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 Irvington.

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 Irvington
1 Civic Square
Irvington, New Jersey 07111

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 Irvington. 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 Borough.

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

“Persons” shall include in its meaning a partnership, joint venture, corporation, associations, trust or any other kind of entity, as well as a natural person.

“Public Entity” shall refer to the Township of Irvington along with any agent, official, or employee of the Township of Irvington 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.
NOTICE OF CLAIM FORM

Forward to:

1. Claimant:

   Last  First  Middle  Area Code/Telephone Number

   __________________________________________  _________________________

   Street Address  Additional Address

   __________________________  ____________________________

   Date of Birth  Social Security Number  City  State/Zip Code

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please complete this section.

   Name  Street Address

   __________________________________________

   Additional Address  City  State/Zip Code

   __________________________________________

   Area Code/Telephone Number  Relationship to Claimant

3. Accident:

   A. The occurrence or accident which gave rise to this claim:

   __________________________________________  ____________________________

   Date  Time
B. Describe the location or place of the accident or occurrence:

_________________________________________________________________

Exact Location of the Occurrence

C. Describe how the accident or occurrence happened. If a diagram will assist your explanation, please use the reverse side of this form.

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

D. State the name and address of the municipality(s) that you claim caused your damage.

_________________________________________________________________

E. State the names of the municipal employees whom you claim were at fault, including any information that will assist in identifying them.

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

F. State in detail each and every negligent or wrongful act of the municipality and the municipality’s employees which caused your damage.

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

G. State the name and address of all witnesses to the accident or occurrence.

_________________________________________________________________
_________________________________________________________________
H. If a vehicle accident, state the names, age, address, phone number, and relationship to you, of all passengers in your vehicle.

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

I. State the names of all police officers and police departments who investigated the accident.

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

4. Claim for damages:

A. Claim for damages: (Check appropriate box)

______Bodily Injury        _____Property Damage        _____Other

If other, explain___________________________________________________________

___________________________________________________________________

B. i. If you claim bodily injury – describe your injuries resulting from this accident or occurrence.

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

ii. Do you claim permanent disability resulting from this injury?

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
iii. For each hospital, doctor or other practitioner rendering treatment, examination or diagnostic service, please list:

Name of Hospital, Doctor or other Facility

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State/Zip Code</th>
</tr>
</thead>
</table>

Date of Treatment | Amount of Charges

Amount Paid if Payable by other sources, i.e., insurance.

iv. If you claim loss of wages or income as a result of the injury, state:

Name of Employer | Your Occupation

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State/Zip Code</th>
</tr>
</thead>
</table>

Date Employed at this Job | Rate of Pay

Dates of Absences from Work | Total Lost Wages to Date

If still out of work, expected date of return.

NOTE: If your claimed loss of income arises from self-employment or other wages, attach a calculation showing the basis of your calculation of lost income.

v. Set forth any and all other losses or damages claimed by you.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
C. If you claim property damage:

i. Describe the property damaged. If vehicle, include make, model, year, color, vehicle identification number, license plate number, state, and parts of vehicle damaged.

_____________________________________________________________________________________________________________

_____________________________________________________________________________________________________________

_____________________________________________________________________________________________________________

ii. The present location and time when the property can be inspected.

_____________________________________________________________________________________________________________

_____________________________________________________________________________________________________________

_____________________________________________________________________________________________________________

iii. Date property acquired ________________________________

iv. Cost of the property ________________________________

v. Value of property at time of accident ________________________________

vi. Description of damage:

_____________________________________________________________________________________________________________

_____________________________________________________________________________________________________________

_____________________________________________________________________________________________________________

vii. Has the damage been repaired?

_________ Yes ____________ No

If yes, by whom, and cost of repairs.

_____________________________________________________________________________________________________________

_____________________________________________________________________________________________________________

viii. Attach each estimate of repair costs to this form.
ix. Set forth in detail the loss claimed by you for property damage.

________________________________________________________________________

________________________________________________________________________

D. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

5. The amount of the claim ________________________________

6. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice?

_______ Yes  ________ No

If yes, set forth the names and address of all persons and the insurance companies against whom you have made such claims.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

7. Are any of the losses or expenses claimed herein covered by any policy of insurance?

_______ Yes  ________ No

For each such policy, state the name and address of the insurance company, policy number, and benefits paid or payable.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
8. Have you received or agreed to receive any money from anyone for damages claimed herein?

_______ Yes ________ No

If yes, set forth the details of such agreement.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

The following items must be submitted with this notice:

1. Copies of itemized bills for each medical expense and other losses and expenses claimed.

2. Full copies of all appraisals and estimates of property damage claimed by you.

3. Copies of all written reports of all expert witnesses and treating physicians.

4. A letter from your employer verifying your lost wages. If self-employed, a statement showing the calculation of your claimed lost income.

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statement made herein is willfully false or fraudulent, I am subject to punishment as provided by law.

____________________________________  ________________________________
Date                                      Claimant or person filing on behalf of claimant.

____________________________________
Print name as signed above.
AN ORDINANCE TO ADOPTING A TORT CLAIMS ACT NOTICE FORM
PURSUANT TO N.J.S.A. 59: 8-6

WHEREAS, the New Jersey Tort Claims Act, N.J.S.A. 59 authorizes a public entity, such as the Township of Irvington, to adopt a tort claim notice form to be completed by claimant seeking to file a claim in accordance with the Tort claims Act; and

WHEREAS, The Township of Irvington is a public entity covered by the revisions of the New Jersey Tort claims Act; and

WHEREAS, the Township of Irvington Counsel deems it advisable, necessary and in the public interest to adopt a Tort Claims Notice form.

NOW, THEREFORE, BE IT ORDAINED BY THE MUNICIPAL COUNCIL OF THE TOWNSHIP OF IRVINGTON as follows:

Section 1. The attached Tort Claims Action Notice form shall be and is hereby adopted as the official Tort Claims Notice form for the Township of Irvington.

Section 2. All persons making claims against the Township of Irvington, its officers, employees, agencies or departments, pursuant to the Notice of Tort Claim Act, N.J.S.A. 59: 1-1 et seq, are required to complete the form adopted by this Ordinance as a condition of compliance with the New Jersey Tort Claim Act notice requirement.

Section 3. Severability. If any provision of this Ordinance or the application of this Ordinance to any person or circumstances is found to be invalid for any reason by any Court of competent jurisdiction, such judgment shall be limited in its effect only to that portion of the Ordinance actually adjudged to be invalid, and the remaining portions of this Ordinance shall be deemed severable from and shall not be affected.

Section 4. Repealer. All Ordinances or parts of Ordinances or Resolutions inconsistent or in opposition to the provisions of this Ordinance are hereby repealed in their entirety.

Section 5. This ordinance shall become effective twenty (20) days after its final passage by the Municipal Council and approved by the Mayor in the time and manner prescribed by law.