New York City Comptroller
Mark Levine

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007

Form Version: NYC-COMPT-BLA-PI1-M3

Personal Injury Claim Form

A claim must be filed in person or by registered or certified mail within 90 days of the occurrence at the NYC Comptroller's Office, located at 1 Centre Street, Room 1225, New York, NY 10007. The claim form must be notarized. If the claim is not resolved within one (1) year and 90 days of the occurrence, you must start a separate legal action in a court of law before the expiration of this time period 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:	

**** Denotes required field(s).***

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The time and place where the claim arose

*Date of Incident:		*Format: MM/DD/YYYY*
Time of Incident:		*Format: HH:MM AM/PM*
Dismissal Date:		*(Police related claims only)*

*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.

**** Denotes required field(s).***

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Medical Information

1st Treatment Date:		*Format: MM/DD/YYYY*
Hospital/Name:		
Address:		
Address 2:		
City:		
State:		
Zip Code:		
Date Treated in Emergency Room:		*Format: MM/DD/YYYY*

Was claimant taken to hospital by an ambulance? ◯ Yes ◯ No ◯ NA

Employment Information (If claiming lost wages)

Employer's Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	
Work Days Lost:	
Amount Earned Weekly:	

Treating Physician Information

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

**** Denotes required field(s).***

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Witness 1 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 3 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 5 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:	

**** Denotes required field(s).***

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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_____

**** Denotes required field(s).***