

(SALARY)
OFFICE OF THE COMPTROLLER - CITY OF NEW YORK
NOTICE OF CLAIM

CLAIMANT INFORMATION

CLAIMANT'S NAME _____ TEL.#: (_____)
STREET ADDRESS: _____ SOC. SEC #:
CITY: _____ STATE: _____ ZIP:

CLAIM INFORMATION

CITY AGENCY INVOLVED:
LOCATION:

WORK PHONE NO.

<u>TYPE OF CLAIM</u>	<u>DATE FROM</u>	<u>TO</u>	<u>AMOUNT DUE</u>
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OVERTIME

COMPENSATORY

TIME

DIFFERENTIAL

ANNUAL LEAVE/VACATION

SICK LEAVE

SALARY

OTHER (SPECIFY)

TOTAL

NATURE OF CLAIM: (ATTACH ADDITIONAL SHEETS OF PAPER, IF NECESSARY)

CLAIMANT'S SIGNATURE:

SS: STATE OF N.Y.

CITY OF N.Y.

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY

OF _____, 20

NOTARY

TO: OFFICE OF THE COMPTROLLER
DIVISION OF LAW - ROOM 1225
1 CENTRE STREET
NEW YORK, N.Y. 10007

QUESTIONS CALL:
(212) 669-4736