NOTICE OF TORT CLAIM AGAINST GLOUCESTER COUNTY, NEW JERSEY AND/OR ITS ENTITIES

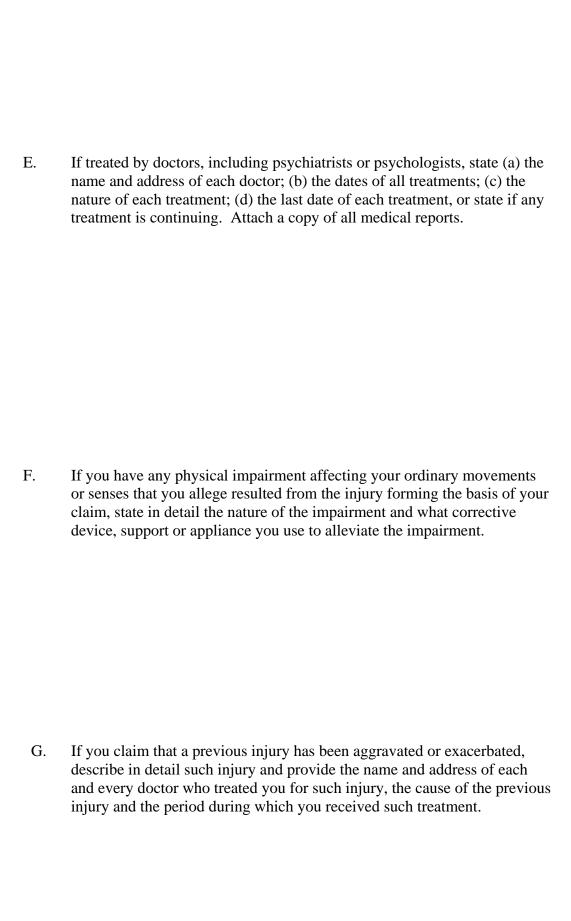
Last Name		First	Midd	lle
Street	Address	City	State	Zip Code
Date of	of Birth		Phone No.	
Marit	al Status:			
At tin	ne of incident		Currently	
Post (Office address wh	ere person presenting	g the claim desires noti	ces to be sent:
	office address with	ere person presenting	5 the claim desires not	ees to be sent.
Street	Address	City	State	Zip Cod
Relati	onship to Claima	nt: Attorney (), or	Relationship	
Circu	mstances of the o	ccurrence giving rise	to the claim:	
A.	Date:		Time:	
B.	Give the exact l applicable):	ocation of occurrence	e (Indicate exact street	address, if

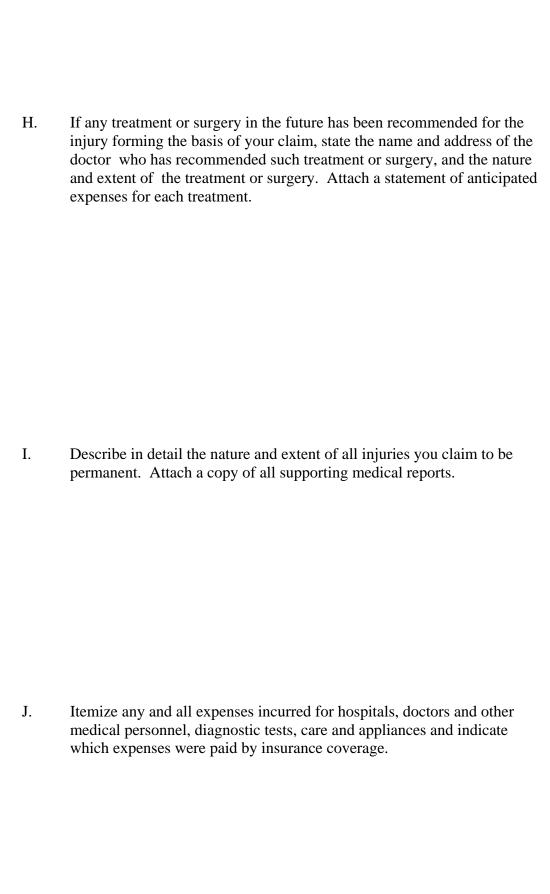
C.	Describe in detail how the incident occurred.
D.	Provide the names and addresses of all eyewitnesses to the occurrence.
E.	Provide the names and addresses of all persons who have knowledge of the occurrence.
F.	Identify each and every Department, Division, Agency or Authority you claim is liable to you for any injury or property damages resulting from the occurrence.

