**Human Resources Office**
420 N 6th Street
P.O. Box 601
Rochelle, IL 61068
Tele: (815) 561-2054
Fax: (815) 561-3522

# CLAIM FORM

(PRINT CLEARLY OR TYPE)

DATE OF REPORT:_____

NAME OF CLAIMANT:_____

ADDRESS:_____

CONTACT NUMBER: HOME:_____CELL/OTHER:_____

EMAIL ADDRESS (OPTIONAL):_____

DATE OF INCIDENT:_____TIME:_____ AM / PM

LOCATION WHERE INCIDENT OCCURRED: (be specific with exact location):

_____

WHO WAS AFFECTED:_____

WHAT PROPERTY WAS DAMAGED:_____

_____

PROPERTY OWNED BY:_____

OWNER CONTACT INFO:_____

NAME ALL WITNESSES TO INCIDENT:_____

_____

_____

***(ATTACH COPIES OF ALL REPORTS AND/OR DOCUMENTS RELATING TO THIS CLAIM: PHOTOGRAPHS, BILLS, INVOICES AND/OR INSURANCE CLAIMS)***

**DESCRIPTION** (step-by-step, describe actions, conditions, and decisions that led up to incident.)

DESCRIPTION OF INCICENT:_____

_____

_____

_____

_____

HAVE YOU SUFFERED ANY PHYSICAL INJURIES AS A RESULT OF THIS INCIDENT: _____ YES _____ NO - IF YES, PLEASE DESCRIBE YOUR INJURIES:_____

_____

_____

_____

HAVE YOU RECEIVED ANY MEDICAL TREATMENT FOR YOUR INJURIES:

_____ YES _____NO - IF YES, PLEASE DESCRIBE THE MEDICAL TREATMENT RECEIVED INCLUDING THE DATE(S), LOCATION(S), AND PHYSICIAN(S) WHO PROVIDED THIS TREATMENT: (Add additional pages as needed)

_____

_____

_____

_____

HAVE YOU MADE A CLAIM AGAINST ANY OTHER PERSON OR ENTITY FOR THIS INCIDENT: _____ YES _____ NO

IF YES, STATE THE NAME, ADDRESS AND CONTACT NUMBER OF THAT PERSON OR ENTITY:_____

_____

_____

_____

HAVE YOU SUBMITTED THIS CLAIM TO ANY INSURANCE COMPANY:

_____ YES _____ NO - IF YES, STATE THE NAME, ADDRESS AND CONTACT NUMBER OF THE INSURANCE COMPANY:_____

_____

_____

_____

COMPLETED BY:_____ DATE:_____

*SIGNATURE*

***INTERNAL USE ONLY:*** DATE RECEIVED:_____RECEIVED BY:_____

DEPARTMENT NOTIFIED:_____ SUBMITTED TO INSURANCE:_____