

# NOTICE OF TORT

## For Damage or Injury

**ATTENTION:**

This form is to be completed by the claimant and is a requirement that if used, be presented to and filed with the clerk or secretary of the public entity involved. This form is being provided as a courtesy to assist you in filing your claim. Providing this form to you, is not an admission nor shall it be construed to be an admission of liability or an acknowledgement of the validity of a claim by the political subdivision. Legal requirements for filing claims can be found in the Idaho Code: Title 6, Chapter 9. All claims must be filed promptly and in writing.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Address for the Six Months Prior to the Date of the Damage or Injury Occurred: \_\_\_\_\_

Home Number: ( ) \_\_\_\_\_ Work Number: ( ) \_\_\_\_\_

Date of Incident: \_\_\_\_\_ Time: \_\_\_\_\_ A.M. or P.M.

Location of Occurrence: \_\_\_\_\_

Injuries that Resulted: \_\_\_\_\_

**Provide a Description of What Happened:**

(Please attach any additional information you deem necessary)

I hereby certify that I have read the above information and it is true and correct to the best of my knowledge.

I hereby make a claim against \_\_\_\_\_,  
(a public entity)

for \_\_\_\_\_ in the amount of \_\_\_\_\_  
(damage, injury, etc.)

If you were injured and you are on medicare/medicaid, please fill out the following as required by 42 U.S. C. 1395.

Date of Birth \_\_\_\_\_

SSN \_\_\_\_\_

Medicare/Medicaid Number \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_