G.	Identify each and every County employee you claim is liable to you for any injury or property damages resulting from the occurrence.
Н.	Describe in detail the negligence or wrongful acts of the entities and/or employees that you claim caused your damages.
I.	Identify each and every other person or entity you claim is liable to you for any injury, damage or loss resulting from the occurrence.
J.	If you allege a dangerous condition of public property, describe such condition in detail, state the basis on which you claim the public entity was responsible for such condition, and give the date(s) on which you claim the public entity received notice of such condition.

	K.	State the names of each and every Police Officer, Police Department, law enforcement agency or joint agency that investigated the occurrence. Attach a copy of all written reports.
	L.	State the name and address of each expert witness retained by you and the subject matter each expert will address. Attach a copy of each expert report obtained by you.
4.		, damage or loss (check appropriate box) rsonal Injury () Property Damage () Other – explain
	A.	If you claim personal injury, describe in detail all injuries resulting from the occurrence.

В.	Describe in detail all injuries you claim to be permanent.
C.	If observed, tested, treated and/or confined to any hospitals as a result of the occurrence, state (a) the name and address of each hospital; (b) the dates of admission to and discharge from each hospital; (c) the nature of the testing and/or treatment of each hospital. Attach a copy of all hospital reports.
D.	If diagnostic tests were taken, state (a) the name and address of each place where such test was taken; (b) the dates of each test; (c) the result or diagnosis of each test. Attach a copy of all test reports.





K.	If employed at the time of the occurrence, state:
	(1.) name and address of your employer
	(2.) position held and the nature of your job duties
	(3.) your average weekly wages for the year prior to the occurrence, attaching a copy of payroll stubs or other complete payroll record
	(4.) period of time lost from employment, giving dates
	(5.) total amount of lost wages to date, if any
	(6.) if still out of work, expected date of return
	(7.) List each and every source of income replacement, including but not limited to income continuation benefits, worker's compensation, social security, or public or private disability benefits.
L.	If other loss of income, profit or earnings is claimed, (a) describe the nature of the loss; (b) give a detailed computation of the loss, including dates and total amount.

M. If you claim property damage:		
	(1.) describe the property that was damaged	
	(2.) give the present location and time when the property may be inspected	
	(3.) give the date the property was acquired	
	(4.) state the value of the property on the date of the occurrence	
	(5.) give a description of the damage	
	(6.) state the amount of loss being claimed	
	(7.) if the property was repaired, state by whom, the amount of the repair, attaching a copy of each repair estimate.	
N.	If any other losses are being claimed as a result of the occurrence, state the nature and dates of each item of loss, and give a complete itemized computation of each item of loss.	

O.	State whether you have agreed to receive any money from any person or entity for the damages claimed herein. If so, identify each such person or entity and set forth the details of each such agreement, and attach a copy of any written agreements.
P.	Are any of the damages or losses for personal injury, property damage, wage loss or other loss covered by any policy of insurance? If so, specify each item loss covered, and state the name and address of the insurance company and policy number covering each item of loss.
designee may a our choice,. TAKE FURT Gloucester to it damages via w	CE that, pursuant to N.J.S.A, 59:8-6, The County of Gloucester or its require you to submit to a physical or mental examination by a physician of HER NOTICE that you may also be required to permit The County of nspect all appropriate records relating to your claim for liability and ritten authorizations. Accordingly, please execute and return the attached for release of medical records and for release of employment/wage
	TIFY that all of the foregoing statements made by me are true. I am aware me foregoing statements made by me are willfully false I am subject to CLAIMANT

NOTE: AUTHORIZATIONS FOLLOW ON THE NEXT FEW PAGES!

