekly salary.

    d. Amount of wages claimed.

    e. If any portion of your salary was paid or your receive any disability or sick pay, state the total amount received and the name, address and claim or policy number of the payor.

6. Set forth any and all other losses or damages claimed by you.

7. 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 and address of all persons and insurance companies against whom you have made such claims and provide all claim numbers, telephone numbers and names of all claims adjusters handling same.

8. 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, claim number and benefits paid or payable.

_____

_____

_____

9. Have you received or agreed to receive any monies from anyone for the damages claimed herein. If yes, state their name, address, claim number, the total consideration involved and attach copies of all written documents involved.

_____

_____

_____

_____

_____

10. The following items must be submitted with this notice:

    a. Copies of itemized bills for each medical expense, 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 calculations of your claimed lost income.

_____ _____

(Dated) **(Signature – Claimant)**

Authorization for Release of Medical Records Form

To:_____ Dated:_____

_____ Re:_____
(Name of Patient)

_____

Patient Address: _____

_____

_____

You are herby requested an authorized to disclose, make available, and furnish to the **MERCER COUNTY IMPROVEMENT AUTHORITY**, or their agent, servant, or employee, all Information, records, X-rays, reports, or copies thereof relating to my examination, consultation, confinement, treatment, and to permit them to inspect and make copies or abstracts thereof. You are also authorized to send any psychiatric, drug, and/or alcohol information if applicable.

Approximate date of injury or admission to hospital, first examination, treatment or consultation:

_____

_____ _____

(Dated) **(Signature of Claimant)**