INSTRUCTIONS: Fill in all blanks with ink or typewriter. Be specific. Give complete information and **attach all requested documentation** and any other information to substantiate your claim. **Statute of Limitations** is one year; if death involved, two years, The burden of proof rests with the claimant. Failure to provide complete information may result in dismissal of your claim. If requested information does not apply to your claim, fill in the blank with "N/A.." **ALL CLAIMS MUST BE SIGNED AND NOTARIZED** (see final page). Submit in triplicate to: **STATE BOARD OF ADJUSTMENT, ALABAMA STATE CAPITOL, MONTGOMERY, AL 36130-1435**.

Do not write in this space.

CLAIM NO.: _____

SUPPLEMENT NO.:_____

_____
(Name of Claimant)

For: _____
(Name of Minor if Applicable)

V. STATE OF ALABAMA

_____
(Name of Department/Agency)

If a SUPPLEMENT to a previously filed claim, give Claim No.: _____

1. **Name & Mailing Address of claimant:** _____

_____ ZIP: _____

Home Telephone: _____ Business Telephone: _____

Social Security/Federal I.D. No. (Required for issuance of state check): _____

If injured party is a minor (under 19 years of age), CLAIM MUST BE SIGNED AND FIELD BY PARENT OR GUARDIAN AS CLAIMANT. Give name and age of minor and the name and relationship of person with whom minor lives.

_____

2. **Claimant's Attorney** (if representing claimant on this claim) : _____

Mailing Address: _____

_____ ZIP: _____ Telephone: _____

Note: All correspondence will be with claimant's attorney.

3. **Date of accident or injury:** _____

4. **Was this an on-the-job injury?** **9** Yes **9** No

Did you receive any time off with pay? **9** Yes **9** No If yes, gives dates: _____

5. **If not an accident or injury, on what date did claim arise?** _____

6. **Where did injury or damage occur?** _____
(street address, highway number, building name, etc.)

7. **Statement of Facts:** Give the name of the department or agency of the state of Alabama involved. Tell in your own words exactly what happened to cause you to file this claim. **Attach a copy of accident/incident report.**

(A) State department/agency involved: _____

(B) Facts:_____

_____

_____

_____

_____

_____

_____

_____

_____

SECOND PAGE MUST BE COMPLETED

RECEIVED BY BOARD OF ADJUSTMENT

_____

8. **IS CLAIM MADE FOR:** (Complete only those parts which apply to this claim.)

(A) **UNINSURED MEDICAL EXPENSES?** **9** Yes **9** No

Amount: $ _____

Do you have insurance? **9** Yes **9** No Company: _____

All medical expenses must be submitted to your insurance company. **Attach documentation to support the amount claimed, such as itemized bills and insurance company statement(s) showing the expenses have been filed and the amount paid or payable by insurance.**

(B) **PERMANENT DISABILITY?** **9** Yes **9** No

Amount: $ _____

Describe: _____
Attach detailed statement by a doctor or vocational expert describing extent of disability.

Rate of pay at time of accident/injury: $ _____ **Attach verification from employer.**

(C) **LOST WAGES AND/OR COMPENSATION FOR LEAVE USED?** **9** Yes **9** No

Amount: $ _____ for _____hrs./days/week/etc.

Period (dates) for which claim is made: _____ Rate of pay at time of accident/injury: $ _____
Attach doctor's excuse for dates missed from work. Attach verification of dates and rate of pay from employer.

(D) **DAMAGES TO PERSONAL PROPERTY?** **9** Yes **9** No

Amount: $ _____
Attach bills, receipts, etc. to substantiate amount claimed. If automobile, attach two estimates of repair cost.

Describe property: _____
(Automobile, watch, eyeglasses, clothing, etc.)

Do you have insurance which would cover all or part of the damage? **9** Yes **9** No

If yes, give name of insurance company: _____

Amount of coverage: _____ Deductible: _____

Have you filed for coverage to which you are entitled under your policy? **9** Yes **9** No

(E) **MISCELLANEOUS/OTHER EXPENSES?** **9** Yes **9** No

Amount: $ _____

Explain: _____

_____

_____
Attach documentation to substantiate.

9. **TOTAL AMOUNT CLAIMED: $** _____
This amount must be stated.

10. No part of this claim has been assigned by me and no amount has been paid to or received by me in payment for any damages/injury complained of herein except as set out as follows: (List amounts received from insurance or any other sources.)

_____

11. Signature of claimant/representative: _____
Must bear original signature (not a machine copy) of claimant or his/her representative.

STATE OF _____

}

_____ COUNTY **AFFIDAVIT**

Before me, a Notary Public in and for said state and county, personally appeared _____, who being made known to me, and being informed of the contents of this petition and the statements by him/her therein, and being duly sworn, says such statements are true and correct.

Sworn and subscribed before me this _____ day of _____, 20_____.

_____
Signature and Seal of Notary Public