GENERAL INSTRUCTIONS: Pursuant to N.J.S.A. 59:8-6, this Notice of Tort Claim form has been adopted as the official **form** for the filing of **claims** against the Township of Barnegat.

The questions are to be answered to the extent of all information available to the Claimant or to his or her attorneys, under oath. The fully completed **Claim Form** and the documents required shall be returned to the:

CLERK OF THE
TOWNSHIP OF BARNEGAT
900 WEST BAY AVENUE
BARNEGAT, NEW JERSEY 08005

IMPORTANT: A **claim** will not be considered filed as required under the **New Jersey Tort Claims Act** until this completed **form** has been filed with the Township of Barnegat. Failure to provide the information requested, will result in the **claim** being treated as not being properly filed.

Timely Notices of **Claim** must be filed within 90 days after the incident giving rise to the **claim.**

The attached Patient Authorization forms must be signed by Claimant to be treated as being properly filed.

If you are unable to answer any questions because of a lack of information available to you, specify the reason the information is not available to you. If a question asks that you identify a document, it will be sufficient to furnish true and legible copies. Where a question asks that you "identify all persons," provide the name, address and telephone number of the person.

DEFINITIONS:

"**Claimant**" shall refer to the person or persons on whose behalf the **Notice** of **Claim** has been filed with the Township.

"**Documents**" shall refer to any written, photographic, video, or electronic representation, and any copy thereof.

"**Person**" shall include in its meaning a partnership, joint venture, corporation, association, trust or any other kind of entity, as well as a natural person.

"**Public Entity**" shall refer to the Township of Barnegat along with any agent, official, or employee of the Township of Barnegat against whom a **claim** is asserted by the Claimant.

If the **claim** involves only property damage, the portion on personal injuries need not be answered. If the **claim** involves no property damage, then the portion on property damage need not be answered.

TOWNSHIP OF BARNEGAT

TORT CLAIMS NOTICE FORM
PURSUANT TO N.J.S.A. 59:8-6

1. NAME OF CLAIMANT: _____

2. POST OFFICE ADDRESS OF CLAIMANT: _____

_____

3. DATE OF OCCURRENCE OR TRANSACTION WHICH GAVE RISE TO THE CLAIM ASSERTED:

_____

4. PLACE OF THE TRANSACTION OR CLAIM ASSERTED:

_____

5. CIRCUMSTANCES OF THE TRANSACTION OR CLAIM ASSERTED:

_____

_____

_____

6. A GENERAL DESCRIPTION OF THE INJURY, DAMAGE OR LOSS INCURRED:

_____

_____

_____

7. IDENTIFY ALL PUBLIC ENTITIES OR PUBLIC EMPLOYEES (BY NAME AND POSITION) ALLEGED TO HAVE CAUSED THE INJURY OR PROPERTY DAMAGE AND SPECIFY AS TO EACH THE EXACT NATURE OF THE ACT OR OMISSION ALLEGED TO HAVE CAUSED THE INJURY OR PROPERTY DAMAGE:

8. IF YOU **CLAIM** THAT THE INJURY OR PROPERTY DAMAGE WAS CAUSED BY A DANGEROUS CONDITION OF PROPERTY UNDER THE CONTROL OF THE PUBLIC ENTITY, SPECIFY THE NATURE OF THE ALLEGED DANGEROUS CONDITION, AND THE MANNER IN WHICH YOU CLAIM THE CONDITION CAUSED THE INJURY:

9. THE AMOUNT CLAIMED INCLUDING THE ESTIMATED AMOUNT OF ANY PROSPECTIVE INJURY, DAMAGE OR LOSS:

10. THE BASIS OF COMPUTATION OF THE AMOUNT CLAIMED:

_____

_____

_____

11. IF ANY PHOTOGRAPHS, SKETCHES, CHARTS, OR MAPS WERE MADE WITH RESPECT TO ANYTHING WHICH IS THE SUBJECT MATTER OF THE **CLAIM,** STATE THE DATE THEREOF, THE NAMES AND ADDRESSES OF THE PERSONS MAKING THE MAPS AND OF THE PERSONS WHO HAVE PRESENT POSSESSION THEREOF. ATTACH COPIES OF ANY PHOTOGRAPHS, SKETCHES, CHARTS OR MAPS:

_____

_____

_____

_____

12. THE NAMES AND ADDRESSES OF ALL OF CLAIMANT'S ATTENDING PHYSICIANS OR DENTISTS:

_____

_____

_____

_____

13. THE NAMES OF ALL HOSPITALS ATTENDED BY CLAIMANT AS A RESULT OF THE INJURY CLAIMED AND THE PERIOD OF HOSPITALIZATION:

_____

_____

_____

_____

14. THE EXTENT OF THE INJURY CLAIMED AND TREATMENT RECEIVED:

15. THE EXTENT OF ANY TEMPORARY OR PERMANENT DISABILITY CLAIMED:

16. THE PROGNOSIS FOR THE INJURY CLAIMED:

17. THE EXTENT OF ANY DIMINISHED EARNING CAPACITY CLAIMED:

18. COPIES OF WRITTEN REPORTS FROM ALL PHYSICIANS/DENTISTS LISTED IN ANSWER TO NUMBER 10, ABOVE, SETTING FORTH THE INFORMATION REQUESTED IN QUESTIONS NUMBER 12 THROUGH 15, ABOVE:

19. AN ITEMIZATION OF ALL BILLS FOR MEDICAL, DENTAL AND HOSPITAL EXPENSES INCURRED:

20. ITEMIZED RECEIPTS OF PAYMENT FOR ALL ITEMS CLAIMED IN ANSWER TO NUMBER 17, ABOVE:

21. DOCUMENTARY EVIDENCE SHOWING AMOUNTS OF INCOME LOST, INCLUDING INCOME TAX RETURNS FOR THE LAST FIVE (5) CALENDAR YEARS:

22. A STATEMENT OF ANTICIPATED EXPENSES FOR ANY FUTURE MEDICAL/DENTAL TREATMENT:

23. A COPY OF ALL HOSPITAL RECORDS OF CLAIMANT FOR TREATMENT OF THE INJURY CLAIMED IN ANSWER TO NUMBER 6, ABOVE:

Authorization for Health Information Disclosure

This form complies with the HIPAA Privacy Rule

Patient Information

(Please Print)

Patient Name: _____Street Address: _____

City: _____ State: _____ Zip Code:_____ Date of Birth: _____

I hereby authorize: _____

Name of Physician's office/medical practice disclosing information

Requestor/Recipient Information

Please disclose the following protected health information to: Municipal Attorney

Christopher Dasti Law Firm

ATTN: Christopher Dasti, Esq.

Street Address: **310 Lacey Road, P.O. Box 779**

City: **Forked River** State: **New Jersey** Zip Code: **08731**

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 any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. 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 or on the following date:

_____

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 about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (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

_____ _____

Description of Representative's Authority (witness signature required) Signature of Witness

_____