ELIZABETH BOARD OF EDUCATION NOTICE OF CLAIM FORM
PURSUANT TO N.J.S.A. 59:1-1, ET SEQ.
THE NEW JERSEY TORT CLAIMS ACT

1. Name of Claimant:_____

   Address: _____

   Social Security Number: _____

2. Post Office Address to which Claimant desires notices and correspondence to be sent:_____

   _____

3. The date, School and/or location and other circumstances of the occurrence which gave rise to the claim asserted herein:

   _____

   _____

   _____

   _____

4. General description of the injury, damage or loss incurred to date:

   _____

   _____

   _____

5. The name(s) of the public entity/entities and/or employee(s) causing the alleged injury, damage or loss if known:

   _____

   _____

6. The amount claimed as of the date of this form, including the estimated amount of any prospective injury, damage or loss, as may be known at this time, with the basis of the computation of this amount:

   _____

7. In detail, state the facts upon which you rely to support your allegation that the Elizabeth Board of Education is responsible or liable for the injuries, damage or loss incurred by claimant (you may attach additional pages):

   _____

   _____

   _____

8. Provide the name(s) and address(es) of all medical providers, including hospitals, physicians, clinics, health care organizations or health care employees who treated the claimant for injuries alleged to have occurred as a result of the incident herein (you may attach additional pages):

   _____

   _____

   _____

9. Attach copies of written reports of the claimant's attending physician(s) or dentist setting forth the nature and extent of the injury and the treatment, any degree of permanent or temporary disability, the prognosis, period of time hospitalized, any diminished earning capacity, duration of pain and suffering, if claimed, and any drugs administered for pain (please see attached medical disclosure form).

10. List claimant's expert witnesses and attach any reports or statements relating to the claim prepared by those experts:

    _____

    _____

11. Attach all itemized bills for medical, dental and hospital expenses incurred or all itemized receipts of payment for such expenses.

12. Attach documentation evidencing the amounts of any income which has been lost and attach written statement from any employer(s) showing actual time lost from employment, whether claimant is a full or part-time employee and the wages or salary actually lost.

13. State the anticipated expense for any future treatments, if necessary:

    _____

14. If the claim is one of injury to or loss of property, real or personal, attach documentation evidencing proof of ownership of the property, a detailed statement of the amount claimed, an itemized receipt of payment for necessary repairs or itemized written estimates of the cost of such repairs, and a statement listing the date of purchase, purchase price and salvage value, whether repair is not economical.

15. If the claim is one based upon death, submit the following:

    (a) An authenticated death certificate;
    (b) Decedent's employment or occupation at the time of death, including monthly or yearly salary or earnings and the duration of last employment or occupation;
    (c) Name(s), address(es), birth date(s), kinship and marital status of decedent's survivors;
    (d) Degree of support afforded by decedent to each survivor dependent upon him for support at the time of death;
    (e) Decedent's general physician and mental condition before death;
    (f) Itemized bills for medical and burial.

16. Set forth the days and time when the Claimant is available, excluding weekends and evenings, for the physical examinations by a physician on behalf of the Board.

_____

17. Attach or provide any pictures, diagrams and/or any other documents that the claimant or claimant's attorney will rely on showing the location of the accident, the loss, the conditions of the property and/or the alleged damage to the property.

18. Name of all insurance carriers and the policy numbers which may pay or reimburse the claimant for any expenses incurred for treatment or repair:

_____

_____

Date Submitted:

_____
Signature of Claimant

(See attached Authorization for Health Information Disclosure attached hereto and made a part hereof this claim form)

Authorization for Health Information Disclosure

(This form complies with HIPAA – The Health Insurance Portability and Accountability Act of 1996)

Patient Information

Patient Name: _____

Street Address: _____

City: _____State: _____ Zip: _____

Date of Birth: _____ Social Security # _____

I hereby authorize: _____

(Name of physician's office/medical practice disclosing information)

Requestor/Recipient Information

Please disclose the following protected health information to:

_____

Street Address: _____ P.O. Box: _____

City: _____ State: _____ Zip: _____

Please indicate the information or types of information to be disclosed:

_____

_____

Specify dates (or date ranges) if applicable:

_____

This request is for the purpose of:

_____

I understand that I have the right to revoke this authorization at anytime. I understand that my revocation must be in writing and addressed to the Elizabeth Board of Education. I understand that the revocation does not apply to information that has already been released in response to this authorization.

Unless otherwise revoked, this authorization will expire in six months.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions concerning disclosure of my health information, I may contact the Elizabeth Board of Education.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, AIDS, HIV, sexually transmitted diseases, tuberculosis, or genetics.

IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL: DO NOT RELEASE

Signature of Patient or Authorized Representative Date

_____ _____

Witnessed By: Date

_____ _____

(Print & Sign)