BOROUGH
OF
NEW PROVIDENCE
ORDINANCE NO. 2022-07

AN ORDINANCE ADOPTING A FORM OF NOTICE OF CLAIM PURSUANT TO N.J.S.A. 59:8-6

WHEREAS, New Jersey Tort Claims Act, N.J.S.A. 59:8-3, states that no action may be brought against a public entity or public employee unless the claim upon which it is based has been presented in accordance with the procedures set forth in said Act; and

WHEREAS, the Act further provides at N.J.S.A. 59:8-6 that a public entity may, by rule or regulation, adopt forms specifying information to be provided in claims filed against it or its employee(s) under the Act; and

WHEREAS, the Borough Council determines that it would be in the best interests of the Borough to require detail of any claim being submitted against the Borough or a Borough employee;

NOW, THEREFORE, BE IT ORDAINED by the Mayor and Council of the Borough of New Providence, County of Union, State of New Jersey that it adopts the Notice of Claim for Damages in the form as attached hereto as Exhibit A and any individual or entity making a claim against the Borough or a Borough employee shall be required to complete such form or their claim may be barred pursuant to the New Jersey Tort Act, N.J.S.A. 59:1-1, et seq.

This Ordinance shall take effect upon final passage and publication in accordance with New Jersey law.

INTRODUCTION: June 28, 2022
PUBLIC HEARING: July 19, 2022
ADOPTION: July 19, 2022

BOROUGH OF NEW PROVIDENCE
COUNTY OF UNIONSTATE
OF NEW JERSEY

_____
Allen Morgan, Mayor

ATTEST:

_____

Wendi B. Barry, Borough Clerk

BOROUGH OF
NEW PROVIDENCE
SETTLED IN 1720

NOTICE OF CLAIM FOR DAMAGES AGAINST THE BOROUGH OF NEW PROVIDENCE

FOR AND TO: Borough of New Providence
360 Elkwood Avenue
New Providence, NJ 07974

DATE OF CLAIM: _____

NOTE: THIS CLAIM FORM MUST BE FILED WITHIN 90 DAYS OF THE ACCIDENT/INCIDENT/OCCURRENCE OR YOUR CLAIM MAY BE BARRED BY THE NEW JERSEY TORT CLAIM ACT, N.J.S.A. 59:1-1, et seq.

1. CLAIMANT:

_____ _____
Last Name First MI Date of Birth

_____
Street Address

_____ _____
City State Zip Code Social Security Number

If notice and correspondence in connection with this claim are to be sent to a person other than claimant, complete item #2.

2. _____
Name

_____
Mailing Address City State Zip Code

Relationship to claim: Attorney ( ) or _____
Explain Relationship

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

_____ _____
Date Time

3(a) If you allege dangerous conditions contributed to your injury or damages, indicate exact location of said condition with referenced to fixed objects by drawing a diagram.

_____ _____
Municipality Exact Location of Occurrence

3(b) Draw a diagram (in space provided) showing the street plan at the location of the accident/occurrence. Label each street and show the direction of travel of each vehicle before and after contact.

3(c) Describe how the accident or occurrence happened. If a diagram will assist your explanation, please use the above diagram.

3(d) State the name and address of the Borough agency or agencies which you claim caused your damages.

3(e) State any names of Borough employees who you claim were at fault, including any information that will assist in identifying and locating the.

3(f) State the negligence or wrongful acts of the Borough and Borough employees which caused your damages.

_____

_____

_____

_____

3(g) State the name and address of all witnesses to the accident/occurrence.

_____

_____

_____

_____

3(h) State the names of all police officers and police departments who investigated the accident/occurrence.

_____

_____

_____

_____

3(i) Submit a copy of the police report or complaint number.

_____

4. Claim for Damages (check appropriate block)

( ) Personal Injury ( ) Property Damage

( ) Other - Explain in detail: _____

_____

_____

_____

4(a) If you claim personal injury:

I. Describe your injuries resulting from this accident/occurrence.

_____

_____

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

( ) Yes ( ) No

If yes, describe the injuries believed to be permanent.

_____

_____

III. For each hospital, doctor or other practitioner rendering treatment, examination or diagnostic service, state:

Name of Hospital, Doctor or Facility	Address	Date of Treatment/ Services	Amount Charged To Date	Amount Paid by Insurance

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

_____ _____

Name of Employer Address of Employer

_____ _____

Your Occupation Date Employed at this Job

_____ _____

Rate of Pay Dates of Absence from Work

_____ _____

Total Lost Wages to Date If still out of work, expected return date

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

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

_____

_____

_____

5(a) If you claim property damage:

I. Describe the property damaged:

_____

_____

_____

II. The present location and time when the property may be inspected.

_____

III. Date property acquired: _____

IV. Cost of property: $_____

V. Value of property at time of accident: $_____

VI. Description of damage: _____

_____

_____

VII. Has damage been repaired? ( ) Yes ( ) No. If yes, by whom, when and what was the cost of the repairs?

_____

_____

VIII. Attach each estimate of repair costs.

IX. Set forth in detail the loss claimed by you for property damage.

_____

_____

6. If you claim vehicle damage:

Description of your vehicle involved in accident.

Year _____ Make _____ Model_____ License Plate No. _____

Driver's Name_____ License No._____

Address_____ City _____State _____ Zip Code _____

Owner's Name and Address_____

Insurance Co. _____ Policy No. _____

Insurance Co. Address _____

Damage to Vehicle _____

6(a) Set forth in detail all the other items of loss of damages claimed by you and the method by which you made calculation.

_____

_____

_____

_____

6(b) Amount Claimed $_____

7. 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 addresses of all persons and insurance companies against whom you have made such claims.

_____

_____

_____

8. 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.

_____

_____

_____

9 **THE FOLLOWING ITEMS MUST BE SUBMITTED WITH THIS NOTICE OF CLAIM:**

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

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

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

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

I HEREBY CERTIFY THAT THE FOREGOING STATEMENTS MADE BY ME A 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 WILFULLY FALSE OR FRADULENT, I WILL BE SUBJECT TO PUNISHMENT AS PROVIDED BY LAW.

Dated: _____

_____
Claimant of person filing claim on behalf of claimant

PLEASE BE ADVISED THAT IN ORDER FOR YOUR CLAIM TO BE CONSIDERED, YOU MUST ALSO COMPLETE AND SIGN THE ATTACHED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION FORM AS TO EACH MEDICAL PROVIDER MENTIONED IN THIS CLAIM FORM.