



Personal Injury Claim Form

Claim must be filed *in person or by registered or certified mail within 90 days of the occurrence* at the NYC Comptroller's Office, 1 Centre Street, Room 1225, New York, New York 10007. It must be *notarized*. If claim is not resolved within *1 year and 90 days of the occurrence*, you must start legal action to preserve your rights.

TYPE OR PRINT

- I am filing:** On behalf of myself.
 On behalf of someone else. If on someone else's behalf, please provide the following information.

Last Name:

First Name:

Relationship to the claimant:

Claimant Information

*Last Name:

*First Name:

Address:

Address 2:

City:

State:

Zip Code:

Country:

Date of Birth: *Format: MM/DD/YYYY*

Soc. Sec. #

HICN:
(Medicare #)

Date of Death: *Format: MM/DD/YYYY*

Phone:

Email Address:

Occupation:

- City Employee? Yes No NA
- Gender Male Female Other

- Attorney is filing.

Attorney Information (If claimant is represented by attorney)

Firm or Last Name:

Firm or First Name:

Address:

Address 2:

City:

State:

Zip Code:

Tax ID:

Phone #:

Email Address:



The time and place where the claim arose

*Date of Incident: *Format: MM/DD/YYYY*

Time of Incident: *Format: HH:MM AM/PM*

*Location of Incident:

Address:

Address 2:

City:

State:

Borough:

***Manner in which claim arose:**

Attach extra sheet(s) if more room is needed.

The items of damage or injuries claimed are (include dollar amounts):

Attach extra sheet(s) if more room is needed.



Medical Information

1st Treatment Date:	<input type="text"/>	<i>Format: MM/DD/YYYY</i>
Hospital/Name:	<input type="text"/>	
Address:	<input type="text"/>	
Address 2:	<input type="text"/>	
City:	<input type="text"/>	
State:	<input type="text"/>	
Zip Code:	<input type="text"/>	
Date Treated in Emergency Room:	<input type="text"/>	<i>Format: MM/DD/YYYY</i>
Was claimant taken to hospital by an ambulance?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NA	

Employment Information (If claiming lost wages)

Employer's Name:	<input type="text"/>
Address	<input type="text"/>
Address 2:	<input type="text"/>
City:	<input type="text"/>
State:	<input type="text"/>
Zip Code:	<input type="text"/>
Work Days Lost:	<input type="text"/>
Amount Earned Weekly:	<input type="text"/>

Treating Physician Information

Last Name:	<input type="text"/>
First Name:	<input type="text"/>
Address:	<input type="text"/>
Address 2:	<input type="text"/>
City:	<input type="text"/>
State:	<input type="text"/>
Zip Code:	<input type="text"/>



Witness 1 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	

Witness 4 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	

Witness 2 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	

Witness 5 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	

Witness 3 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	

Witness 6 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	



Complete if claim involves a NYC vehicle

Owner of vehicle claimant was traveling in

Last Name:

First Name:

Address

Address 2:

City:

State:

Zip Code:

Non-City vehicle driver

Last Name:

First Name:

Address

Address 2:

City:

State:

Zip Code:

Insurance Information

Insurance Company Name:

Address

Address 2:

City:

State:

Zip Code:

Policy #:

Phone #:

Non-City vehicle information

Make, Model, Year of Vehicle:

Plate #:

VIN #:

City vehicle information

Plate #:

City Driver Last Name:

City Driver First Name:

Description of claimant:

- Driver Passenger
 Pedestrian Bicyclist
 Motorcyclist Other

***Total Amount Claimed:**

Format: Do not include "\$" or ",".

Date _____ Signature of Claimant _____

State of New York
County of _____

I, _____, being duly sworn depose and say that I have read the foregoing NOTICE OF CLAIM and know the contents thereof: that same is true to the best of my own knowledge, except as to the matter here stated to be alleged upon information and belief, and as to those matters. I believe them to be true.

Sworn before me this day _____

Signature of Claimant _____

Signature of notary _____