Authorization for Release of Medical Records

HIPAA Compliant / Pursuant to 45 CFR 164.508

THIS AUTHORIZATION MUST BE FULLY COMPLETED, SIGNED AND DATED

TO:Name of Health Care Provider/Physician/Facility		RE: Patient Name		
I au	thorize the disclosure of all protected health information	Date of Birth	Social Security Number est that the designed records	
cust	todian of all covered entities under HIPAA identified all ormation, including the following:			
	Complete patient chart/file including but not limit diagnostic testing results, etc.	ed to office notes, trea	tment notes, radiographic/	
info				
	TE: Release of "psychotherapy notes" as defined in 45 CFR 1 armation about diagnosis or treatment for alcohol/substance ally)			
	Yes, disclose HIV/AIDS information OR No.	, do NOT Disclose HI	V/AIDS information	
	Yes, disclose alcohol/drug abuse information OR	No, do NOT discl	ose alcohol/drug abuse information	
	s protected health information is disclosed for the followard. This disclosure is made at my request in compliar scription of legal proceeding Tort claim against Glouces.	nce with 45 CFR 164.5		
	Other (describe)			
	are authorized to release the foregoing records to the following ve-entitled matter who have agreed to pay reasonable charges			
	ervco Insurance Services, Inc. ne of Representative			
	rd Party Claims Administrator (duly appointed via GCI resentative Capacity (e.g., Attorney, Records Requestor, Ager			

3150 Brunswick Pike Street Address

<u>Lawrenceville, NJ 08648</u> City, State and Zip Code

This authorization does not apply to psychotherapy notes.

I acknowledge that I have the right to revoke this authorization, in writing, by sending written notification to you at the above-referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer to be protected under HIPAA privacy rules.

I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization, unless a condition set forth at 45 CFR 164.508(b)(4) applies.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

This a	authorization shall be in force and effect until:		
	Date:		
	Event (describe): dismissal or settlement of claim		
		Dated:	
Signat	rure of Patient or Personal Representative		
Name	of Patient or Personal Representative		
Descri	ption of Personal Representative's Authority to Sign for Patien	t (attach documents that show authority)	
		Dated:	
Witne	ss Signature		

Authorization and Request for Employment Records (Accident/Loss of Income)

TO:	Name of employee
	Address
	SSN:
You are hereby requested and authorized entities whose name and address is:	d to furnish to the following representatives of Gloucester County and its
Inservco Ins. Services, Inc. 3150 Brunswick Pike Lawrenceville, NJ 08648	
The information requested below, conce on:	erning my loss of wages or earnings as a result of an accident which occurred
Dated:	Employee
	Employee
Occupation and kind of work	
2. How long employed by you prior to o	date of accident
3. Average number of hours per day	
4. Average number of days per week	
5. Date stopped work	
6. Date returned to work	
7. Wages or earnings before date of acc	ident: Hourly rate \$
Average regular weekly pay \$; Average weekly overtime pay \$
8. Wages or earnings after date of accid	lent: Hourly rate \$
Average regular weekly pay \$; Average weekly overtime pay \$
9. If any wages or earnings were paid to	employee for period during which he/she was out:
a. How much was paid (total) \$b. for what periodc. nature of payment	
ADDITIONAL REMARKS:	
Dated:	By: Title:

Authorization and Request for Employment Records (History Status)

TO:	RE:
	Name of employee
	Address
	SSN:
You are hereby requested and authorized to furrentities whose name and address is:	nish to the following representatives of Gloucester County and its
Inservco Ins. Services, Inc. 3150 Brunswick Pike Lawrenceville, NJ 08648	
	er information you may have regarding my past or present going along with any other requested information. I would
Dated:	, Employee
ADDITIONAL DEMARKS.	
ADDITIONAL REMARKS:	
Dated:	By:
Dated.	Title: