New York City Comptroller
Scott M. Stringer

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007
Form Version: NYC-COMPT-BLA-LE-B

City Employment Claim Form

For most claims, under GML § 50-e, a notice of claim must be filed within 90 days of the occurrence. A notice of claim can be filed electronically on the NYC Office of the Comptroller's website. For most claims, if the claim is not resolved, legal action must be started within one (1) year and 90 days of the occurrence.

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: NEW YORK
*Zip Code:
*Country: USA
Date of Birth: *Format: MM/DD/YYYY*
Soc. Sec #:
*Phone:
*Email Address:
*Retype Email:
Occupation:
Current City Employee? ☐ Yes ☐ No ☐ NA
Current Agency:

Gender: ☐ Male ☐ Female ☐ Other

☐ Attorney is filing.

Attorney Information (if represented by attorney)

+Firm or Last Name:
+Firm or First Name:
+Address:
Address 2:
+City:
+State:
+Zip Code:
Tax Id:
+Phone:
+Email Address:
+Retype Email:

The time and place where the claim arose

*Incident Date from: *Format: MM/DD/YYYY*
*Incident Date to: *Format: MM/DD/YYYY*
*Incident Location:
Address:
Address 2:
City:
State:
Borough:

** Denotes required fields. Either a claimant or attorney email address is required.*
\+ Denotes field that is required if Attorney is filing.

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***Nature of Claim/Description of Claim**

If you need additional room, attach your description as an additional document.

What agency/employer are you making this claim against?

*Agency:	
Address:	
Address 2:	
City:	
State:	
Zip Code:	

Work days lost:	
Amount Earned Weekly:	
Amount Earned Yearly:	

Were you employed by a City Contractor at the time of claimed occurrence? ☐ Yes ☐ No

++Contractor Name:

**Denotes required field*
++Denotes field that is required if you were employed by a City Contractor.

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Salary/Benefit Claimed Damages

	Date From:	Date To:	Amount:
Overtime:			
Compensatory time:			
Differential:			
Annual Leave/Vacation:			
Sick Leave:			
Salary:			
		Total:	0.00

Additional Claimed Damages

		Amount:
Specify:		
Specify:		
Specify:		
Specify:		
Specify:		
	Total:	0.00

****Total Claimed Amount:**

I certify that all information contained in this notice is true, and correct to the best of my knowledge, and belief. I understand that the willful making of any false statement of material fact herein will subject me to criminal penalties, and civil liabilities.

**Denotes field that is required.*
***Total Claimed Amount will be automatically calculated after all required fields are entered.*